

Minute Man

Minute Man
National Historical Park
Massachusetts

National Park Service
U.S. Department of the Interior



The Battle Road has undergone many changes in the two centuries since the fight. The Nelson Road section shown here

has a dirt and clay surface that represents the original surface of the entire road.



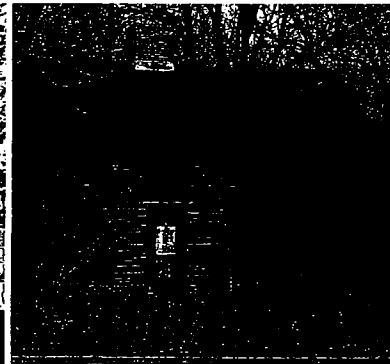
Hartwell Tavern (a 1775 building with later additions) was a typical country inn of the period. The British marched proudly

by on their way to Concord, but returned under heavy fire.



Nearly a million visitors a year cross the North Bridge. After the historic bridge was removed in 1793, the site stood

empty until a commemorative bridge was built in 1875. The current bridge was built in 1956.



The Meriam House, at Meriam's Corner, is one of the oldest houses in Concord. The shots exchanged here between

the British and the provincial militia began the fighting that continued for 16 miles.



The Wayside, home to the Hawthornes and one of five National Historic Landmarks in Concord, represents the mid-19th

century American literary renaissance. It became part of Minute Man National Historical Park in 1965.

Where the Revolution Began

It was a curious field of battle for the opening of the Revolution: 20 miles of winding, hilly road connecting a port city and several country towns. But word of the fighting on Lexington Common, at Concord Bridge, and on the road to Boston raced throughout the American colonies to unite men and women behind the patriot cause. What had begun as a struggle between British authorities, determined to enforce the will of Parliament, and the people of Massachusetts, just as determined to retain their rights as Eng-

lish citizens, soon escalated into a war for independence which lasted more than eight years. Much of that country road is now an urban highway, but the Battle Road still follows generally the same route, passing the sites of the bitterest fighting and the buildings that stood nearby, helping recall the dramatic events of April 19, 1775

Many visitors begin their tour with the film and map program at the Battle Road Interpretive Center.

Following the Battle Road



The North Bridge Area
The North Bridge, where the "shot heard 'round the world" was fired, was the site of the first effective forcible resistance to British rule in America. Visitors can cross the North Bridge and see the Minute Man statue. The North Bridge Visitor Center overlooks the site.

The Wayside
Samuel Whitney, muster master for the Concord militia, lived in the Wayside during the Revolution. The house later was the home of literary figures and reformers, in-

cluding the Hawthornes, Alcotts, and Lothrop.

Meriam's Corner
The Meriam House and barn gave cover to the militia, allowing them to get close to the British column as it crossed the narrow bridge there. The shots exchanged between the colonists and the British rear guard opened the running battle on the road to Boston.

Hardy's Hill
North from Sudbury and towns to the south joined the fighting at Hardy's Hill, where the British

were subjected to fire from both flanks.

Bloody Angles
The Battle Road made two sharp turns after Hardy's Hill, providing ambush points for the Woburn militia and others. The British, exposed to a murderous crossfire, lost eight dead—thus the name "The Bloody Angle." Here they realized how desperate was their situation.

Hartwell Tavern
In 1754 Ephraim Hartwell opened a part of his home as a tavern, where travel-

ers were provided bed and board. It was also a popular gathering place for local people.

Capt. William Smith House
This restored 18th-century house, typical of its period, was the home of the Captain of the Lincoln minute men

Paul Revere Capture Site
Paul Revere, Dr. Samuel Prescott, and William Dawes were confronted by a British patrol as they rode to warn Concord of the approaching British column. Revere was cap-

tured and Dawes was forced back to Lexington, but Prescott escaped to carry word of the British march to Concord.

The Bluff
A small rocky hill along the Battle Road presented a significant obstacle to the British while it was held by the colonials. The column appeared trapped until Major Pitcairn sent a detachment to occupy the high ground while the column moved past and reformed.

Fiske I Site
The area around the



house of Ebenezer Fiske was the scene of intense, close-quarter fighting, as British flankers tried to flush out the concealed ambushers. The historical park ends here, but the fighting continued on through Lexington, Menotomy (present-day Arlington), and Cambridge until the British reached Bunker Hill.

The Minute Man statue
was sculpted by Daniel Chester French to memorialize the citizen-soldier of 1775. It was unveiled for the Centennial of the North Bridge fight.

About the Park

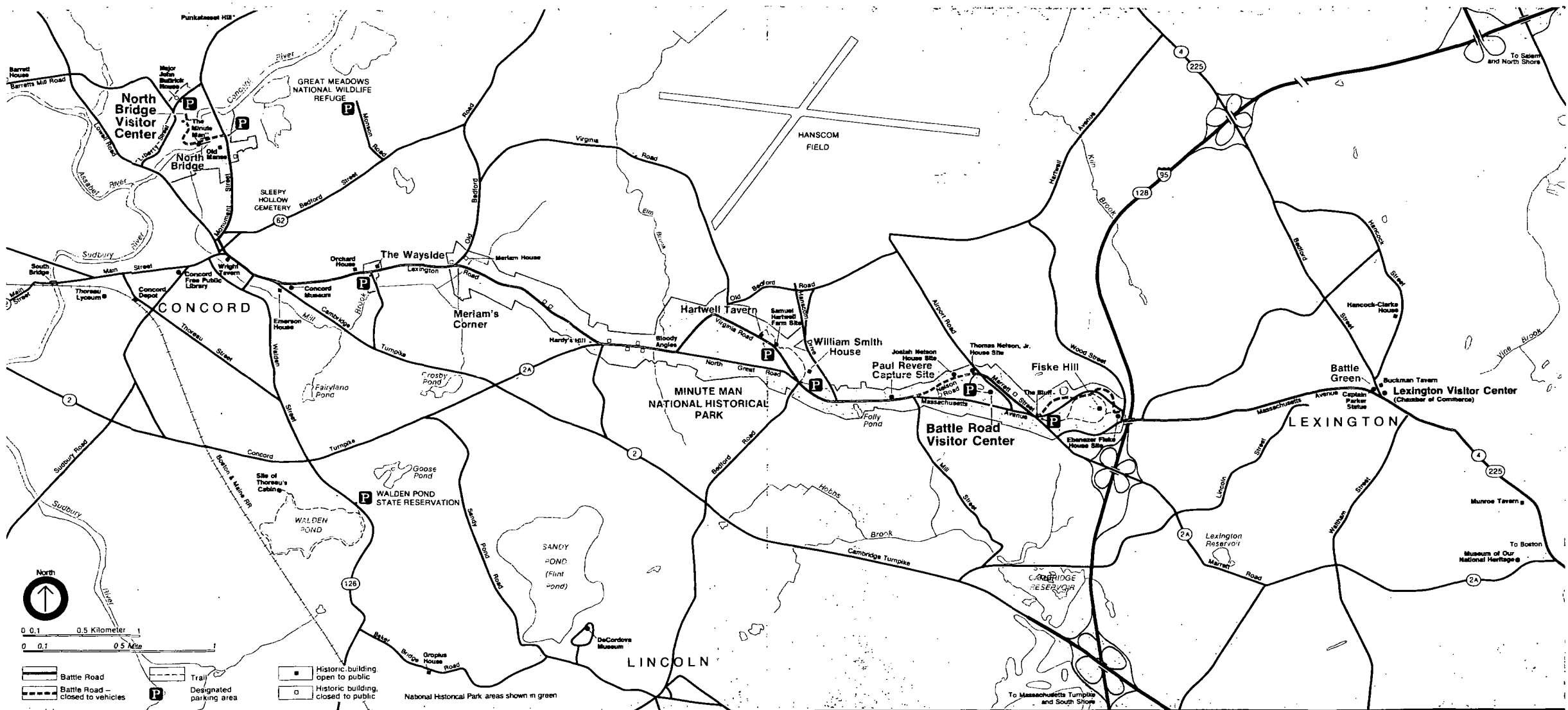
For Your Safety
The Battle Road, not a park-owned road, carries heavy traffic in many areas. It may not be safe to slow down and sight-see.

Please respect the rights of private families living within the park boundary.

The protection of historic and natural resources within the park is a primary concern. It is unlawful to excavate, remove, disturb, deface, or destroy any structure, exhibit, artifact, animal, or plant life.

The park has instituted a "Park Watch" program to protect park resources and to provide for a safer environment for our visitors. You can help by reporting any criminal activity or safety hazard to park rangers at: (508) 369-6993.

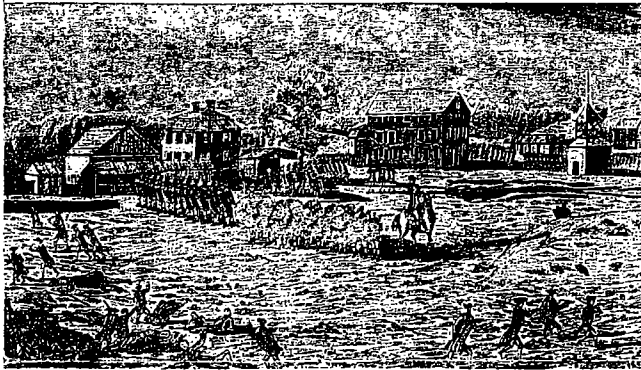
Administration
Minute Man National Historical Park is administered by the National Park Service, U.S. Department of the Interior. A superintendent, whose address is Box 160, Concord, MA 01742, is in immediate charge of the park.



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Two weeks after Lexington and Concord, militia-
man and artist Ralph Earl
sketched the events of
April 19 from eyewitness

accounts. Amos Doo-
little's engravings of the
drawings are the most re-
liable depiction of the
fighting. On Lexington

Common British soldiers
fired at American militia-
men in the first hostile
action of the American
Revolution.



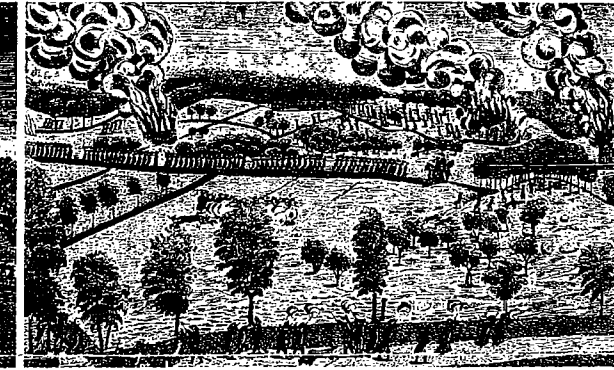
Colonel Smith and Major
Pitcairn watched as
British troops searched
Concord door-to-door for
provincial arms stores,

which they burned or
threw into the town pond.



The first real engagement
of the day took place at
North Bridge outside
Concord, where the Brit-
ish withdrew across the

bridge and were driven
back into Concord by
rebel militia.



Colonel Smith's troops
(far right), retreating un-
der American fire (fore-
ground), were met and
saved by General Percy's

reinforcements, who fired
three Lexington homes
and scattered Americans
with cannon fire.

Connecticut Historical Society

In Service of the King



1 Yale Center for British Art,
Paul Mellon Collection



2 Lexington Historical Society



Thomas Gage (1), Com-
mander in Chief of the
British Army in America
and Governor General of
Massachusetts, knew
conflict was inevitable.
"The first stroke will de-
cide a good deal," he told
London. Maj. John Pit-
cairn (2), a respected of-
ficer, was appalled at the
uncontrolled firing by
British soldiers. Lt. Col.
Francis Smith (3) headed
the expedition. Though
experienced, he was slow
and deliberate — a disad-
vantage in a surprise op-
eration. Lord Percy (4),
general of the rescue bri-
gade, countered Ameri-
can tactics with artillery
and saved the British col-
umn from annihilation.

The American Resistance



1 Museum of Fine Arts, Boston



Paul Revere (1), a propa-
gandist and courier for
the Committee of Corre-
spondence, rode to warn
provincial leaders that the
British were marching.
Dr. Joseph Warren (2)
was an orator and fighter
who encouraged militia
with the words: "They
have begun it — we will
end it." Patriot firebrand
Samuel Adams (3) hoped
the fighting in Massachu-
setts would spur other
colonies to take up arms.

"A People Armed and Numerous"



Art by Louis Glanzman

To British soldiers trained
in formal European war-
fare, the militias' tactics
were cowardly and undis-
ciplined, but British Gen-
eral Percy recognized
that their "irregular" at-
tacks were carried out
with "perseverance and
resolution." The militias'
preference for individual
firing from behind cover
nullified the British tactic
of close-range volleys at
opposing ranks followed
by a bayonet charge.



The smoothbore musket
was a reliable but heavy-
rate weapon that a trained
soldier could fire four
times a minute.

The Public Reaction



The Provincial Congress's
official narrative of the
day's events exaggerated
British atrocities and
American helplessness.
The account was sped by
couriers to newspapers
along the coast which
further embellished the
story. The *Salem Gazette*
broadside, complete with
coffins, was typical. As a
propaganda tool, the re-
port was highly success-
ful. Colony after colony,
enraged by the "car-
nage," called up mil-
itia and prepared to fight.
In England, the Whig op-
position also profited,
lampooning the King's
army in widely circulated
cartoons.

The discontent smoldering in the American colonies under British rule flared into open hostilities on April 19, 1775. On a stretch of country road outside Boston, a prolonged skirmish between 3,500 colonial militiamen and 1,700 of His Majesty's redcoats opened the American Revolution. The initial fighting in the war was a local action between Britain and her recalcitrant colony of Massachusetts. The government had clamped down in reaction to the colony's resistance to the Mother Country's economic policies. For a year a British army, under Gen. Thomas Gage, had occupied Boston. Pressed by the ministry in London to quell rebellion by arresting the rabble-rousers Samuel Adams and John Hancock, Gage chose instead to take what he thought was the less inflammatory step of confiscating the patriots' arms supply in Concord. But incompetence and miscalculation doomed what he meant to be a limited, routine operation. Gage depended on secrecy to seize the arms before the people of Concord could resist, but Boston knew of the operation before his troops left, and the arms at Concord were soon hidden. Couriers Paul Revere and William Dawes notified Adams and Hancock in Lexington that the British were on their way. Mixups delayed the British departure for hours, giving the colonists more time to prepare. Finally, the local militia and minute men were not the contemptible, undisciplined mob Gage took them to be. They had trained for months and had well-rehearsed plans for immediate reaction to a British incursion.

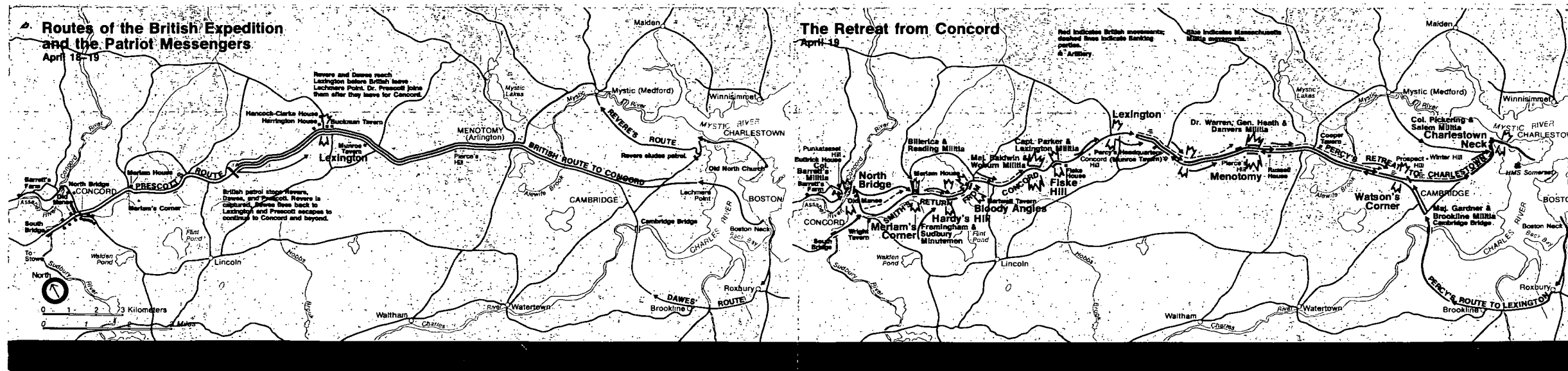
Gage gave command of the British troops to Lt. Col. Francis Smith, a ponderous, tactically unimaginative officer who slowed an already delayed operation. By the time Smith's advance troops under Maj. John Pitcairn arrived in Lexington it was dawn and Capt. John Parker had his militia lined up on Lexington Common. Because he had only 77 men, Parker had no thought of impeding the 700 British soldiers. He wanted to make a display of patriot resolve. But as the militiamen slowly obeyed Pitcairn's order to disperse, a shot was fired—it is not clear from which side—and the green British soldiers, ignoring orders to stop, began firing at will at the fleeing Americans. When Pitcairn and Smith regained control, eight Americans lay dead. As the British troops continued down the road to Concord, news of the shooting spread to neighboring communities, and militiamen flocked to the British line of march between Boston and Concord.

At Concord, British soldiers began searching house-to-house for arms. Smith sent seven companies across the North Bridge to seize the supplies hidden at Col. James Barrett's farm. The militiamen who had fallen back to Punkatasset Hill advanced on the three companies left to guard the bridge. As the militia approached, they saw the smoke of burning military supplies rising from town. Fearing that their homes were being put to the torch, they set out to save them. After the British withdrew across the bridge the colonials continued to advance until the British

fired a volley. Major Buttrick of Concord then gave the order, "Fire, fellow soldiers, for God's sake, fire!", and for the first time Americans fired a volley into the ranks of British soldiers. The British, outnumbered four to one and with half of their officers wounded, retreated to the center of town. The troops returning from Barrett's farm were allowed to march by unharrassed. After pausing about two hours to regroup and feed his troops, Smith began the march to Boston. Flankers moved along the mile-long ridge on the left that separated the column from the colonials. At Meriam's Corner, where the ridge ended, the flankers had to be drawn in to cross the narrow bridge, and the militia, reinforced by companies from towns to the north, gathered near the road, taking cover where they could. Here began the running skirmish which continued to Boston. The British encountered heavy, unrelenting fire from the hundreds of militiamen behind building, wall, and tree, but the range was too great for the muskets to do much damage, and the British escaped with relatively few injuries.

Having attacked a British column, the Americans had committed themselves. From this point on, the British ranks had to run a gauntlet of colonial fire. Already there seemed to be a musket behind every tree, and fresh militiamen were pouring in from towns like Reading, Salem, and Lexington. Luckily for the British, the Americans were far enough from the road most of the day that few of the thousands of bullets fired found their

mark. When the flanking parties could operate, most of the militiamen were driven out of range. But British soldiers fell steadily at every hill or curve where the Americans had position. After the column had passed one spot, the militiamen would cut across country and be ready for them farther up the road. Exhausted and near panic, the British troops staggered into Lexington at about 2:30, where they were met at last by 1,000 reinforcements under Lord Percy. Under cover of artillery, the British rested briefly before starting the final retreat to Boston. Percy knew that his troops were in danger of annihilation unless they kept moving. The worst fighting occurred on the road into Menotomy (now Arlington), where over 5,000 men were involved and both sides lost more men than in any other fighting along the road. After escaping Menotomy, Percy had to use cannon several times to scatter the Americans concentrated at his rear. That was probably the edge that allowed him to make it across Charlestown Neck after nightfall to the safety of Bunker Hill, where he was protected by the guns of HMS *Somerset* in Boston Harbor. But he had lost 73 dead and 174 wounded, with 26 missing. The American losses were 49 dead, 40 wounded, and 5 missing. Soon after, Boston was under siege and Gage was reduced from governor to a general of forces occupying one city. The performance of the militia that day convinced Percy that this rebellion ran deeper than he or the ministry had suspected. The Americans were indeed prepared to fight for their rights.





OJDP

Shay Bilchik, Administrator

March 1997

JUVENILE JUSTICE BULLETIN

Child Development—Community Policing: Partnership in a Climate of Violence

Steven Marans, M.S.W., Ph.D.
Miriam Berkman, J.D., M.S.W.

The New Haven Department of Police Services and the Child Study Center at the Yale University School of Medicine have developed a unique collaborative program to address the psychological impact of the chronic exposure to community violence on children and families. The Child Development—Community Policing (CD-CP) program brings police officers and mental health professionals together to provide each other with training, consultation, and support, and to provide direct interdisciplinary intervention to children who are victims, witnesses, or perpetrators of violent crime. The New Haven program serves as a national model for police-mental health partnerships across the country.

Children's Exposure to Violence

The experience of victimization by violence is far too common among children in America, as evidenced below:

- ◆ In 1994, almost 2.6 million youth ages 12 to 17 were victims of crime—simple and aggravated assaults, rape, and robbery (Bureau of Justice Statistics, "National Crime Victimization Survey." Unpublished table.).
- ◆ In 1994, an estimated 3.1 million children were reported to public welfare agencies for abuse or neglect. More than 1 million of those children were

substantiated as victims (Wiese and Dara, 1995).

- ◆ Homicide is the leading cause of death among African American males ages 15 to 24 (Hawkins, Crosby, and Hammett, 1994).
- ◆ A survey of inner-city high school students revealed that 45 percent had been threatened with a gun, or shot at, and one in three had been beaten up on their way to school (Sheley and Wright, 1993).

In addition, an alarming number of children who are not the direct victims of physical assault become potential psychological casualties as they witness violence both at home and in the broader community. For example:

- ◆ In a study conducted at Boston City Hospital, 1 out of every 10 children seen in their primary care clinic had witnessed a shooting or a stabbing before the age of 6—50 percent in the home and 50 percent in the streets. The average age of these children was 2.7 years (Taylor et al., 1992).
- ◆ In a study of New Haven 6th, 8th, and 10th grade students, 40 percent reported witnessing at least one violent crime in the previous year (New Haven Public Schools, 1992).
- ◆ In a survey of fifth and sixth grade students in Washington, D.C., 31 percent reported having witnessed a shooting;

From the Administrator

Too many of our Nation's children are falling victim to pervasive violence. Even young people who do not bear the physical scars of domestic and societal violence are often emotional casualties.

The tragic consequences to children of chronic exposure to violence are considerable. They include depression, anxiety, stress, and anger. Alcohol abuse, academic failure, and the increased likelihood of acting out in a violent manner are part of the costly legacy left by a climate of violence.

With the support of the Office of Juvenile Justice and Delinquency Prevention, the New Haven Department of Police Services and the Yale University Child Study Center have established a program that addresses the adverse impact of continuing exposure to violence on children and their families, and attempts to interrupt the cycle of violence impacting so many of our children.

Reflecting New Haven's commendable commitment to community policing, the Child Development—Community Policing Program brings law enforcement and mental health professionals together to help children who are victims, witnesses, and even perpetrators of violent acts.

I am pleased to present this promising model of professional partnership for your consideration.

Shay Bilchik
Administrator

17 percent had witnessed a murder; and 23 percent had seen a dead body (Richters and Martinez, 1993).

- ◆ Among males in some high schools as many as 21 percent reported seeing a person sexually assaulted; 82 percent had witnessed a beating or mugging in school; 46 percent had seen a person attacked or stabbed with a knife; and 62 percent had witnessed a shooting (Singer et al., 1995).

Children's exposure to violence and maltreatment is significantly associated with increased depression, anxiety, post-traumatic stress, anger, greater alcohol use, and lower school attainment (Garbarino et al., 1992; Martinez and Richters, 1993; Singer et al., 1995; Cicchetti and Carlson, 1989).

Richters and Martinez (1993) produced substantial evidence that parents tend to significantly underestimate their children's exposure to community violence as well as associated stress symptoms. Recognition of and verbal dialog regarding children's experience with violent events were seen as the most likely ways to mitigate the formation of stress symptoms.

Youth who are repeatedly exposed to multiple risk factors—for example, socially isolated, impoverished, violence-ridden neighborhoods—require the most “intensive integrated, sustained, coordinated, and comprehensive intervention” according to the recommendations of a consensus of professionals in the field (Carnegie Council on Adolescent Development, 1992a; Citizens Committee for Children, 1993; Greene, 1996; Palmer, 1983; Schorr, 1989).

In addition, as indicated by the following figures, children who experience violence either as victims or as witnesses are at increased risk of becoming violent themselves:

- ◆ In an OJJDP-funded study of children in Rochester, New York, children who had been victims of violence within their families were 24 percent more likely to report violent behavior as adolescents than those who had not been maltreated in childhood. Adolescents who were not themselves victimized but who had grown up in families where partner violence occurred were 21 percent more likely to report violent delinquency than those not so exposed.

Overall, children exposed to multiple forms of family violence reported twice the rate of youth violence as those from nonviolent families (Thornberry, 1994).

- ◆ In a survey of 30 incarcerated delinquent adolescents in Connecticut, 83 percent reported previously witnessing a shooting, 67 percent reported witnessing a stabbing, and 53 percent reported witnessing a killing. Sixty-three percent of the respondents reported having been shot at and 50 percent reported having been stabbed (Vitulano et al., 1996).
- ◆ In a survey of New York City's juvenile detention facility, 79 percent had seen a person stabbed or shot; 58 percent had a family member who had been shot or stabbed; and 38 percent had been shot or stabbed themselves (City of New York, 1993).

These children are of particular concern to law enforcement as they perpetuate the cycle of violence into the next generation.

Police officers, as the first responders on scenes of violence and tragedy, have frequent contact with the children and families most at risk as a result of their exposure to violence. However, officers ordinarily do not have the training, the practical support, or the time to deal effectively with the psychological aftermath of children's experiences with violence. While mental health professionals may be equipped to intervene to ameliorate the psychological consequences of children's exposure to violence, traditional, clinic-based therapists often have no opportunity to treat these children until months or years later, when they are presented with entrenched symptoms such as school failure or dangerous, disruptive, and violent behavior. The CD-CP program, developed in New Haven, Connecticut, brings police and mental health professionals together to develop new, collaborative approaches to problems that are beyond the reach of either profession when working in isolation. This opportunity is especially clear in the context of the New Haven model of community policing, which places officers on permanent assignment in neighborhoods, expands their role in building relationships with community residents, and encourages their regular contact with children and families in a range of nonconfrontational settings.

Community Police Responses

At best, police can provide children and families with a sense of security and safety through rapid, authoritative, and effective responses at times of danger. Often, however, children's contacts with police officers arouse more negative feelings. For example, the arrival of officers after a violent event can reinforce a child's sense of being unprotected and the feeling that those in charge provide too little, too late. For many children, particularly those in impoverished inner cities, the police are seen as representatives of a dominant, insensitive culture and quickly become targets of children's anger toward a hostile and uncaring society.

Community policing provides officers with opportunities to minimize these negative experiences and instead offer children positive models for identification. Police officers who take on a consistent, authoritative presence in their neighborhoods are potential heroes for young people for whom there are all too few prosocial adult models. As community policing places individual officers on long-term assignments in specific neighborhoods and encourages them to work with community residents to analyze and solve problems before they erupt in lethal violence, children and families come in contact with officers in a wide variety of helping roles well beyond the context of such traditional police functions as making arrests or executing search warrants. As community policing integrates officers within their communities they become known as individuals, rather than by role, and they come to know the people they serve as individuals. These strategies allow officers to develop relationships and assume roles in children's lives that would not be possible in a more impersonal, incident-driven policing system.

For example, following a child's exposure to a serious incident of violence, regular contact with a familiar beat officer can serve to increase the child's sense of security, provide a prosocial adult model for identification, and support the child's family to obtain needed mental health or other social services. Similarly, regular, nonconfrontational contact with a neighborhood officer may help some young delinquents to control their impulses to engage in criminal activity and to abide by court-imposed restrictions. As figures of authority, police officers are also in a position to broker services for families

and to coordinate the responses of other institutions. The assumption of such expanded roles in the lives of children also imposes new burdens on police officers and requires new modes of training and operational support.

The CD-CP program reflects and contributes to a more general change in the approach to policing in New Haven. In this model of community policing, the establishment and maintenance of relationships between community-based officers and community residents is of central importance. As New Haven officers have become part of the social landscape of the neighborhoods they serve, they no longer represent an anonymous target for the pent-up frustration and rage felt by underserved and disadvantaged community residents. Consequently, both the physical risk to officers and officers' feelings of apprehension in the community have diminished.

The central focus on relationships between police and community members has also resulted in other markers of law enforcement success. When officers know the community, they recognize that the majority of citizens are law abiding and represent potential partners for a better neighborhood. This frees officers to focus more effective enforcement efforts on the small number of career and violent offenders. For example, after the 1991 inception of community-based policing in New Haven, four major drug gangs were targeted by a joint Federal/State task force on drug enforcement. Relationships between community patrol officers and residents in neighborhoods most affected by drugs and associated violence led to extensive intelligence that was invaluable to the effective Federal prosecution and long-term incarceration of high-level leaders in all four gangs. Similarly, the New Haven police focus on personal relationships as the core of community policing has resulted in a 95-percent closure rate of all homicide investigations.

Collaborative Responses

The CD-CP program is a partnership that developed out of the shared concerns of New Haven police and mental health professionals regarding the experiences of children and adolescents exposed to and involved in community violence. The program aims to coordinate the efforts of community police officers and mental health clinicians to reduce the

psychological burdens of violence on children and families, community members, and mental health professionals themselves. The CD-CP program is closely related to and dependent on the reorientation of the New Haven police to a community-based policing philosophy. Through the application of principles of child development and human functioning to the daily work of neighborhood police officers, the program provides officers with an expanded frame of reference and more varied options for intervening in the lives of children and families exposed to violence. Similarly, through a reorientation of the traditional relationships between mental health clinicians and police professionals, the program extends the roles that mental health clinicians play in the lives of the same children and families (Marans and Cohen, 1993; Marans et al., 1995; Marans, Berkman, and Cohen, 1996).

The CD-CP program has become a foundation for officers to broaden their roles as problem solvers. The process of consultation and collaboration with mental health and allied professionals breaks down barriers to the idea that complex problems require multiple solutions that involve new partners. As the burden and problem-solving tasks are shared, officers experience a greater sense of effectiveness and are increasingly able to sustain their engagement in the lives of children. When problems can be assessed in the context of the CD-CP partnership, intervention can not only take place in a more timely fashion but also without the fragmentation of services that so often leads to a squandering of limited resources.

Program Outline

The CD-CP program model consists of interrelated training and consultative components that aim at sharing knowledge and developing ongoing collegial relationships between police officers and mental health professionals.

1. Child Development Fellowships for Police Supervisors

Child Development Fellowships help provide supervisory officers with the special psychological expertise they need to lead a cohesive team of community-based officers in a wide variety of crime prevention, early intervention, and relationship-building activities involving children, families, and community agencies in their individual neighborhoods. Child Development Fellows spend 3 to 4 hours per week

over the course of 3 to 4 months in the Child Study Center. Fellows participate in a range of activities and observations that familiarize them with developmental concepts, patterns of psychological disturbance, methods of clinical intervention, and settings for treatment and care. Police supervisors involved in the fellowship also provide basic knowledge about police practice to their mental health colleagues. A major goal of the fellowship is to establish relationships between the fellows and the child mental health professionals with whom they will be collaborating in the future.

2. Police Fellowships for Clinicians

The Police Fellowship provides clinicians with opportunities to spend time with police colleagues in squad cars, in police stations, and in the streets observing and learning directly from officers about their day-to-day activities. This exposure assists clinicians in understanding the environment to which children and families are exposed, the relationships between members of the community and the police, and the various uses of police authority in daily interactions with community residents. Observing the realities of officers' interactions with children provides a framework for understanding the roles that officers play in the psychological lives of children and families and prepares mental health professionals to intervene collaboratively with police partners in cases referred through the consultation service. Extended contact with police colleagues through the fellowship also provides the basis for trust in the ongoing working relationships on which the program depends.

3. Seminar on Child Development, Human Functioning, and Policing Strategies

The CD-CP seminar on child development, human functioning, and policing strategies is a course for police officers, mental health clinicians, and related professionals (e.g., probation officers) that is co-led by a team of clinical faculty members and a police supervisor experienced in the CD-CP program. The seminar meets each week for 1.5 hours over a period of 10 weeks. Using case scenarios drawn from the experiences of the seminar members and group leaders, the seminar applies principles of child development to the daily work of police officers to provide officers and clinicians with knowledge and a sense of personal empowerment to intervene positively with

children and families. Exposure to developmental principles introduces officers to the importance of thinking about children's development and their own influence on children. Exposure to police perspectives on children, families, violence, and crime expands clinicians' understanding of the children they work with and the role of legal authority in containing children's responses to violence.

4. Consultation Service

As community-based police officers become more active and visible within their neighborhoods, they establish more frequent contact with children and families who are in danger or distress, including victims or witnesses of violence, truants from school, and teens involved with gang activity. These neighborhood officers need a resource to turn to for discussion, guidance, and an immediate clinical response, especially when the child is in great distress, as happens so often following exposure to serious violence. The CD-CP consultation service allows police officers to make referrals and to obtain immediate clinical guidance, especially in the aftermath of children's traumatic experiences. Consultation service clinicians and police supervisors experienced in the program are on call 24 hours a day to discuss difficult situations involving children and adolescents. When a direct clinical response is necessitated by the urgency of a child's distress (e.g., a child who has just witnessed the murder of a relative), a clinician will respond immediately and may see the child and family at the clinic, the police station, or the child's home. Less urgent clinical meetings, referrals to other services, coordination with other agencies, and regular followup by both police and clinicians are also arranged.

5. Program Conference

Police officers and clinicians who staff the CD-CP program meet weekly to discuss difficult and perplexing cases that arise from officers' direct experiences in their neighborhoods and from the consultation service. The case discussions provide a forum for police, clinicians, and allied professionals to examine cases from a variety of perspectives in order to understand better the experience of children and families exposed to violence, to explore the limits of current intervention strategies, and to develop improved methods of collaboration and response. The conference also provides a regular forum for planning and evaluation of pro-

gram activities and for examining systemic, institutional, and administrative issues. Police supervisors representing all sectors of the city participate in the program conference and bring to the discussion the various concerns of community residents in their districts.

Juvenile Justice Response

Many of the children and adolescents about whom police officers and clinicians are most concerned are those who have experienced chronic exposure to violence and who are now becoming involved in delinquent activities. To respond to these children and adolescents, the CD-CP collaboration has expanded to include representatives of the juvenile justice system. In addition, the team's approaches to intervention with this group of children have expanded the use of legal authority to provide external structure where internal and family structures are lacking.

As a result of the placement of juvenile probation officers in several New Haven neighborhoods, with offices in the local community substations, police officers, clinicians, and juvenile probation officers have more closely coordinated their work with young delinquents. In this context, the CD-CP training and weekly conference has provided a central forum for examining comprehensive approaches to programmatic innovation as well as case planning for individual juveniles. As a result of this planning process, neighborhood police officers and juvenile probation officers collaborate in the supervision of young offenders by regularly sharing information about children and adolescents on probation and assigning police officers to supervise some community service projects. In addition, CD-CP clinicians provide regular consultation to juvenile probation officers and the local juvenile detention center regarding the mental health needs of children and adolescents involved in the juvenile justice system.

Results of the CD-CP Program's First 5 Years

The expected outcomes of the CD-CP program can be generally stated as broadening the frames of references that govern the work of the police, mental health professionals, and additional collaborators and that contribute to an increasing array of coordinated responses to the witnesses of community violence and to

youth involved in the perpetration of violence and other gateway criminal activities that may involve or lead to violent crimes. These outcomes may be indicated by:

1. Organizational changes in the provision of police and mental health services.
2. Development of protocols and procedures for responding to youth exposed to or involved in violent and other at-risk, criminal activities.
3. An increase in the number of cases in which consultation and coordinated interventions occur.
4. An increase in the number of collaborations with schools, child welfare, probation, etc., for primary prevention and intervention.
5. Police officers' greater knowledge of the experience of children and greater appreciation for the potential benefits of collaborative intervention.
6. Clinicians' increased knowledge of policing strategies and practices and greater appreciation of the potential therapeutic value of police authority.
7. Implementation of a protocol for regular tracking and monitoring of children referred to the consultation service across a variety of domains, including exposure to additional violent incidents, involvement in delinquent activities, and experience of post-traumatic symptoms.

Training

Since the CD-CP program began formal operation in January 1992, the entire department has received orientation and training regarding program goals and utilization of on-call and referral services; a range of inservice training related to CD-CP principles and practice has been presented; approximately 250 officers have completed the 10-week CD-CP seminar; the assistant chief of police and 39 supervisory sergeants and lieutenants have completed the Child Development Fellowship and continue to attend the weekly Program Conference; 8 Child Study Center faculty members have completed the Police Fellowship; and an elective for mental health professionals in training has been developed.

Referrals and Consultations

The Consultation Service has received approximately 350 referrals regarding

more than 600 children. Calls to the Consultation Service have concerned children of all ages who have been involved in a variety of violent incidents as victims, witnesses, or perpetrators, both in their families and in the larger community. Children who have been referred have been seen both individually and in groups in their homes, police stations, hospitals, schools, and the Child Study Center. In addition, formal protocols have been developed regarding such practices as notification of the Consultation Service in critical incidents involving children as victims, witnesses, or perpetrators; distribution of informational pamphlets describing the psychological impact on children of their exposure to violence and the availability of assistance through the CD-CP program; and routine followup by neighborhood officers to ensure the security and stability of families exposed to violence.

The results of the CD-CP program can also be seen in the following representative examples of cases referred by police to the Consultation Service:

- ◆ A mother and two children, ages 2 and 10, were present when a relative was shot to death through the door of their apartment. The district supervisor, a CD-CP fellow, offered a referral for mental health services and also provided the mother with his beeper number. The supervisory sergeant accepted daily calls from the mother, during which he provided her with information regarding the family's protection from reprisal and reminded her that clinical support was available. With the ongoing support of the sergeant, the mother was able to accept the mental health referral for herself and her children. After intensive treatment, both children are functioning well in school and the mother was able to relocate her family to a safer neighborhood.
- ◆ A woman was stabbed to death by her estranged boyfriend in the presence of her eight children. CD-CP clinicians responded to the scene, provided acute clinical assessments of the children, and consulted with relatives and police as to how to tell the children their mother was dead. Police conducted followup visits to the family, providing practical recommendations for the security of the home and information regarding the status of the prosecution. The efforts of police, mental health, child welfare, and home-

based support professionals, coordinated by the CD-CP team, allowed the children to remain together rather than be dispersed to multiple foster homes. CD-CP clinicians evaluated each of the children and engaged several members of the family in long-term psychotherapy. All of the children are currently attending school. Symptoms of anxiety, depression, and aggressive behavior have diminished.

- ◆ A 15-year-old boy was robbed at gunpoint by two men. In the immediate aftermath of the robbery, he was too shaken to say anything to police about what had happened. Officers referred him for an urgent clinical evaluation, which took place at the local hospital. During the course of the clinical interview, the boy reported wanting to get a gun and take revenge. By the end of the interview, however, he had recovered sufficient memory of the events to become an effective aid to investigating detectives, who were then able to arrest the robbers. Local community-based officers established regular contact with the boy, supporting him in the maintenance of his good school record and deterring an early-stage involvement with neighborhood drug dealers.
- ◆ A 14-year-old boy was involved in leading a group of other teens in a series of beatings and criminal mischief that terrorized his neighborhood. Although police officers were aware of his activities, they were unable to obtain sufficient evidence to arrest him. CD-CP officers and clinicians convened a series of meetings regarding community safety, which were attended by local officers, school officials, juvenile probation, clinical consultants, and community leaders. As a result of the meetings, police obtained more effective cooperation from the community and eventually arrested the boy. The CD-CP program conference provided a forum for case planning, and the collaborative group recommended close probation supervision to the court. Under strict supervision, the boy's criminal activities were curtailed, and he returned to school. Throughout his probation, police and probation officers maintained close contact to monitor his behavior.
- ◆ A 12-year-old boy was arrested 8 times for auto theft. He had been truant from school more days than not over a 2-year period. When the boy's cases

were finally adjudicated, he was referred to a pilot project, developed and coordinated by the CD-CP program, in which strict probation supervision is supplemented by community service, home-based case management, recreational activities, and group therapy. The boy returned to school and has not been rearrested in 4 months. Friends from his neighborhood ask to come with him to group activities.

- ◆ Following the shooting death of a 17-year-old gang member, there was good reason for concern about retaliation and further bloodshed. In the days that followed the death, grieving gang members congregated on the corner where the shooting had taken place. Efforts at increased presence and containment took the form of police, neighborhood-based probation officers, and clinicians spending time on the corner listening to gang members' express their grief. As one senior police officer put it, "We could show our concern for their trauma by being with them, lending an adult ear to their misery. Alternatively, we could put more officers on the street, show them who's boss, and with a show of force, sweep them off the corner as often as necessary. . . . We could then offer them an additional enemy and wait for them to explode." At this crucial moment, the police did not assume the role of enemy. They did not serve as a target for displaced rage or, in confrontation, offer an easy antidote to sadness and helplessness. Rather than exacting "payback" in blood, the typical gang response, the gang discreetly assisted the police in making a swift arrest in the shooting. As one gang member, the brother of the victim, put it to a neighborhood cop, "You were there for us; that helped. . . ."

Juvenile Justice Responses

Because of their powerful and positive experience with the addition of juvenile probation to the CD-CP program, the group has also developed a pilot intervention project that applies the program's collaborative principles to community-based work with adolescents who are beginning to engage in delinquent activities. This Gateway Offenders Program brings together community-based police officers, community-based probation officers, CD-CP clinicians, school officials, and case managers to provide coordinated, comprehensive, and structured

assessment and intervention for a small group of juvenile offenders who are at high risk of escalating criminal involvement and removal from the community. Probation and police officers provide the external authority necessary to contain program participants through intensive supervision, frequent monitoring, and the imposition of variable sanctions for violations. In close collaboration with these figures of authority, clinicians, educators, and case managers provide a range of educational, therapeutic, and recreational interventions, including life skills and conflict resolution training, community service projects, afterschool activities, wilderness experiences, group psychotherapy, and coordination with participants' parents. In this context, clinical evaluations and treatment are not seen as an alternative to judicial action but as part of a coordinated response. In the first 4 months of the project, only 1 of 15 participants has been rearrested for new criminal behavior (Juvenile Services Unit, New Haven Department of Police Services).

Since the implementation of the CD-CP program, there have been significant changes in police approaches to juvenile delinquency and corresponding changes in results. Based on community officers' familiarity with New Haven neighborhoods and the coordination of their efforts with community-based juvenile probation officers, there are no outstanding warrants for the arrest of juveniles in New Haven (Juvenile Probation Division, New Haven County). In addition, while New Haven currently refers twice the number of juvenile offenders to the juvenile justice system, it sends only half the number of juveniles to correctional facilities as Hartford, and three times fewer than Bridgeport. This suggests that, in the community in which the collaboration was developed, alternatives to incarceration have increased significantly.

Truancy Intervention

The CD-CP program has also had an impact on rates of truancy in New Haven. As an outgrowth of the police-mental health collaboration, police have increased their involvement with the New Haven public schools. Teams of community-based officers and dropout prevention workers canvass New Haven neighborhoods during school hours, approaching suspected truants, identifying them, taking them to school, and contacting school personnel and parents about their attendance and other school-related problems

(e.g., fighting, drug or gang involvement, etc.). Responding to reports from the daytime team, evening shift officers follow up with visits to the children's homes, discussing truancy issues with both the student and his or her parents. For many parents, these visits mark the first time that they become fully aware of the extent of a child's truancy. The first visit is followed by others if the student continues to miss school and contingencies are developed with parents, school officials, mental health professionals, probation officers, and social service workers who are already involved or may need to be involved with the youngster and his or her family. With a mixture of authority, psychological sophistication, and persistence, officers involved in the truancy reduction efforts have been enormously successful. In the first 6 months of operation, the truancy initiative accounted for a reduction of 20,000 unexcused absences. In one urban middle school, daily unexcused absences have decreased from more than 120 to fewer than 70 (New Haven Schools). It is anticipated that the decrease in truancy will, in turn, result in a reduction in criminal activity in New Haven, where police have estimated that juveniles were responsible for 60 percent of auto thefts (Juvenile Services Unit, New Haven Department of Police Services).

Program Evaluation Research

The nature of the collaboration, and the clinical, consultative, and specialized police work that occurs within the collaboration, is a challenge to document reliably and consistently. CD-CP research staff have developed a comprehensive electronic case and activity recording system that is the centerpiece of data collection. This system allows program personnel to enter detailed information describing the nature of each case and the response to that case, information regarding the event and the roles of children with regard to that event (e.g., witness, victim, perpetrator, etc.), characteristics of the home and school of children served, diagnostic and evaluation data, intervention data, functional outcome measurement, and other clinical and police activities. An interview protocol has been developed for a retrospective study of children seen in the first 4 years of the consultation service, which will investigate children's general developmental status, posttraumatic responses, exposure to additional episodes of violence, and sub-

jective experience of the CD-CP intervention. In addition, surveys have been developed to measure changes in the attitudes and practices of police officers and mental health professionals as a result of their involvement in the collaborative program.

Program Replication

The CD-CP program is a national model that is now being replicated under an OJJDP grant in four cities: Buffalo, New York; Charlotte, North Carolina; Nashville, Tennessee; and Portland, Oregon. Additional, privately funded program replication efforts are under way in Baltimore, Maryland; Framingham, Massachusetts; and Newark, New Jersey. A CD-CP program manual, *The Police Mental Health Partnership: A Community-Based Response to Urban Violence* (Marans et al., 1995), has also been developed with OJJDP support.

The Program Replication Process

While each police-mental health partnership will develop its own unique attributes based on the specific needs and resources of the community in which it operates, the CD-CP program model assumes that each new collaborative program will adopt the basic program elements described in this bulletin. CD-CP program staff have been intensively involved in providing training, consultation, and technical assistance to developing programs. The following points highlight the requirements for effective implementation of the program model, based on the experience of the program's developers.

1. Institutional Investment

Because the CD-CP program seeks to achieve fundamental change in the operations and the climate of the police department and a collaborating mental health agency, the leadership of both institutions must commit themselves to a process of questioning and modifying traditional practices and be prepared to support their respective staffs in the implementation of collaborative approaches to intervention with children and families exposed to and involved in violence in their community. Issues of time, money, staffing, program expectations, and evaluation should be identified and addressed at the outset. In many of the communities currently involved in the replication project, a single sector of the city has been selected to begin a program pilot.

2. Participating Police Department

The CD-CP program model builds on the philosophy of community policing and therefore requires that the participating police department have implemented community policing strategies or be engaged in the process of their implementing, particularly with regard to children, adolescents, and families. The program also requires that the policing agency be committed to (a) allowing sufficient time for supervisors and rank and file officers to participate in CD-CP training (approximately 15-20 hours for each seminar and 40 hours for CD-CP Fellowship training); (b) allowing time for supervisors centrally involved in the program to act as seminar leaders and to maintain participation in a weekly program conference; and (c) providing observation and training experiences for mental health professionals involved in the program (e.g., ride alongs, short courses in policing practice).

3. Participating Mental Health Agency

The CD-CP program requires a mental health collaborator with staff who are (a) experienced in the evaluation and treatment of children, adolescents, and families, including individuals exposed to criminal violence and other traumatic events; and (b) experienced in teaching and training other professionals in child development principles. The program requires the mental health agency to provide opportunities for police officers to observe children in different clinical settings. The mental health institution also must provide partial salary support for participating staff (three or four clinicians to start) to spend sufficient time observing and meeting with police colleagues, responding to emergency calls from the police for consultation, and co-leading the CD-CP seminar. Funding is not required for ongoing mental health treatment; public benefits, private insurance and/or out-of-pocket payment should be available.

4. Other Participating Institutions

Developing collaborative programs may wish to include other institutions that are centrally involved in addressing the needs of children and families exposed to violence such as juvenile probation, schools, or child welfare agencies. In considering expansion of the CD-CP model, program developers should take into account both the benefits to be derived from a broader coordination and the difficulties associated with developing and maintaining a more complex set of institutional and personal relationships.

5. Training, Consultation, and Technical Assistance for Developing Programs

Staff of the New Haven CD-CP program are available to provide a program of training and technical assistance to developing programs. Consultation begins with the heads of the participating agencies developing clear goals for the collaborative program. Agency leaders then identify a small working group of community policing supervisors and mental health clinicians who will be responsible for implementing the police-mental health collaboration in their community and who will work closely with the CD-CP consultants. Members of the working group attend a series of intensive meetings and observations, co-led by New Haven police supervisors and Child Study Center clinicians. These meetings provide a comprehensive introduction to the CD-CP program and a forum for considering the steps needed to adapt and implement the program in each replication site. Following the New Haven-based training and consultation meetings, CD-CP consultants provide ongoing on- and off-site technical assistance to guide and support the developing new programs. In addition, CD-CP consultants teach and implement procedures for standardized data collection that serve the program evaluation research. A national network of CD-CP programs facilitates sharing information about the process and results of the interdisciplinary collaboration through conferences, newsletters, and other means.

6. Program Evaluation Research

To facilitate consistent data collection across the replication sites and to permit comparisons among the sites, CD-CP consultants will provide personnel in each developing program with copies of the data collection software and survey instruments designed to evaluate the collaborative program (described above). CD-CP staff will provide technical assistance in implementing the data collection and will analyze and report survey results.

One of the fundamental goals of the CD-CP program is to broaden and shift the perspective of officers and clinicians participating in the collaboration. It is believed that officers develop greater knowledge of child development, insight into psychological contributions to human behavior and the implications for policing, a capacity to reflect on and consider a broader range of options, an awareness of the experience of children,

an understanding of and favorable attitude toward mental health personnel, and the merits of interventions that emphasize structure, authority, and/or clinical service. Similarly, it is believed that clinicians acquire knowledge of policing and a greater appreciation for the role of police officers in development and therapeutic intervention, the therapeutic value of structure, and the value of mental health consultation to law enforcement. It is changes of this sort that make collaboration possible and presumably result in benefits to children and families in the community. In order to evaluate these changes, CD-CP staff have developed two surveys that provide a comprehensive assessment of officer and clinician knowledge, attitudes, and assumptions noted above as well as overall satisfaction with the program. Administration of the surveys in the replication sites will allow the program evaluators to follow the development of officers and clinicians over time within each site and also to compare across replication sites. Additional measures of program replication outcome in the various sites will include changes in policing and mental health protocols, numbers of referrals, attendance at collaborative meetings, participation in collaborative training seminars, and outcome measurements related to the children served.

Further information about the CD-CP program can be obtained from:

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It was prepared under grant number 95-JN-FX-0022 from the Office of Juvenile Justice and Delinquency Prevention (OJJDP), U.S. Department of Justice.

Points of view or opinions expressed in this document are those of the authors and do not necessarily represent the official position or policies of OJJDP or the U.S. Department of Justice.

The Office of Juvenile Justice and Delinquency Prevention is a component of the Office of Justice Programs, which also includes the Bureau of Justice Assistance, the Bureau of Justice Statistics, the National Institute of Justice, and the Office for Victims of Crime.

U.S. Department of Justice

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The labyrinth of
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MOSTLY CLOUDY

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STATE EDITION

The Hartford Courant.

Established 1764

Volume CLVIII, Number 21 Copyright 1996, The Hartford Courant Co.

Sunday, January 21, 1996

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Newsstand \$1.50

For children caught in cycle of violence, a rescue mission

By EDMUND MAHONY
Courant Staff Writer

NEW HAVEN — The phone call that woke Miriam Berkman on a muggy, sum-night more than a year ago was, quite simply, horrifying — even if it was the kind of middle-of-the-night call she and her colleagues had come to expect.

There had been another shooting. The victim, a mother of six, was murdered by her live-in boyfriend. She died on the living room floor while the children watched. They were 5 to 18 years old.

Berkman concentrated on the children as

she left her home and drove across the city. How would they be? Hysterical? Would they still be staring at the stain caused by their mother's blood?

The police, as expected, had taken over the children's home. They were bagging evidence, taking photographs and, within hours, they were close to closing the file on another death.

Outside, Berkman met Dr. Steven Marans, her colleague at Yale University's Child Study Center. Together, they began work on their part of the case: to reassemble the shattered lives of six children.

Their mission, part of an innovative col-

laboration between the New Haven Police Department and child-development specialists, is attracting widespread attention.

It is an odd coupling that can seem quirky at times. Veteran street cops, accustomed to cruising around the inner city in police cars, find themselves sitting around a table conferring with enthusiastically caring Ivy League therapists — one with a pet dog, another cuddling an infant — talking about the emotional condition of a drug dealer.

But the program has flourished. In more than four years, it has treated 500 youngsters in an attempt to break the cycle that transforms childhood victims of violence

into violent adults.

"During my years on the force, I've seen a lot of these so-called programs come and go," said Lt. Mike Sweeney, a patrol supervisor who was a homicide detective for nearly 20 years before becoming an administrator. "This is the only one that has worked."

As patrol officers criss-cross New Haven each day on foot, horseback and in police cars, they carry the electronic pager numbers of the clinicians on call at the child study center. The children the police report as in need of assistance are called "referrals," in the parlance of what has come to be

known as "The Program" — the Child Development Community Policing Program.

Child development specialists, such as psychoanalysts at the Child Study Center, are on 24-hour call. When officers respond to a crime scene where children are victims or witnesses to violence, they page the center. A clinician responds within minutes, just as Berkman and Marans did.

Initially, the clinician evaluates the child or children and decides if there is a need for follow-up therapy — which can involve entire families and continue for years. But

Please see A rescue, Page A6

A rescue mission for the youngest victims of violence

Continued from Page 1

contact with the child can be enormously complicated, and the center brings much more to the partnership.

Very important to the program is designed by Marans, its director as well as Harris professor of child psychoanalysis at Yale, is a training component that will eventually reach every member of the police department, from recruits to top administrators. More than half the officers on the New Haven force completed the 10-week, part-time program.

There, officers learn the rudiments of child development. But they also go through what might be called a consciousness-raising curriculum — a persuasive pitch to police officers to revise the way they think about the causes of crime, roles as cops and the behavior of young people.

The program is taking hold in the police, and that, participants agree, is a credit to New Haven Police Chief Nicholas Pastore. Simply put, Pastore would rather have officers who are role models to city kids, not anti-crime crusaders.

If the partnership with the child study center is one of the more progressive manifestations of community policing, it is being warmly received by officers at all levels. During shift changes, patrol officers discuss with one another their training programs and referrals of children to program clinicians.

6 orphans

The muggy night the telephone rang, Berkman and Marans reached the six children about an hour after police. For this article, Marans insisted that the children, like all the youngsters involved with his program, not be identified. Doing so, he said, could violate medical privacy laws and focus public attention on the children. To be singled out in the newspaper, Marans said, could unravel therapeutic progress already made.

Officers had calmed the children and collected them in a neighbor's apartment. With approval from the supervisory officer, Marans and Berkman divided the children into two groups: Berkman took one group, Marans, the other.

Often, Berkman said, adults — including policemen — are reticent to talk to children about traumatic events, fearing something they might say will worsen the situation. Berkman, who has degrees in law and social work and a new baby, opened her discussion with a statement. "Well," she said, "something awful has happened."

"Then we sort of went to the kids and let them tell their story, in really gruesome detail," she said. "What I'd seen. The way their mother's body looked. The blood. Their relationship with the mother's boyfriend. The many incidents of violence in the past."

"The kids were very afraid of this. He had broken into the house. He had threatened their mother. And eventually, he killed her."

The discussion shaped up as a narrative of events leading to the shooting. The children exhibited a gamut of emotions: sadness about their mother, fear for themselves, anger at their mother's boyfriend. Because they were children, they competed for attention. They spoke of how awful life was in a violent household where alcohol and illegal drugs were used in excess.

As she almost always does, Berkman had drawing paper and crayons with her. Would you like to draw a picture? she asked. Just draw whatever is on your mind.

"You can see their primary concerns," Berkman said. "Their overwhelming fear of this man, how huge his gun was, the mean expression on his face, how angry he was, how dangerous he was."

The children's shifting emotions fell into a fairly predictable pattern. They suffered pangs of guilt, punishing themselves for what they might have done, but did not do, to prevent the assault. One wished she had hit the boyfriend with a broom. A boy was angry he did not get a knife from the kitchen.

But guilt manifested itself in another, troubling fashion in the emotional stew that was boiling within the children. They could not always differentiate between fantasy and

reality. Some were afraid their anger about their mother's drug or alcohol use somehow had precipitated the attack.

Finally, the session hung on the children's reluctance to believe their mother was really dead.

"On the one hand, the kids knew the parent was dead because they saw it," Berkman said. "On the other hand, the mind works very hard not to believe. You hear kids asking each other whether she is alive."

It was important to put to rest any question about the mother's death and, as sometimes is the case, the police asked the clinicians to deliver the news. Berkman and Marans decided the final notification would best be delivered by a relative. They asked the oldest child, an 18-year-old daughter, to tell her siblings. Close to three hours later, the children were put to bed at the neighbor's, and Berkman left. She returned the following day.

Sounding the alarm

The New Haven program has reached speed at a time when issues of children and violence have become a cause of national alarm. Possibly nowhere are such issues being studied as closely as they are at Yale's Child Study Center.

While the incidence of violent crime in general dropped sharply last year in large cities across the country, violent crime and gun-related crime by children surged.

James A. Fox, dean of Northeastern University's school of criminal justice, believes recent drops in violence are merely a temporary lull before a sharp upward spike in violence by a generation of youngsters entering their teens.

Dr. Mary E. Schwab-Stone, who works at the child study center, closely tracks violence and its effect on children in New Haven. In 1992, about 40 percent of the sixth-, seventh- and 10th-graders from New Haven that she surveyed reported witnessing a shooting or stabbing by their middle school years. The figure dropped to 32 percent by 1994.

While childhood victims of violence and childhood perpetrators may seem to fall into different categories, research suggests they are linked.

In most cases, child-victims — like the six Berkman found stunned into incomprehensibility — can expect little in the way of emotional care. Shootings, for example, are the domain of the police, and the police traditionally are neither hired nor trained to treat emotional trauma in children.

Left untreated, exposure to violence can have a progressively worse effect on a child's emotional development and ability to cope with violent impulses. It can hinder attentiveness and hamper school performance, leading to aggression and, eventually, adult violence.

A Boston City Hospital survey of children seen in their primary care clinic disclosed that 10 percent witnessed a shooting or stabbing before age 6, half in their homes and half on the streets. A survey of inner city grade-school students in New Orleans revealed 80 percent had witnessed violence, 60 percent had seen a weapon used, 40 percent had seen a dead body.

Police take lead

Given the pervasiveness of violence in cities such as New Haven, the Child Development Community Policing Program is not conceived as a solution. It is an attempt to coordinate with the police the delivery of assistance to the most vulnerable of victims, Marans said. The program is a clearinghouse for services ranging from juvenile probation officers to school counselors.

It is paid for through a variety of sources, including federal grants to Yale, money budgeted to the police department and by private and social service agency funds paid by or for families of the affected children.

When the program functions effectively, Marans said, it coordinates agencies that sometimes work at cross purposes. In addition, he said, it gives some psychic relief to police officers who encounter a mind-numbing array of battered children in their duties, but who often must move onto new cases without the satisfaction of knowing that something will be done to help. As a mental defense to their own

resulting feelings of frustration, Marans said, police officers and others regularly exposed to child victims sometimes move through cases almost mechanically, trying to minimize involvement with victims.

That attitude can lead to feelings of resentment in victims, who may come to see police as anonymous authority figures who uncaringly intervene in their lives during times of great trauma, Marans said.

"During my years on the force, I've seen a lot of these so-called programs come and go. This is the only one that has worked."

MIKE SWEENEY
NEW HAVEN POLICE

Involving police as the lead agency benefits children directly, Marans said. But he said it also benefits officers, who feel more personal satisfaction. And when officers feel better about their jobs, people they come into contact with feel better about the police.

The image of a kinder, gentler, more caring police department plays right into notions about community policing held by Marans and one of its most vocal advocates around the country, Police Chief Pastore. To them, the goal of policing is an officer who prevents a crime through his concern about and knowledge of a neighborhood. The benefits are obvious: No one has to solve a crime because none was committed.

Case in point

Every Wednesday, the program's core group — about 20 men and women representing the police, the child study center, the state Department of Family Services, the New Haven School system, and the juvenile probation department — meets to discuss the previous week's referrals.

They talk about the medical condition of injured children and the status of cases in the criminal justice system. If cases merit psychotherapy, they discuss treatment schedules. If someone thinks of some other agency that could render assistance, that agency is called. Occasionally, a friendly, community-based police officer will be dispatched to provide a security check at the home of a child who was recently petrified by a burglar.

But if the meetings ostensibly were designed to discuss case follow-up, a couple of recent Wednesdays suggest they are also a forum for Marans to reinforce the ideas he

and Pastore share about community policing.

During recent weeks, a gang shooting in the Fair Haven section of the city was prominent in Marans' thinking. Members of one group shot a member of another in a gas station parking lot. Police feared retaliation.

Members of the dead youth's faction decided to memorialize him by spray-painting adjacent real estate with gang graffiti and erecting candle and floral shrines in the gas station, activities that did not help the owner's sales volume.

In a discussion outside the Wednesday meeting, Marans raised the events in Fair Haven as an example of how to bring a knowledge of child psychology and development to community police work.

"One way of approaching that would be to say, 'These people are involved in group activities that in this particular situation are very likely to lead to violence. We have to break up the group. Clear the streets. Make sure there is no congregating.' And that's exercising authority. It is use of authority to re-establish and reassert who is the boss."

Not a good solution, Marans believes. It simply displaces the youngsters' rage onto the police.

Why not let them keep their floral and candle shrines?

"The answer is to not go over with squad cars and roust the kids. But go over and hang with them. Talk with them. Listen to them," Marans said. "What does that do? Ah, it's just turning cops into social workers. We'd say, absolutely not."

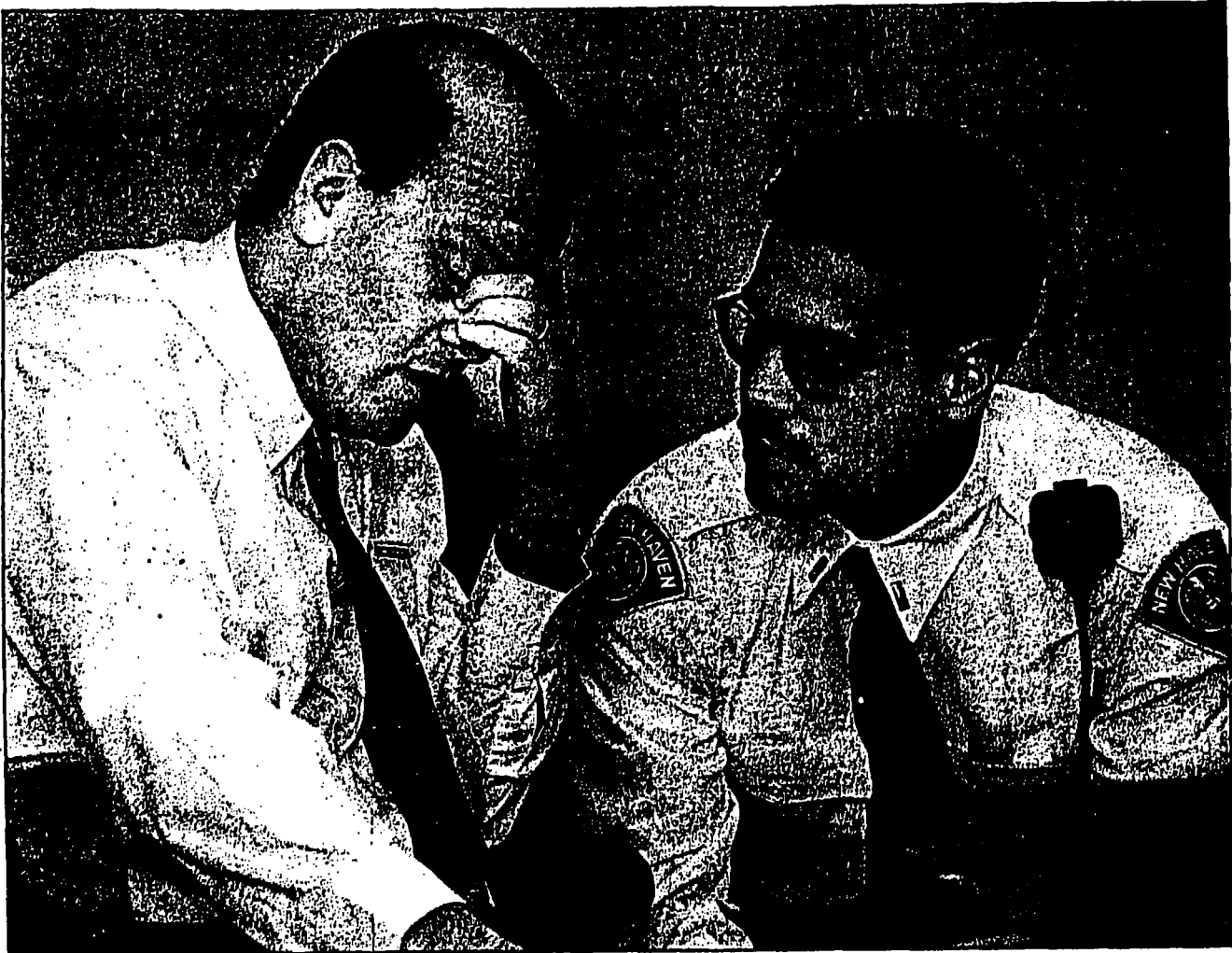
By listening and understanding the emotions that the youngsters are experiencing, Marans said, the police are better able to control the actions that follow.

"These kids end up being incredibly appreciative of these adult authority figures who actually took the time and seemed to care. The police are no longer just the bad guy, you know, the beat down posse who are out to get kids."

"The other thing is, if there are relationships that develop, perhaps these kids actually have another outlet for the revenge principle, which is to make damn sure that the police are able to make a swift arrest. Or to keep them posted about what activities are going on that may escalate into something dangerous and fatal."

The police and probation department tried Marans' suggestion in Fair Haven, but early results were not promising. The kids took off whenever they saw the officers approaching. And after permitting a mourning period lasting a few days, the shrines came down, too.

Still, Marans says the correctness of his thinking is born out in the success authorities have had in prosecuting gang violence and drug dealing in New Haven. When youths trust the authorities, they report things, he said.



Dean Esserman, left, former New Haven assistant police chief, and New Haven police Lt. Francisco Ortiz confer during a meeting of the

Child Development Community Policing Program Wednesday. Ortiz is on the faculty of Yale University's Child Study Center.

Stephen Dunn / The Hartford Courant

Federal agents and prosecutors who led the gang crackdown are not so quick to attribute its successes to understanding community police officers. But they said that it can't hurt and that the New Haven police have an outstanding data base of intelligence on local drug dealers and gangsters.

One child, a girl then about 10 years old, had disturbing symptoms, many similar to those experienced by people suffering from traumatic stress disorder. She was hyper-aroused, which may be an instinctive means of coping with threats and danger.

She was nervous, unable to and constantly on guard. She was also focused on revenge, which Berkman said is a largely predictable psychological attempt to undo what had happened. The girl aggressive and a provocateur.

What began as a wish by the girl that police had acted differently, that they had been able to prevent her mother's death, grew into rage at the police and at authorities in general for letting the boyfriend out of jail for an earlier offense.

She thought the police didn't arrive early enough. Her rage exacerbated by a sibling who speculated a policeman arrived early enough to prevent the crime but did not enter the house until back-up arrived.

"These kind of ideas come up whether they are true or they are not true," Berkman said. "It's a way of finding some sort of explanation, as if someone could have turned it around so it didn't happen."

Berkman scheduled what became a long series of therapy sessions with the girl. As with children, the sessions with the girl involved play-acting rather than discussion. Berkman looked for clues to the child's emotional state.

"A lot of the work is to help the child with their own feelings to realize they were helpless. I couldn't have prevented it, so they don't feel guilty," Berkman said.

The girl needed to be coaxed the developmental track that helped her learn not to act out violent impulses, but to control them. The adults in her life did not by example. Also, she needed to know that her anger did not kill her mother.

Berkman said the girl still not properly mourned her mother's death. She has been in therapy for nearly two years now and the plan is to continue. But there has been progress, Berkman said.

She is involved in fewer fights at school, she has improved academically. Trouble she had concentrating seems to be clearing up. She no longer falls apart at loud noises, like slamming doors. And she has gotten over her rage at authorities.

Recently, in a school assignment to write an essay about her heroes, she said she wants to be a police officer when she grows up.

"The answer is not to go over with squad cars and roust the kids. But go over and hang with them. Talk with them. Listen to them."

DR. STEVEN MARANS
YALE UNIVERSITY, CHILD
STUDY CENTER

One child at a time

At the Wednesday meetings, and at separate weekly meetings where the clinicians discuss treatment programs, there is usually a recitation of the traumas inflicted on New Haven's children: children sexually abusing other children. A man forcing a woman to drink his blood in front of her children. Children robbed at gunpoint by other children. Children shot by other children. Children accompanying parents who were robbed by other children.

The six children Berkman met the muggy night her telephone rang were, sadly, typical. Berkman returned to their home each day after the shooting until therapy sessions were set up.

During one meeting that followed the shooting, the state Department of Children and Families was brought in. Since there was no surviving parent, the children were at risk of being divided among different foster homes, something Berkman said would have compounded their emotional wounds.

The state agency arranged what it calls an in-home support program. A team would visit to help the eldest daughter run the family and take care of the short-term bureaucratic headaches involving leases, welfare collection and rent payments.

The boyfriend was quickly caught and arrested, and the children were kept informed of his continuing incarceration and progress through the judicial system. Police schooled them on home security. They were afraid the boyfriend would get out of jail and come after them.

"Getting the best information to survivors is helpful to a cure," Berkman said. "It helps them to differentiate between what's real fear and what is imagined."

But other damage from the shooting was not so easily cured.

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EDITORIALS

Helping kids understand

New program will counsel youngsters exposed to crime

Children who grow up in bad environments eventually get desensitized to sights that should shock and frighten them — drug peddlers beating up non-paying customers, gangs threatening them if they walk across "their turf" (which could be a housing project playground), gunfire ringing out while they are sitting on their porch or playing in their front yard.

In turn, these children too often accept this behavior as normal and grow up to repeat it. The cycle of violence continues. In fact, it worsens.

Nashville children who grow up in this type of environment stand to benefit from a new program designed to help youngsters at crime scenes. We've all seen these children, standing on the fringe of a crowd as a body is being carried away — the ones who are left to try to make sense of some horrific act they've witnessed with their own young eyes.

Now that Nashville has been selected as one of a handful of American cities to participate in a model of the 4-year-old Child Development-Community Policing Program begun by Yale University and the New Haven, Conn., Police Department, perhaps these children will have a better chance to realize that the violent behavior they see is not normal.

The program will begin this fall in Nashville's Enterprise Community, which includes the Napier, Vine Hill and

OUR VIEW

It's important for children not to accept cycle of violence as normal behavior

Edgehill communities, where, according to Assistant Police Chief Debra Faulkner, 33 percent of the 14,000 residents are under the age of 18. These are high-crime, high-drug-activity neighborhoods.

Police who find children at a crime scene will be able to call a 24-hour consultation service provided by Family and Children's Service to determine the children's needs. Help could come in the form of crisis response and trauma debriefing for the youngsters and their families, on-going support groups and follow-up family or individual counseling by the Family and Children's Service or by referral to another counselor.

"It makes you feel better," said one young boy who had been helped by this program. "You don't have this big brick house, or you don't feel you have these weights on your shoulder. That ton of bricks or big brick house comes off and you feel better about yourself."

All children deserve that kind of freedom.

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B

Helping kids to talk, repair violent lives

Metro police, counselors offer early intervention

By **Kimberly Hadley**
BANNER STAFF WRITER

Thomas stood under a cascade of life-shattering events two years ago, and tried to withstand the onslaught alone.

In a span of eight months, his mother was murdered by her ex-husband, his best friend was shot and killed, and he was attacked and injured by another high school student.

Metro Juvenile Court Referee Mary Walker stepped in to help Thomas, which is not his real name. She ordered him to attend counseling sessions at Family and Children's Service.

It was that move that started Thomas on a path to being able to talk about the tragedies of his past and go on with his life.

Family and Children's Service, the Success by Six program and the Metro Police Department have become allies in a new program designed to give other children and families who have been victims or witnesses to violent acts the same help Thomas received.

Metro police will have access to a 24-hour consultation service provided by Family and Children's Service to assist in determining how to respond to the needs of children at crime scenes.

Direct services will include crisis response and trauma debriefing for the children and their families, on-going support groups and follow-up family/individual counseling by the Family and Children's Service or by referral.

Peg Leonard-Martin
Family and Children's Service

Nashville was one of several cities across the country accepted to participate in this model of the 4-year-old Child Development-Community Policing Program begun by Yale University and the New Haven, Conn., Police Department.

The program begins this fall. It covers Nashville's Enterprise Community, which includes the Napier, Vine Hill and Edgehill communities where 33 percent of the 14,000 residents are younger than age 18, says Assistant Police Chief Debra Faulkner. The area is known for "high street-drug sales and high crime," she says.

Children growing up in a violent environment may come to identify with "the aggressor" in their community, resulting in them not being able to imagine "a world that you would not respond to in violence," says Peg Leonard-Martin, director of clinical outreach services at Family and Children's Service.

The point of the program is to help the children to cope with what they have seen and to realize this should not be normal behavior, she notes.

"We're targeting the really young ones," Leonard-Martin adds. "The sooner we get in, the better."

With this service, "these police can leave the scene of a major crime without thinking they are abandoning these kids," Leonard-Martin says. "They can turn them over to a professional they know will help them."

Stopping the cycle

City officials hope Metro's use of the counseling/police partnership will decrease the cycle of violence.

Sgt. Ben Dicke, who works in the Napier community, says the program is "needed desperately

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*We're targeting the
really young ones.*

*The sooner we get
in, the better.*

Please see **KIDS**, page B5



A child being counseled through Family and Children's Service after witnessing violence drew this picture of a helicopter shooting at two men fighting. Such children often draw themselves as a hero who stops the violence.

Kids

Continued from page B1

because for years there's been no way for police officers to deal with the children."

"The increase in teen violence — part of those problems, I think, stem from the violence they experienced and there was no intervention," Dicke says.

Faulkner agrees that "some of this is learned behavior. I don't think anybody is born to this."

Faulkner recalls that when she was an arresting officer going to a crime scene involving domestic violence or a shooting, "in the background, you would see children and you would say, 'I wish there was something I could do. What are they learning from this? They are the next generation and how are they being impacted by this?'"

The answer to Faulkner's concern has come from time to time, via a news article or police report passing over her desk, allowing her to see a familiar name.

"They are the child or grandchild of somebody I arrested," she says.

Children growing up in violent surroundings often imitate what they see and the cycle continues, Faulkner notes.

Yet, "at some point it has to stop and you have to do an intervention."

"We hear from teachers when something has happened on a playground or to one of their friends, it's up to two weeks before they can settle down and start learning again," Faulkner adds.

"You've got to get them back to where they can be a kid again and learn and grow in a healthy environment."

'So desensitized'

An exchange of drug-related gunfire near Napier Elementary School's playground last year was one of the incidents that confirmed to counselors at Family and Children's Service that some-

thing needed to be done to help children exposed to violence, Leonard-Martin says.

The incident came just one week after Metro officials applied to take part in the Yale pilot program.

What Faulkner recalls most about the "drug deal gone wrong" was when the shots rang out, "the kids just kept on playing. They were so desensitized to it. And the teachers were saying, 'Get down, get down, get down,'" Faulkner says.

Then perhaps even more shocking to counselors from the Family and Children's Service, who visited with the children, was the reaction of children closest to the gunfire.

Counselors attempted to help the children work through their feelings by using toys to "tell their story," such as "where were you standing when the gunfire occurred?" says Leonard-Martin.

What they found instead were children who considered the sound of gunfire commonplace.

"As the children told their stories, they started competing for who had heard the most gun shots the night before," Leonard-Martin says.

"One boy said he heard five or six shots," she says. "The boy next to him said, 'That's nothing, I heard 14 last night.'"

Then "a little girl next to him said, 'We don't even sleep in our beds anymore (because of fear of gunfire through windows). We sleep on the floor.'"

This was just one of the incidents leading counselors to inform Leonard-Martin that "it's getting worse and worse out there and the victims are getting younger and younger."

Shelia Fanning grew up in Napier Homes public housing development and still lives there with her 4-year-old daughter.

"A lot's changed since I grew up over here," she says. "I guess counseling is needed."

"There's a lot of gunshots, a lot of shooting, killing, robbing," she concedes. "They set there and sell drugs in front of your face. That's bad."

"That's one of the things that's

bad — kids seeing drug dealing in front of their face.

"I think they think this is normal when it's not normal," Fanning says.

Demarius Claybrooks, 15, who lives in Napier Homes, says counseling is needed because when violence occurs, kids are upset and need someone to talk to.

Right now many are talking to friends, he says.

'Weights on your shoulder'

Thomas did not want to talk to anybody about his pain — especially a counselor.

"I felt it would do no good," he says.

It took a year of weekly talks before Thomas finally felt comfortable enough to talk about his feelings.

"It makes you feel better," he finally says. "You don't have this big brick house, or you don't feel you have these weights on your shoulder. That ton of bricks or big brick house comes off and you feel better about yourself."

Counseling helps Thomas deal with the day-to-day aspects of living, which have changed since violence struck his life.

Thomas has had to deal with going to summer school to make up for the classes he failed the year his mother died.

"I hardly did my class work," he recalls.

Thomas is also dealing with the realization that violence "can happen to anybody no matter where you're at. It can be in your own home."

"Back then, I didn't pay any attention to things on TV, people getting killed, raped," Thomas says. "Now, I pay attention to what's going on on TV."

"Back then I'd go anywhere," Thomas adds. "Now, all this violence comes up and you watch everything you do."

Talking about these feelings are important, Thomas now recognizes. Not talking means "you can either hurt yourself mentally and physically or you can hurt somebody else mentally and physically."

VICTIMS OF VIOLENCE

Special program to help boy who witnessed brutal killing

By LOU MICHEL

News Staff Reporter

The 6-year-old boy softly cried as he looked at his aunt's body in the coffin.

Two days earlier, an intruder forced the child to watch as he plunged a knife into Alma Rosa Gonzalez in her West Side apartment.

"When Toly saw my sister at the funeral home, he said, 'Titi, titi,'" said Lina Gonzalez, the sister of Alma Rosa Gonzalez.

"I want to give her a kiss," the child said, and he kissed her.

"We had to take him out at that point because he started to cry," Lina Gonzalez said.

A final kiss has not erased the pain that Toly still feels for his "titi," which is an affectionate name for aunt in Spanish.

"He walks around, and you can see it on his face that his mind is playing over and over what happened to my daughter," said Vita Lina Gonzalez, Alma Rosa Gonzalez's mother.



Alma Rosa
Gonzalez

A special program that assists young children who are subjected to crime and violence will try to help Toly overcome the emotional scars from watching his aunt being killed Monday.

"I heard he was a gem. Everybody says he's a bright, delightful 6-year-old. We're making arrangements to get him help," said Lt. Genevieve A. Fahmer, a member of the program

staffed by the Buffalo Police Department and Crisis Services Inc.

Mary C. Langl, a community crisis specialist with Crisis Services, said

See Boy Page A10

Dec 6, 1996
Buffalo News

Boy: The program's goal is to put the child in touch with his feelings and go from there

Continued from Page A1

children like Toly are first assessed to determine if they need help.

"The child could possibly enter a support group in which other young survivors of incidents of homicides and suicides meet, or he could enter out-patient counseling," Mrs. Langi said.

The goal is to get the child in touch with his feelings and go from there, she explained.

Toly's family says he has gone into shock, and they are anxious to get him into the program.

The memories that Toly, a black haired boy with big brown eyes, will have to cope with are huge.

Here is an account of what happened, based on interviews with family members and law enforcement officials:

Toly and his aunt, who was baby sitting him, had been watching television when Ricardo B. Maisonet entered their Vermont Street apartment and made Ms. Gonzalez go into the bathroom with him.

Homicide detectives believe the 250-pound roofer, a convicted robber, had showed up to rob them.

Once Ms. Gonzalez was in the tiny bathroom, the 34-year-old man looked out and ordered the boy to join them.

Toly was scared. He started to cry and Maisonet told him to be quiet. Toly obeyed and watched the killing.

In his mind, he counted: one, two, three, four, five, six, seven, eight, for each time the knife struck his aunt, who pleaded for mercy.

"Toly looked and my daughter was gone," said Mrs. Gonzalez, who pressed her hands against her chest and cried. "My daughter had a big heart, a good heart. I don't understand why this has happened."

Maisonet, who was released

from prison in May 1995 after serving 15 years of an 18-year prison sentence for several robbery convictions in the New York City area, then left the bathroom with Toly and bound his hands and legs.

Toly was placed on the couch.

"Toly told me the guy was waiting for our uncle to return to their apartment," said 12-year-old Anthony, also a nephew of Ms. Gonzalez.

At approximately 1 p.m., Ms. Gonzalez's husband, Geraldo Duran, returned home from work for lunch.

Maisonet threatened him with the same knife and shouted, "I killed your wife and I'm going to kill you," according to a relative of Ms. Gonzalez.

The struggle between Maisonet and Duran ended with Duran being forced to sit on the couch beside his bound nephew.

"My uncle asked for a drink of water and he (Maisonet) went into the kitchen to get it and that's when my uncle escaped by jumping off the second-floor porch," said nephew Anthony.

Maisonet fled without any money.

Homicide detectives believe robbery was the motive, but declined to say if what Toly told them provided clues that led to Maisonet's arrest a day after the killing, following a feverish search for him.

What amazed, even astounded the veteran investigators, was how composed and calm the child behaved in retelling the gruesome details, according to Capt. Joseph Riga, chief of the Homicide Bureau.

"Outwardly, the boy appeared to be coping very well. He was very well mannered," Riga said.

And if Maisonet was in the upper apartment at 137 Vermont St.

as detectives charged in their two counts of second-degree murder against him, he was there in violation of an agreement he had signed with the state parole board before his release.

Because of claims that he had acted in a sexually inappropriate manner with children, Maisonet was required to avoid contact with children under 18 and stay away from places where children congregate, according to parole and law enforcement officials.

The board's agreement, which Maisonet signed before leaving prison, even prohibited him from having children's toys in his possession, said Tom Grant, a parole board spokesman.

In prison, Maisonet had met a female corrections officer and subsequently married her. The woman resigned her position and the couple moved to Cheektowaga last year, according to parole officials.

As for Toly, his family is proud that he was able to keep his composure during the conversations with homicide detectives.

"He was a real man," said Anthony, the other nephew, adding that the past few days have taken a heavy toll on Toly.

But there is the prospect of help from the Child Development-Community Policing Program that assists youngsters traumatized by violence.

And, there is another ingredient family members think will bring Toly around.

That is love.

After Toly had kissed his aunt good-bye at the funeral home, his other aunt took him aside and spoke to him.

"Titi is gone," Lina Gonzalez told Toly, "but I'm another Titi here for you. And you can come and play with my children anytime you want."

BALTIMORE CITY/COUNTY

COUNTY
BEST

Focusing on children exposed to crime

In Baltimore City

\$600 in lunch money stolen from driver of armored car

A man who witnesses said staked out the Walbrook Senior High School parking lot in the 2000 block of Edgewood St. in Southwest Baltimore for two hours pistol-whipped an armored-car driver and stole \$600 in school lunch money yesterday, city police said.

Local and federal authorities said the robber wore a black coat and was armed with a .45-caliber handgun. They said the robber also took a snub-nose .38-caliber revolver from the security guard during the 12:15 p.m. incident.

Police said the robber did not get money from the locked van. The guard, Kenneth Van Douern, 61, suffered slight injuries when the suspect hit him behind the left ear with the revolver.

Man sentenced to 30 years for shooting cashier

A Baltimore man has been sentenced to 30 years in prison in the shooting of a cashier in a crowded Giant supermarket during an attempted robbery.

Anthony Chris Drake, 37, of the 3000 block of Southland Ave. was sentenced Friday in Baltimore Circuit Court immediately after he pled guilty to attempted first-

Hopkins Hospital, police seek to offer counseling aimed at cycle of violence

By BRENDA J. BUOTE
SUN STAFF

A partnership led by Johns Hopkins Hospital announced plans yesterday to provide mental health counseling for children in East Baltimore who are exposed to violent crime, in an attempt to break the cycle that transforms childhood victims into violent adults.

The program, to be launched this spring by Hopkins in collaboration with city police, will focus on the Eastern District — a 4-square-mile area that includes some of the city's roughest neighborhoods, with high levels of street violence and domestic abuse.

"Trauma by exposure to violence results in a sort of emotional bleed," said Dr. James Lewis III, a

clinical coordinator at Hopkins' East Baltimore Child Development Community Oriented Partnership Services. "This program is an attempt to stop that emotional bleed and begin the healing process."

The Child Development Community Policing program will pair therapists with veteran street officers.

Patrol officers will carry the electronic pager numbers of clinicians on 24-hour call at the child development center. When officers respond to a crime scene where children are victims of or witnesses to violence, they will page the center and a clinician will respond within minutes.

"This program gives us an opportunity to reach children when they are most vulnerable," said Officer Loretta Bolling, 44, who established the Eastern District's Domestic Violence Unit in October 1994.

A former patrol officer and five-year veteran of the department, Bolling said she sees at least 50 children each week who are ex-

posed to violent situations. An average of 250 incidents of domestic abuse are reported in Eastern District each month, police records show.

"A lot of parents are in denial that the violence in their home affects their children," said Bolling's partner, Officer Sandra D. Redd. "And if we can't reach the parent, then it's difficult to reach the child."

"The children who see these events tend to have all sorts of symptoms," Lewis said. "Some children lose some of the developmental skills they had once mastered. They start wetting the bed or stop walking. Others become aggressive. They strike out in an attempt to control their environment."

The Hopkins program — the only one of its kind in Baltimore — is sponsored by the Baltimore Police Department and the East Baltimore Mental Health Partnership, which has on-site counselors in 19 East Baltimore schools. Funding for the program has not been secured.

Nevertheless, six police officers, including Bolling and Redd, and four mental health workers have volunteered to become participants. For four hours each week, they are in training — conferring about the emotional condition of children who have been exposed to violence.

The Baltimore program is part of a nationwide effort. Similar programs have been established in Framingham, Mass.; Newark, N.J.; Buffalo, N.Y.; Portland, Ore.; Charlotte, N.C.; and Nashville, Tenn.

More than 60 apply for jobs on Baltimore school board

Nomination deadline pushed until end of month

By JEAN THOMPSON



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Psychoanalysis on the Beat

Children, Police, and Urban Trauma

STEVEN MARANS, PH.D.

Anna Freud's legacy to child psychoanalysis was her understanding and description of the complexities of development and her ability to apply her findings to the care of children both within and outside of the consulting room. In addition to her approach to consultation with nonanalytic professionals concerned with children's development and well-being, she established a model for generations of child analysts and other analytically oriented clinicians. Both of Ms. Freud's concepts of development and collaboration with other professionals have served as a basis for the implementation of the Child Development-Community Policing Program in New Haven, Connecticut. This collaboration between mental health and police professionals will be described in this paper, with particular emphasis on the application of Ms. Freud's work to attempts to intervene on the behalf of children and families exposed to urban violence.

WHILE THE SITES SHIFTED—FROM THE CONSULTING ROOM, TO THE WAR nurseries, to the care of Holocaust survivors, to the well-baby clinic and nursery school of the Hampstead Clinic—Anna Freud's gift of observation and her capacity to consider the perspective of the child remained constant. From her multiple vantage points, Anna Freud was

Harris Assistant Professor of Child Psychoanalysis, Yale University Child Study Center, New Haven.

The author is grateful to the Rockefeller Foundation, the Smart Family Foundation, the Jewish Women International, and the U.S. Dept. of Justice, Office of Juvenile Justice and Delinquency Prevention, for their support of this work.

The Psychoanalytic Study of the Child 51, ed. Albert J. Solnit, Peter B. Neubauer, Samuel Abrams, and A. Scott Dowling (Yale University Press, copyright © 1996 by Albert J. Solnit, Peter B. Neubauer, Samuel Abrams, and A. Scott Dowling).

10

Experiencing Violence in a Developmental Context

STEVEN MARANS
ANNE ADELMAN

BACKGROUND

As the number of children exposed to violence in the United States has increased, so too have concerns about the short- and long-term effects of such exposure (Marans, Berkman, & Cohen, 1996; Pynoos, Steinberg, & Wraith, 1995; Osofsky, 1995; Singer, Anglin, Song, & Lunghofer, 1995; Taylor, Zuckerman, Harick, & Groves, 1992). Rather than viewing violence or its effects as uniform across ages and experiences, it is important to recognize that childhood exposure to violence occurs in the context of shifting modes of adaptation, which reflect the unfolding maturational process and developmental fluctuations in the nature and expression of children's impulses, wishes, and fears. Children's experience of violence is not only determined by the events they witness, but also by their own capacity to mediate both external and internal sources of danger, and to contend with the pressure of conflictual urges and longings that change according to phases of development. These factors are linked to emotional, cognitive, and physical capacities that shape children's responses to internal and external demands, expectations, and impingements. The aggression, for example, that is expressed in the violent acts that children witness also plays a central role in normal development. In this latter context, aggressivity serves as a means of achieving a sense of power and competence; it is also a source of conflict between love and hate. Over the course of development, the more direct

enactments of the toddler's hitting, biting, and kicking shift to the preschooler's fantasies and play of destructive power, to the competition on the school-age child's sports field, to, finally, the vicissitudes of affection and anger that are a part of adolescent and adult relationships (Marans & Cohen, 1991, 1996; A. Freud & Burlingham, 1973). When the capacity to move from such early, direct displays to more prosocial expressions of aggressivity is undermined by poverty, family dysfunction, overstimulation, and threatened or actual physical danger, the basic preconditions for feeling competent—including physical safety, stable relationships, and success in achieving desired goals—are eradicated.

Multiple Experiences of Violence

The Child Development–Community Policing (CD-CP) Program (Marans et al., 1995) and its 24-hour Consultation Service has afforded investigators the opportunity to observe children of varying ages and backgrounds and their families shortly after their exposure to violent incidents that include shootings, stabbings, beatings, maimings, and death. In this work, we have witnessed and investigated the impact of violence on the developmental process of infants and young children. Violence, here, refers to a situation in which individuals' actions carry the intention to injure or to abuse; in which actions become furious, turbulent, and potentially lethal; in which individuals become excited or enraged to a point of loss of control; and in which the essential components of the sense of psychological safety—regulation of affective states, predictability of the environment, consistency in caregivers' responsiveness, physical safety and well-being, containment of anxieties and terrors—are shattered. In considering a child's exposure to violence, it is essential to understand the multiplicity of experiences and responses that are determined by an interplay of factors both within the child and in his or her surroundings, which include:

- Characteristics of the violence itself—that is, the child's relationship to the perpetrator and victim, proximity to the incident, response of the caregivers.
- The developmental phase of the child who is exposed—that is, the status of emotional and cognitive resources for mediating anxiety associated with objective and fantasized dangers.
- The familial and community context of the violent incident—that is, is the incident isolated and unusual or part of a chronic pattern of experience of daily life?
- Recognition of, and sustained responses to, the possible effects of the child's exposure to violence by family members, school personnel, and community institutions.

Children seen through the CD-CP program have ranged in age from 2 to 17 years. Initial clinical contact has occurred from within minutes of a violent event to several days later. The immediacy of clinical contact has given investigators an unfolding picture of the children's and families' responses from the acute moment to longer term adaptations.

Although there is tremendous variation among children, at the acute moment of a traumatic event, common observations have been reported, including:

- Intense longing for the presence of and concern about the safety of primary caregivers.
- Disbelief and denial of the outcome or occurrence of the event.
- Revival of memories and much talk about previous losses, injuries, fights witnessed.
- Emotional lability that can range from isolation of affects to tearfulness (although not so common) to rage and replaying of events with ideas that might have altered the real outcome (e.g., "If only he had . . . ,", "If only I had . . .") and developing intervention fantasies (Pynoos et al., 1995).
- Attribution of blame to those not involved in the violent event (e.g., with social institutions, etc.) and attendant, at times explosive, anger.
- Reveling in the excitement of the action with bravado (e.g., talk of the type of weapons used; who got "capped," "waxed," or "aired").
- Apparent indifference (e.g., "it [violence] happens all the time, it's no big deal")

In both the acute response and longer term adaptation, how the child makes sense of what he or she witnessed and the particular meanings that emerge over time as the child begins to digest and to organize fragments of traumatic memory are embedded in a developmental matrix. A child's responses to traumatic events thus reflect both the unique characteristics of the event, as well as the particular phase-specific concerns, anxieties, and fears that are stimulated and made more complicated by what the child has witnessed. In order to understand both the child's greatest areas of vulnerability to trauma and the phase-specific attempts at restitution and/or symptom formation, it is essential that the clinician consider nodal developmental constellations as they determine the specific experience of each individual child.

Violent Trauma in a Developmental Context

Children's exposure to violence, whether occurring in the home, on the streets, or in the school, may lead to overwhelming levels of stimulation

and ego disorganization. Numerous contemporary investigators have contributed to our understanding of childhood trauma, whether elaborating on the traumatic moment and typologies of associated phenomena (Pynoos et al., 1995; van der Kolk, 1994; van der Kolk, Greenberg, Boyd, & Krystal, 1985; Terr, 1989, 1991; Marans, 1994; Marans, Berkman, & Cohen, 1996), the nature of intervention fantasies (Pynoos et al., 1996), rates of children's exposure (Martinez & Richters, 1993; Osofsky, Wewers, Hann, & Fick, 1993; Schwab-Stone, 1996; Garbarino, Dubrown, Kostelny, & Pardo, 1992; Taylor et al., 1992; Singer et al., 1995), or the neurophysiology of mediation/regulation of stress/overstimulation (Southwick et al., 1993; Perry, 1994 and Chapter 7, this volume; van der Kolk, 1994; Yehuda & MacFarlane, 1995).

Perhaps one of the most important elements of earlier conceptualizations of childhood trauma is the notion that internal, or endogenous, dangers change as development progresses, for example, from the threat of loss of the mother as object to loss of bodily integrity, to loss of the mother's love and, ultimately, to loss of the superego's love, and call for alterations in the individual's relationship to the external world (S. Freud, 1926/1974). As Freud suggested, these feelings have their roots in "some situation that has been experienced in the past," and he points out that "in relation to the traumatic situation, in which the subject is helpless, external and internal dangers, real dangers and instinctual demands converge" (p. 168).

Any experience can be traumatically overwhelming for both children and adults. When a situation arises in which the individual's protective and defensive resources are overwhelmed and he or she cannot metabolize an exceptional experience, psychic trauma may ensue. However, what sets childhood trauma apart from adulthood trauma is that, for children, the adaptive capacities, defensive structures, and internal resources—as these are determined by developmental processes—are vastly different than those potentially available to adults. In the throes of the maturational process, children have fewer and more uneven psychological resources at their disposal; their developing defensive organization is acutely vulnerable to traumatic disruptions, derailments, and impingements from the environment. The child's experience of helpless surrender to overwhelming circumstances threatens to undermine newly consolidated and most recently attained developmental capacities. Such regression often leads the child toward earlier configurations of needs, fears, conflicts, and anxieties, as well as earlier modes of mediating them. As children progress through infancy, preschool years, and school-age years into adolescence and adulthood, the nature of their defensive and adaptive capacities is transformed with the unfolding of the developmental processes, becoming more robust, less brittle, and more able to withstand the regressive shifts in functioning at times of extreme stress, whether

internally or externally founded. Children whose development is already fragile, and who have not attained the optimal potential of each developmental phase, are at greatest risk. In light of this situation, considering the child's developmental status can help bring us closer to understanding the experience of childhood exposure to violence and trauma.

INFANTS AND TODDLERS

The early development of affective life unfolds within the matrix of the mother–infant relationship, through which the baby comes to know itself, others, and the world in which it lives. The normal developmental tasks of infancy involve the gradual unfolding of a sense of self-consolidation and the emerging capacity to regulate internal states and achieve a state of homeostasis. Neurophysiological development, the ability to engage in and sustain mutually satisfying reciprocal interactions, a sense of orientation to objects and people, and the development of awareness and cognition, flourish at moments when the infant, untroubled by internal distress, interacts with the world with the calm attention of an alert, active state. These tasks are facilitated by two types of experience. One is related to the regular, reliable “good-enough” care the infant receives, including being bathed, held, and rocked, whereas the other arises out of accrued experiences of shifts in internal states and consequent state regulation (Mayes & Cohen, 1993).

Infants must gradually acquire the ability to manage a range of affective state internally and, when they cannot, to develop an ever-increasing array of defensive strategies to protect the self against an onslaught of intolerable emotions. In early infancy, the good-enough mother's empathic sense of her infant's states and her intuitive awareness of its ever-growing affect array enable her to serve as a filter, or auxiliary stimulus barrier. In this way, she allows the child to experience increasingly intense affective states, intervening to provide comfort, and soothing when the tension level threatens to be overwhelming (Krystal, 1988). Gradually, the child internalizes the parent's regulatory function. The caregiver–child matrix thus forms the basis and organization of the baby's earliest affective experiences. Adequate environmental provision permits the infant to develop a cohesive sense of self, which leads to the capacity for purposeful, goal-oriented movement and direction.

A world made unpredictable and hazardous by the intrusion of unanticipated and overwhelming dangers compromises the infant's healthy curiosity and increasing exploration of the environment. Violent events threaten a child's sense of secure attachment, which is an essential, stable base from which the child can venture forth in exploration of the sur-

rounding world. Confronted with adults who harm or fail to protect them, young children may turn inward, no longer expect to find help from adults or others, and attempt to rely on their own (largely inadequate) internal resources.

This unreliability can be particularly devastating to toddlers, whose increased ability to function autonomously rests on the parent's ability to encourage and applaud their strivings toward mastery, while remaining a constant and reassuring source of support and mirroring. Such young children may increasingly doubt their own competency, and may gradually come to avoid contact with potential sources of help, instead of seeking out trusting and helpful relationships (A. Freud & Burlingham, 1943; Hellman, 1962; Laor et al., 1995; Furman, Solnit, & Lang, 1968; Osofsky, 1995).

Conversely, young children who experience violence may evidence their distress by desperately clinging to a parent or caregiver, unable to tolerate the peril of repeated loss. In this case, one may see behaviors that include anxiety, clinginess, inconsolability, sleep disturbances, toileting problems, and temper tantrums related to difficulties in separation. For the young child who is learning to actively master his or her own aggressive impulses—in increasing efforts to conform to parental expectations and, ultimately, internal, or superego, demands—exposure to uncontrolled hostility on the part of others may unleash a wave of regressed, disorganized, and unchecked aggressivity. This, in turn, can produce heightened fearfulness and anxiety for the child, now unsure of either the limits of his or her rageful, destructive urges or the caregiver's capacity to help contain the aggressive behaviors and destructive fantasies.

LARRY

After his 18-month-old sister was drowned to death in the bathtub while the siblings shared a bath, 2½-year-old Larry became irritable, defiant, and incapable of tolerating even minimal amounts of frustration. Larry was sent to live with his maternal grandparents by the child protective services agency. He was told that his sister was in heaven, where she was happy and well. However, this explanation failed to allay his concern; he repeatedly looked for her and asked to see her. His evident confusion about recent events, including, from his 2-year-old point of view, his sister's mystifying disappearance, his perplexity about why she did not return and why he could not see her, the grief of the adults around him, and his unexplained separation from his mother, left him anxious and insecure. He needed constant reassurance that neither his significant caregivers nor, indeed, he himself would disappear and be gone forever, like his sister. As the weeks progressed, Larry's behaviors became increasingly dis-

ruptive at home, with frequent temper tantrums, demandingness, and clinginess.

There were various ways in which Larry could give expression to his frightening experience of the violent death of his sister. Both Larry's mother and grandmother were frustrated and disappointed by his increased difficulties in separating, which they construed as his "acting like a baby" and "trying to get attention." They had previously viewed him as a precocious youngster and were proud of his independent ways and his saucy manners. Unsure of him now, they alternately indulged him and rebuked him. They were covert in their praise of him and tended to be watchful and to discipline him often, encouraging him to "be a good boy." His family's attempts to make him "grow up" only increased his anxiety and the very behaviors that they found so irritating. Larry became more aggressive, frequently lashing out at his caregivers, kicking and throwing. His preoccupation with themes of aggression, violence, and power were demonstrated in his perseverative play that included dinosaurs that battled, animals that attacked, and baby dolls that were strangled. He was especially worried about his own bodily safety, and was frightened by the intensity of his aggressivity.

What began as play often deteriorated into disorganized, explosive displays in which the line between imagination and reality became frighteningly blurred. The adult caregivers were often unable to recognize when he needed their help in tempering the level of excited, violent activities and the anxiety that often followed. Larry's mother and grandmother began to use the clinical meetings as an opportunity to explore the meanings of his symptomatic behaviors and to respond with increased appreciation for his developmentally appropriate needs. For example, recognizing his anxiety associated with leaving home, they permitted Larry to carry a small toy from home when he went to day care. After a few months, Larry's mother gave him a photograph of his sister and allowed him to keep it in a special place he chose.

PRESCHOOLERS

For preschool children (4–6 years old), normative issues regarding competition with same-sex parents, sibling rivalry, power and size, curiosity, struggles between loving and hating, and concerns about bodily integrity, take the foreground, providing the context in which children experience violent events. Such was the case involving seven children, aged 5 and 6 years, who were sitting on a school bus when their classmate was struck in the head by a bullet that went astray in a gun battle between rival drug dealers (Marans, 1994). The wound was not fatal. The children were seen by CD-CP clinicians within minutes of the shooting. Through

drawings and discussion, each of the children initially focused on the wish to see their mothers, and on concerns that something awful might happen to them (e.g., the mothers might be shot themselves, get into a car accident on the way to picking up the children, or get lost). As police officers and clinicians reassured the children that each of their parents had been notified and were on their way, the discussion with the children shifted. As one child asked a clinician to draw a picture of a head, all of the children began discussing their questions about what happens when a head is shot with a bullet. Although there were some questions about what was happening to the friend who had been shot, the majority of questions and comments had to do with curiosity about bodily functions—How much blood does the body have? Can parts of the body fall off?—and quickly turned to a more spirited group discussion about various physical feats each could perform. The discussion was punctuated by the sidelong glances to the door as parents began to arrive to pick up their children (Marans et al., 1995).

Five of the seven children received follow-up psychotherapy because of enduring posttraumatic stress symptoms—disruptions in sleeping and eating; increased separation anxiety; and hypervigilance, generalized anxiety, and avoidant behaviors—that were not part of the premorbid history. Each of these children was in treatment for 4–6 months. The presenting symptoms resolved as the children could be helped to disentangle and clarify what they had witnessed from the age-expectable fantasies and conflicts that were aroused, exacerbated, and complicated by the shooting.

Young children who witness real-life damage to limbs, gunshots to the body, or bloody scenes of violence may worry profoundly about their own bodies being whole and kept together. Similarly, children who witness their parents or caregivers engage in violent fights may be terrified that *one* aspect of their competitive wishes for an exclusive relationship with one of the partners may in fact come true. In addition, preschool children's exposure to interpersonal violence may introduce additional confusion as they are consolidating their sense of right and wrong. In the aftermath of exposure to violence, the unreliability of the developing sense of justice, or conscience, only heightens their anxiety as they attempt to monitor and contain the enactment of their own hostile and destructive urges.

In the face of both external and internal dangers, a range of symptoms may follow, including difficulties in separating from caregivers; difficulties sleeping, eating and toileting; fearful avoidance and phobic reactions; social withdrawal; poor attention; provocative and demanding behavior; regressed or infantile presentation.

When exposure to interpersonal violence breaches the boundary between fantasy and reality, identifications may also be impaired, particu-

larly when caregivers or significant figures in the child's life are violent and/or victimized. For example, a boy's sense of his own masculinity may be complicated if the primary figure for identification demonstrates his manhood through hostile and aggressive behavior. Similarly, for a young girl whose mother is either an overwhelmed, bruised victim or an aggressive attacker, the model for feminine identification is based on frightening images of either helpless submission or destructive power. For both, intimate adult relationships may continue to be viewed in their earliest, infantile forms, dominated by excitement, danger, pain and suffering. This was the case for Dayvon.

DAYVON

Dayvon, a 5-year-old boy who had witnessed his father murder his mother and then shoot himself to death, struggled with what it meant to wish to be like his father—big, powerful, manly—without having to kill his longed-for mother or to receive the fatal punishment that his father inflicted on himself. For this boy, the complication of normative conflicts led to difficulties both in his new home with his grandparents and at school. Dayvon alternated dramatically between, on the one hand, being a hostile, combative, and “tough guy” who was fearless and dangerously powerful, and on the other hand, a fearful infant who could only seek much-needed emotional contact with mother substitutes through clingy, demanding behaviors.

Magical Thinking

Witnessing or being exposed to violence also impacts on the young child's development of reality testing (Marans et al., 1996), making the presence of real experience of death, loss, or bodily injury especially powerful and disruptive. In the aftermath of violence, children's inner lives are affected by their knowledge that things that should reside only within the depths of unarticulable, archaic fantasy, are no longer confined to fantasy. The violent horrors that belong to the world of the child's most primitive fears and terrors are materialized in real-life experiences. In the inner worlds of these children, there is a danger of a blurring of boundaries between fantasy and reality. Individuals who have undergone traumatic events often have difficulty in “maintaining the ‘make-believe’ quality of fantasy” (Levine, 1982, p. 75). Traumatized children do not have difficulty in drawing the line between what is real and what is unreal, but rather, in distinguishing what is *not* unreal—although it should be—from what is, indeed, the product of their own imagination. A reality infused with terror collides with the world of fantasy and symbolic representation.

A young child's developing representational world permits the child to begin to contain the anxiety associated with forbidden wishes, to give expression, in fantasy, to conflictual urges, and to delay gratification of impulses. Nonetheless, powerful urges press forward, and forbidden wishes that challenge the rudimentary representational capacities rise to the surface. Children who witness or are exposed to violence may evidence confusion about the boundary between the imagined "bad" thoughts they hold inside—the greedy wishes, rageful fantasies, or urges to mess they have attempted to renounce in favor of gaining adult approbation and avoiding censure—and the real-life events that terrify them. Although some children may rely on their magical thinking in an attempt to reassert a sense of control, as a form of restitution in the face of overwhelming helplessness, such thinking may allow them to wrongly conclude that the "evil" thoughts they secretly harbor are indeed dangerous and powerful, and are the root of the "bad" events. The resulting harsh self-evaluation leads to internal confusion, feelings of shame and badness, threatened loss of the real object or loss of love, giving rise to heightened anxiety and attendant symptom formation (Marans, 1994).

Similarly, for the young child whose level of thinking is preoperational, abstract events and concepts such as "death," "heaven," and "God" are confusing and easily misconstrued, with the associated danger of mystification and misapprehensions about the world. A child attempting to make sense of fragmentary knowledge and frightening memories may generate his or her own "explanations," often fantastical and grotesque in nature, that are far scarier or more distressing than what has actually occurred. Such faulty explanations may be accompanied by the onset of behaviors aimed at restoring some sense of order and predictability, which ultimately fail to provide relief, such as perseverative play or ritualistic behaviors. Because young children's thinking can be so concrete, for example, reassuring talk of "heavenly resting places" may also give rise to frightening fantasies of meeting up once again with the victim of violence and attempting to repair the loss, or come to grips with it, while also being terrified by the imagined vengeance that may accompany such a ghostly visit.

SCHOOL-AGE CHILDREN

The next phase of development, latency, occurring between ages 7 and 12, introduces a new context in which the child experiences and organizes his or her exposure to violence. Continued development of intellectual, sensorimotor, and social skills and opportunities offers the school-age child various pathways for less direct expression of the urges and norma-

tive conflicts that dominated earlier phases of development. For example, close friendships, involvement with a peer group, and relationships with other admired adults or teenagers support the child's shift away from the exclusive reliance on parents, while introducing an expanded range for the child's exploration of the world outside the family. Optimally, the curiosity about the parents' intimate life, anatomical differences, and the origin of babies that dominated earlier years can now be exercised both in and outside of school. The school-age child is now capable of having a clear sense of right and wrong, of having empathy with the feelings of others, and of "playing by the rules" (Marans et al., 1996). Optimally, the school-age child engages in aspects of daily living such as hygiene, dressing, and looking after possessions with greater autonomy. The capacity for operational thought and problem solving, along with increased frustration tolerance, increases the range of potential activities and sources of satisfaction.

For school-age children, the greatest threat is the reemergence or breakthrough of earlier longings and urges that are now felt to be too babyish, dependent, or intimate, and undermine their emerging sense of competence and autonomy. For that reason, the school-age child's close encounter with violence may be extremely disruptive, requiring various attempts to ward off the associated feelings of fear and helplessness. As with younger children, school-age children may respond to their exposure to violence with circumscribed symptoms, involving sleeping difficulties, nightmares, worries about burglars, bodily injury, and death. In addition, regression to earlier modes of relating to parents may be prominent. For example, increased struggles over food, self-care, schoolwork, or household responsibilities may be some of the behavioral phenomena that accompany children's attempts to defend against and give expression to the anxiety associated with witnessing interpersonal violence.

AMANDA

Eight-year-old Amanda was referred for evaluation after her 14-year-old brother fatally stabbed her mother's boyfriend of 2 months. Amanda reported that she was asleep at the time of the incident, but in the days following, she experienced recurrent nightmares, fearfulness, distractibility, and difficulty separating from her mother. As a young child, Amanda had been exposed to numerous distressing events after her parents' divorce, at which time her father began to stalk and terrorize the family.

Following the murder, Amanda was preoccupied with themes of danger, violence, and lack of protection. In play, pretending to be under assault by a hungry, man-eating dinosaur, she developed

elaborate safety devices to secure her hiding spots and built an arsenal of weapons with which to defend herself. She played hide-and-seek games that gradually reached peaks of excitement mingled with foreboding. During this period, she maneuvered to have illicit telephone conversations with her imprisoned father—contact that she knew had been forbidden by the terms of her father's jail sentence. The phone calls gave rise to fantasies of being reunited with her idealized father. As her excitement mounted, so did her fearfulness, dread, and shame. In this instance, the more recent events—the death of her mother's boyfriend, which had transformed her brother into a murderer—had stirred memories of earlier times with a father who was both exciting and beloved, and simultaneously terrifying and dangerous. The intensity of her yearning for her father illustrates her powerful wish to deny and undo the reality of her memories of terror, as well as her inability to relinquish the arousal laden with excitement and dread associated with her father.

When there is no success in helping a child to reorganize and resume progressive development, symptoms may become chronic adaptations to feelings of helplessness and fear. In the wake of exposure to violence, there may be an accretion of secondary disruptions to developmental progression. For example, the child's initial withdrawal into fantasy and inattentiveness at school leads to academic failure, which now serves as an additional source of lowered self-esteem. The response of turning passive into active may move from teasing to bullying, to the child's dominant representation of him- or herself as a strong but bad kid. Similarly, identifying with the aggressor may become a chronic hedge against feeling vulnerable to attack as the child courts recognition and affiliation with the toughest figures on the neighborhood streets and becomes involved in antisocial and violent activities. Whether immediately or long after a violent event, school-age boys in particular may respond primarily with excitement or awe about the technological power of weapons and their effects. These responses may be misconstrued as evidence that they are not upset, disturbed, or affected by what they have seen. Often, it is because of this initial presentation that many of the children who witness violence in the streets of their neighborhoods are not identified as at-risk or in need of greater parental and, perhaps, professional attention.

LEROY

Leroy, an 8-year-old boy, attends a therapy group for children who are HIV-affected. He lives in a violent neighborhood where drug houses and drug lords preside. His mother is HIV-positive, and he has lost several family members to drugs and violence. Leroy was

having numerous difficulties both at home and in school. His teachers reported that during classes, Leroy seemed distracted and inattentive, staring out the window and often not responding when addressed. In the past few weeks, he had begun to exhibit increasingly dangerous and reckless behaviors, spoke perseveratively about guns, shootings, and accidents he had witnessed, and expressed vague fears that he himself would come to harm.

On the evening that his mother was hospitalized for a surgical procedure, there was a drug-related shooting behind Leroy's house. Forty shots were fired. The next day in group, Leroy spoke excitedly about holdups and stabbings. He vividly illustrated how he would defend himself if anyone ever tried to get *him*, pantomiming stabbing his assailant in the chest and ripping off his imagined mask. Although the therapist wondered whether Leroy linked these scary ideas to his mother's illness, the boy avoided referring to his mother and instead related in a highly agitated way a series of scary, dangerous events that had taken place in his neighborhood over the last few days. He expressed an admixture of admiration and awe for the drug dealers in his neighborhood and acknowledged that he knew them all and sometimes even worked for them. He gleefully reported that they have lots of money and that he, too, would like to have money to buy things. He referred to their guns, which excited him. He then rapidly spun into a series of frightening episodes, including one younger brother getting hit by a car and another almost choking on a sourball. In his retelling, he leapt up to demonstrate the choking in an exaggerated, wild way, with much excited giggling, and declared that he knew what he would have done if he had been there. A few moments later, he decided to make a get-well card for his mother, which served as a window into the vulnerable and needy feelings so deeply buried beneath bravado. In it he wrote, "Dear Mommy, I hope you get well soon, I love you, you are the best mommy. Love, Leroy."

ADOLESCENTS

Adolescence is one of the most dramatic phases in the course of development, marked by profound changes in biological, psychological, and social functioning. With great intensity, biological processes focus the young adolescent's attention on concerns about bodily changes, sexual sensations, and intimate relationships. These changes are often greeted with a mixture of pleasure and trepidation (Marans et al., 1996; Dahl, 1993; Kestenberg, 1980; Blos, 1970); in the entry into man- and womanhood, the changes can be experienced as happening too quickly or not quickly enough. Increased excitement and anxiety accompany the adoles-

cent's recognition that he or she now possesses the equipment for acting on sexual and aggressive urges in ways that had previously been in the realm of fantasies that accompany earlier phases of development.

One result of increased internal tension may be seen in the adolescent's more tumultuous relationships with parents, involving struggles between the wish to remain dependent and close and the urgency to achieve independence and new relationships. These struggles are often played out around old issues having to do with bodily care and hygiene, cleanliness and orderliness of personal property, insensitivity to the feelings and needs of others, and intense preoccupation with immediate satisfaction of one's own needs (Blos, 1962; A. Freud, 1958; Laufer, 1985; Marans et al., 1996; U.S. Department of Justice, 1995).

Disregard for family rules may at once serve the adolescent's attempts to gain emotional distance while implicitly inviting parents to remain intensely involved. Additionally, the adolescent finds refuge from the claustrophobic pull of family ties in academic, athletic, work/money, musical, and political interests, and potentially in illicit drug use, drinking, and crime as well. Similarly, as the adolescent withdraws from his or her parents, the intensity of the attachment to them is shifted to the peer group and new intimate relationships. The push for mastering anxiety associated with dependency and infantile incompetence provide added push to the adolescent's move toward real independent functioning. Given the enormous demands that are already inherent during this phase of development, exposure to violence places an additional and special burden on the adolescent's attempts to feel competent, autonomous, and safe. As suggested earlier, the individual's response to an acute episode of interpersonal violence will, in large part, be determined by the nature of the violence itself and by the status of the individual's negotiation of past and current developmental tasks. As increasing numbers of adolescents are exposed to violence—particularly in urban, high-crime neighborhoods—the effects may be seen in changes at home, at school, and in perceptions about the world in which they live.

In addition to the posttraumatic symptoms described earlier, adolescent experiences and perceptions of their own vulnerability may lead to increasingly risky reactions that interfere with the tasks and requirements of this phase of development. Reactions may range from staying away from school in order to avoid the potential for violence on the streets and in the classroom, to arming themselves as protection, to involvement in gang or other criminal activities (Appelbone, 1996). As with disturbances of neurovegetative functions, withdrawal into fantasy, social isolation, and regressive symptomatology, these responses serve the adolescent's attempts to guard against and even reverse feelings of helplessness and overwhelming fear.

Adolescents' general experience of feeling unsafe is underlined by the finding of a number of investigators (Harris & Associates, 1996; Schwab-Stone, 1995; Singer et al., 1995; Martinez & Richters, 1993) and by Justice Department reports that teenagers between the ages of 12 and 15 are victims of crime more than any other age group, and that adolescents of all ages are victims at twice the national average (U.S. Department of Justice, 1995). Although the numbers suggest the extent of the real danger of urban violence that confronts all too many teenagers on a regular basis, they do not tell us about the fuller experiences of those who face it. As with younger children, when we are unavailable or unable to listen, we are unable to learn about the specific meanings or individual contexts in which exposure to violence occurs, or about the various responses that follow.

CHARISSE

Charisse was 15 years old and living with her mother, father, and two younger brothers when she was robbed of her leather coat at gunpoint and beaten. She suffered minor bruising and was very shaken after the event. She was referred to the CD-CP consultation service by the officer who had responded to the scene, and was seen by a clinician for 3 months following the robbery. For several weeks, she was unable to sleep through the night, refused to go to school and, perhaps most notably, she was unable to go into any of the rooms in her house unaccompanied. After several nights, Charisse insisted that her mother sleep in the same room with her. Although she had been doing well in school and had purchased her leather coat from earnings from a part-time job, Charisse described feeling like a "frightened baby" no longer able to look after herself. As she continued to feel frightened and jumpy, or hypervigilant, both Charisse and her mother reported increased bickering between them that often ended in screaming battles. In the clinical work, a more conscious link could be made between the strength of Charisse's increased feelings of dependence, her repudiation of these feelings, and her fights with her mother. Additionally, helping Charisse's mother recognize the connection between her own anxiety about the event and a resurgence of a wish to overprotect and control Charisse's activities as if she were younger, helped both mother and daughter to disengage from the intensity of the struggles that followed the robbery and assault.

During the course of her treatment, Charisse was also able to confide in the therapist that throughout the robbery she feared that she would be raped. Over time, she made a significant link between this fear and her avoidance of school. She described a budding relationship with a boy at school and the fact that her thoughts about him had become increasingly "romantic." However, since the robbery,

Charisse had felt especially anxious and somehow ashamed every time she thought of this boy. For Charisse, the normative adolescent anxiety associated with burgeoning sexuality had become intertwined with and potentiated by the intense vulnerability she felt following real danger, bodily damage, and loss of control. She came to understand that her school refusal did not simply reflect avoidance of the now dangerous streets she would have to traverse on the way to school. By staying at home, Charisse also attempted to avoid the powerful sexual feelings associated with her ideas about this, potentially, first boyfriend.

Although Charisse experienced disruption in multiple areas of her development following her victimization, her heightened conflicts and symptoms concerning autonomy and sexuality did not continue to dominate her adolescence. She did not forget the robbery/assault or the anger and sense of vulnerability that followed. However, she was also able to disentangle the multiple meanings of what she had experienced and return to school, to important relationships, and to the path of optimal development. For Charisse, this event of close, personal contact with violence was the first. Her healthy development prior to the event, family support, and additional help aided her negotiation of and recovery from her traumatic experience.

However, for many other children the acute episode of violence is experienced in the context of multiple traumatic events and adverse factors that have undermined development from early on.

ANDRE

A clinician from the CD-CP program was called to the hospital to consult with medical staff about a 15-year-old boy who had been shot twice in the upper thighs by rival drug dealers. His friend lay in a coma in the ICU with what would prove to be fatal gunshot wounds to the chest and head. The 15-year-old, Andre, was medically stable but was noncooperative with staff, alternating between screaming tirades about the slow food service, rules about visiting hours, checks of vital signs, and so forth, and sullen withdrawal—hours of staring into space, ignoring the attempts of hospital staff to engage him in discussion about his condition or about what had happened to him. When the clinician arrived on the floor, hospital staff described Andre as both a “pain in the ass” and as scary.

After the clinician introduced himself, Andre’s deadened stare shifted as he curled his lips and revealed a full set of gold-capped teeth with the initials “RIP” stenciled on the upper caps and his initials in the lower set. When this introduction was followed by angry demands for a second line to his phone so that he could keep up with the incessant beeping from his pager, the staff’s description rang true.

What emerged in discussions with his mother and, subsequently, with his public defender was the story of a boy who had multiple contacts with social services, the police, and the courts. He had a long history of developmental difficulties that began with the diagnosis of a malignant tumor at age 2 that was followed by several years of intermittent chemo and radiation therapies. His father, a mainlining heroin addict who seemed to appear in the boy's life only when desperate for a place to sleep, when stealing what meager possessions the family had in order to feed his habit, or when frustrated in those efforts, beat Andre's mother. Andre's mother suffered chronic, untreated depression and had difficulties sustaining any employment. Housing was never permanent, and frequent moves within and between towns contributed to Andre's declining abilities in school and final, persistent truancy. Having lived in another city, it was only in the last 4 months that Andre had begun spending much of his time in New Haven and, with two recent arrests for street-level dealing, Andre was becoming known to the police and to the juvenile courts. In fact, at the time of the shooting, Andre's case was pending, following his failure to stay with an Alternative to Incarceration outpatient drug abuse program. His next court date was to be in 6 weeks.

Andre's threats of seeking violent revenge were intensified with news of his friend's death and by the acute psychotic episode that followed. He was hospitalized on a psychiatric unit for several days until his psychosis cleared and the acute demand for beds led to his discharge. Before appearing in court, 4 weeks after the shooting, Andre was admitted twice to ERs in another town with PCP psychosis and subsequently arrested on another drug dealing and, now, weapons charge prior to his being adjudicated to the state juvenile corrections facility for 18 months. In this case the developmental psychopathology was beyond therapeutic help, and earlier intervention proved too little, too late. Since leaving that institution, Andre has returned to the streets, where he has rejoined the legion of young men who find their sense of potency and effectiveness in the lucrative drug trade and at the business end of a gun.

SUMMARY

In considering the traumatic potential of children's exposure to violence, we have relied on a concept of "trauma" defined as an exceptional experience in which powerful and dangerous stimuli overwhelm the child's capacity to regulate his or her affective state. Initial and subsequent responses can be understood as both restitutive and self-protective in nature. Children's responses to traumatic violence are best understood in light of current developmental attainments and mastery of previous developmental challenges, as each developmental phase brings with it

unique developmental demands that simultaneously enrich the children's array of defensive abilities and give rise to particular developmental vulnerabilities.

In the face of a violent episode, children's feelings of insecurity and impotence undermine their normative strivings toward a sense of mastery and competence in the environment.

Younger children, for example, depend on their caregivers to mediate their environment and to titrate and regulate experiences that are distressing. As children learn to mediate the press of normative aggressivity, they enter a developmental period in which acute episodes of danger, loss, and violence can interfere with the age-expectable attainments of school-age children, such as the ability to engage genuinely in academic endeavors, to expand beyond the family into the social world of peers and extrafamilial adults, and to take pleasure in increased autonomy and self-reliance. In adolescence, the experience of violence can give rise to uneasy, dreaded feelings of helplessness or neediness, which threaten to override the developmental thrust toward increasing autonomy, affiliative longings, and burgeoning sexuality.

Without help from the environment or, alternately, without relief from unremitting episodes of violence, specific and circumscribed symptoms may cease to serve a restitutive function and may instead come to reflect a chronic maladaptation that compromises the development of children's more adaptive and progressive developmental attainments, whether in the realm of cognitive, affective, or regulatory capacities. The ways in which children negotiate the consequences of exposure to violence, bodily damage, and loss rely in large part on the environment's capacity to recognize and support the attempts to work through the specific meanings, concerns, and restitutive attempts. When overlooked or misunderstood, children's attempts to ward off feelings of helplessness, guilt, or shame may have an enduring effect on adaptation and may derail the path of optimal development and functioning.

However, a traumatic event may hinder caregivers' abilities to listen or decode children's symptomatic language that signals their distress. The adults' inability to attend to children's needs in the wake of violence may be a natural consequence of their own attempts at restitution and self-protection from the feelings of vulnerability and traumatic disorganization. In the face of traumatic exposure to violence, for example, a mother who is already having difficulties tolerating the demanding advances in her child's development may experience her child's needs especially acutely in the aftermath of violence and overwhelming anxiety. Similarly, a parent who has been exposed to violence may experience a heightened intolerance for the normative aggressivity of young children.

Parents may not readily associate an increase in behaviors such as biting, kicking, or hitting with recent exposure to trauma. Misunderstanding the source of their child's behavior may lead parents to adopt a punitive, detached, or irritable stance, which can frustrate or shame the traumatized child. At these times the child must contend with the dual burden of the caregiver's own experience of anxiety, neediness, and disorganization along with a lowered threshold for the confusing and demanding signals regarding dependence and autonomy. For parents and professionals alike, the nature of a child's traumatization is too often viewed solely in terms of the external circumstances of the violent events. Such assumptions often fail to consider the child's own unique experience and the particular meanings attributed by the child in its aftermath. Thus, an important opportunity may be missed to generate intervention strategies that are based on an appreciation of the interplay between the child's experience, developmental status, and the greater environmental context within which the violence has occurred. If, however, parents are better prepared to appreciate the full range of their child's experience, they can better help him or her to tolerate and work through the feelings, confusion, and uncertainty—neither denying the reality of what the child witnessed with his or her own eyes, nor flooding the child with more detailed and complex information than the child can digest. Exploring the broadest array of the child's unique experience of violent events also has direct implications for developing immediate and follow-up strategies for intervening with those institutions involved in the life of children and their families, and within their community. When there is no one available to listen, children are alone with the distress and disorganization that so often follows their close encounters with interpersonal violence. On their own, attempts to recover from overwhelming fear, uncertainty, and helplessness may be at a very high price to children's developmental potential as well as to the communities that have been unable to protect or support them.

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Child Development and Adaptation to Catastrophic Circumstances

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In this chapter the authors focus on the effect of communal violence in the United States on the development of children. The authors, all of whom are associated with the Yale Child Study Center, approach the milieu of violence as an increasingly severe public health problem, but they also show how the individual child is affected by it.

Steven Marans, Miriam Berkman, and Donald Cohen and his colleagues have gathered statistics that document the scope of the problems faced by so many of the children growing up in urban North America today. These appalling statistics represent a perverse competition: the United States is far "ahead" of other countries in the prevalence of crime and violence and in the number of homicides and premature deaths among young people. Some of these data and others are also reviewed in chapter 7, in which Michael Greene emphasizes their impact on young adults and adolescents. Younger children who live among violence know too soon and too well that they are at risk. They know it from the fear and protectiveness their parents display; they know it from incidents that mar their daily lives.

In this chapter the authors view external violence from the perspective of the child, who under normal circumstances struggles with his own aggressive impulses and their expression or repression. They show how the worker's attunement to the child at a time of external crisis can allow the child to learn, to feel better and more secure, and to advance developmentally—not to crystallize fear, hate, and revenge fantasies that would inevitably lead to the repetition of the destructive cycle.

Furthermore, they show how such psychoanalytic work with individual children can be

done in the context of an ongoing community program. This chapter builds on chapter 3 by showing examples of individual therapy with children.

The Child Development–Community Policing Program in New Haven, Connecticut, is an outstanding project that other communities, especially those with an existing infrastructure (that is, a police department and child development experts), would do well to emulate. The program spreads knowledge about and responsibility for children among more adults, providing a larger safety net and more possibilities for primary as well as secondary prevention of trauma. For the police, the cooperative program offers greater humanization of their job, more regard from the public at large, and greater personal dignity and self-respect. For mental health professionals, the program is an opportunity to apply skills beyond the consulting room, to have a wider and deeper impact on children—and the future.

Children who live in nations torn by war for many years feel that their neighborhoods are dangerous and their world unsafe. They cannot walk the streets with a sense of mastery, ownership, and security. Instead, the sight of wounded and dead bodies on the sidewalk and the sounds of nightly gunfire are daily reminders of the hazards they must negotiate; friends in caskets are evidence of what could happen to them. These children also sense that their communities are surrounded by a safe, prosperous society from which they are excluded. They often lack the supports of family or of the community and its institutions to help them deal with their anxiety and despair. It is a horrifying fact that much the same can be said of children in the American inner city.

The statistics regarding the incidence of assaultive violence are disturbing testaments to the scope of the danger confronting so many American children today.

- From 1984 to 1993 there was a 51 percent increase in violent crimes (murder, forcible rape, robbery, and aggravated assault) in the United States (U.S. Department of Justice, 1994).
- In 1993 there were 24,526 murders, 104,806 rapes, 659,757 robberies, and 1,135,009 aggravated assaults nationwide.
- Between 1983 and 1992 there was a 46.1 percent increase in arrests for possession of weapons.
- In 1991, 2.2 million people suffered nonfatal injuries from assaultive violence.
- Homicide is the second leading cause of death among fifteen- to twenty-four-year-olds.
- African American male teens are eleven times more likely to be killed by guns than are their white counterparts.

- From 1989 to 1990 Boston had a 45 percent increase in urban violence; Denver had a 29 percent increase; Chicago, New Orleans, and Dallas had increases of 20 percent (Surgeon General's Workshop on Violence and Public Health, 1991).

Studies of rates of children's exposure to scenes of violence produce equally alarming statistics.

- At Boston City Hospital it was reported that one out of every ten children seen in the primary care clinic had witnessed a shooting or stabbing before the age of six—half in the home, half on the streets. The average age of these children was 2.7 years (Taylor et al., 1992).
- In New Haven, 41 percent of a sample of sixth-, eighth-, and tenth-grade students reported having seen someone shot or stabbed in the preceding year (New Haven Public Schools, 1992).

Such exposure to violence was associated with feelings of depression and anxiety, higher levels of antisocial and aggressive activities, greater alcohol use, lower school attainment, and increased risk taking.

Violence in America is only one of the many significant environmental factors that affect the lives of many American children. For example, each year more than 1 million children feel the effects of divorce and separation (U.S. Congress, 1989); over 1 million babies are born to unwed mothers (National Center for Health Statistics, 1988); and more than 13 million children live in poverty—over 2 million more than a decade ago. While most poor children are white, minority children are much more likely to live in a poor family: 44 percent of African American and 36 percent of Hispanic children are poor, compared with fewer than 15 percent of the white children (U.S. Department of Commerce, 1990). One indicator of the outcome of so many stressors is the fact that one in five American children between the ages of three and seventeen are reported by parents to have had a developmental delay, learning disability, or behavioral problems (Zill and Schoenborn, 1988). About 30 percent of ninth-graders do not graduate from high school, and about 500,000 youngsters drop out each year (Kaufman and Frase, 1990). In the nation's urban centers as many as half of all students drop out. Dropouts are 3.5 times as likely as high school graduates to be arrested and 6 times as likely to become unmarried parents (Schorr, 1988).

In addition, children and adolescents increasingly are becoming active participants in the violence that has contributed to the climate of social adversity and despair in which they have been raised. Nationwide juvenile arrests in 1992 included:

- 3,092 children and adolescents arrested for criminal homicide;
- 4,750 arrested for rape;
- 40,499 arrested for robbery;

- 62,039 arrested for aggravated assault;
- 138,713 arrested for simple assault; and
- 47,369 arrested for weapons offenses.

Overall, between 1989 and 1993 juvenile arrests for violent crime rose about 36 percent and juvenile arrests for weapons offenses rose 66.6 percent. The vast majority of the children and adolescents accused of violent crimes are male, and a disproportionate percentage come from minority groups and poor families (U.S. Department of Justice, 1994). Though these numbers are disturbing in themselves, statistics alone do not describe the nature of the disruptions that occur in the inner lives of children who are repetitively exposed to violence in their homes and communities.

Children's Exposure to Violence in a Developmental Context

Children's exposure to interpersonal violence disrupts basic preconditions for their optimal development. Children who witness violence do so in the context of developmentally shifting modes of expressing their own aggressive impulses and feelings. Aggressivity plays a central role in development as a means of achieving a sense of power and competence; it is also a source of conflict between love and hate. Over the course of development, the more direct enactments of the toddler's hitting, biting, and kicking shift to the preschooler's fantasies and play of destructive power, to the competition on the school-age child's sports field, to the vicissitudes of affection and anger that are a part of adolescent and adult relationships (Marans and Cohen, 1993; A. Freud, 1972). However, this capacity to move from enactment to more sublimated expressions of aggressivity is undermined when the basic preconditions for feeling competent—including physical safety, stable relationships, and success in achieving desired goals—are overwhelmed by poverty, family dysfunction, overstimulation, and threatened or actual physical danger.

In the lives of all children there are expectable experiences of aggression, violence, and bodily harm at the hands of parents, siblings, and peers, or in the context of accidental injuries. With optimal development, the child is able to distinguish between fantasy and reality, between wishes and enactment, and between projections and real dangers. Again, optimally, parents and other significant adults support children in their attempts to establish these boundaries. They help children feel that the world is basically secure and safe, that there are no demons in the shadows, that their wounds will heal, that there are limits to the expression of aggressive urges, that their *wishes* to harm others cannot cause accidents that may occur, and that they can express their scary thoughts without worrying that they will be hurt in retaliation.

The potential trauma that follows the child's direct exposure to violence does not simply represent a shock that happens from outside; its impact depends on the diverse personal meanings that a given external event may carry for

passive, frightened victim and to chronic exposure to violence. Alterations in character development deriving in part from identification with the exciting and powerful role of perpetrator may become a reliable hedge against the feelings of fear and helplessness that were aroused by the actual experiences of overwhelming danger. When the most powerful models in the home and neighborhood exercise *their* potency at the end of a fist or gun, aggressive enactments rather than sublimations may be an adaptive response to both internal and external sources of danger (Marans, 1994).

Impact on Families and Communities

Adults are not immune to a range of similar responses when they are confronted by communal violence. Their inability to listen and attend to children's needs in the aftermath of traumatic events may be a natural consequence of their own attempts at restitution and self-protection from feelings of vulnerability and traumatic disorganization. The potentially detrimental effects on individual and family functioning may also be mirrored in the larger community. Extended family, friends, and neighbors may be inhibited from listening to traumatic narratives and providing distressed individuals with appropriate support for reasons similar to those that inhibit parents from listening to children. In urban neighborhoods, where drug- or gang-related violence is particularly prevalent, many residents may have such a strong psychological investment in avoiding open discussion of their chronic fear and helplessness that there are few people in the community who are emotionally available to share the burdens of other community members at times of acute exposure to new episodes of violence.

Fried described the traumatic situation as one in which the individual has experienced helplessness in the face of a danger whose magnitude outweighs the subject's estimation of his own strength" (1926, 166). In many poor urban and rural settings, the instability of families and the extended community places a special burden on existing social institutions that are called on to respond to both victims and perpetrators of violence. However, when service providers—mental health professionals, medical providers, school personnel, protective service workers, and law enforcement officers—operate in isolation in their attempts to address the multiple needs of children and families caught in the cycle of violence, they too may find themselves overwhelmed and immobilized. Alternatively, these seemingly disparate professional groups may attempt to regroup, capitalizing on knowledge gained independently, and consolidate their efforts in developing new strategies for intervening in the cycle of interpersonal violence. If mutual health professionals are to play a broader role in these efforts, then clinical expertise and research must be increasingly applied to a range of services that extend beyond the consulting room. While a violent event may precipitate a host of responses that compromise children's developmental potential, it may also provide a window of opportunity for introducing psychotherapeutic interventions and the application of what we have learned in the consulting room to the

children in terms of their own internal concerns, past experiences, and phase-specific development.

Acute and Long-Term Effects

When children witness or directly experience real communal violence, the line between fantasy and reality is blurred: their most powerful and potentially frightening fantasies about bodily injury, loss of relationships, and loss of impulse control are enacted before their eyes. In the face of stabbings, beatings, and shootings, children may be traumatized because they cannot contain the stimulation within existing mental structures that allow for accommodation and assimilation. When the capacity to anticipate and contain exceptional events of danger is lost, the child feels that dreaded aspects of internal fantasies are vivified and are overwhelmingly real. These traumatizing experiences cannot be adequately dealt with immediately by the usual behavioral responses (fight or flight), and at the same time, the mind is unable to prepare and to rely on familiar defenses (denial, repression, avoidance, intellectualization, and so on). When these behavioral and mental systems are immobilized—when the child is rendered passive in the face of events that are threatening to his body and mind—a cascade of psychological and physiological processes ensue. The violent events are remembered differently from other events, and the experience is handled in a special fashion. In response to the potentially traumatic circumstances of exposure to violence, children may develop specific, circumscribed symptoms involving disruptions in patterns of sleeping, eating, toileting, attention, and relating, and may also experience generalized fearfulness, disorganization of the startle reflex, and flashbacks of aspects of the violent event (American Psychiatric Association, 1994). The child's avoidant behaviors and general hypervigilance may reflect attempts to guard against the anxiety aroused by persistent, preoccupying memories of various features of the violent event, or they may appear more episodically in response to specific traumatic reminders that derive from a range of circumstances and subjective phenomena associated with the original trauma (Pynoos, 1993). In addition, a child may resort to turning a passive experience into an active response in an attempt to regain a sense of power and control when the dangers of real violence provoke feelings of helplessness and fear. That is, rather than feeling the anxiety and humiliation of being the victim or feeling vulnerable to the aggression of others, the child may become the perpetrator. Like the other post-traumatic stress-related symptoms, oppositional behavior at home and at school may be a transient means for the child to reassert his power precisely when he is feeling most vulnerable. However, when the child is regularly exposed to the dangers of violence, symptoms may no longer serve the function of restitution and recovery but may reflect a chronic adaptation in which vegetative, cognitive, and affective capacities and optimal regulation of functions are severely compromised. In a similar way, the perception of violence may represent another long-term adaptation to the experience of being the

coordination of diverse services that have an impact on the daily lives of children and their families. New Haven's Child Development-Community Policing Program represents one such model of interdisciplinary collaboration (Marans et al., 1995).

From the Consulting Room to the Streets: A Collaborative Response

The Child Development-Community Policing (CD-CP) Program was formed out of the joint recognition of leaders within the Yale Child Study Center and the New Haven Department of Police Service that police officers and mental health clinicians share serious concerns about the fate of children and families exposed to chronic urban violence, but that, for different reasons, neither group is able to intervene effectively. Though police officers are in daily contact with children who are victims, witnesses, and perpetrators of violence, they do not have the professional expertise, the time, or the other resources necessary to meet these children's psychological needs. Conversely, clinic-based mental health professionals may be professionally equipped to respond to children's psychological distress following episodes of violence, but the acutely traumatized children who are most in need of clinical service rarely are seen in existing outpatient clinics until months or years later, when chronic symptoms or maladaptive behavior bring them to the attention of parents, teachers, or the juvenile courts. Valuable opportunities to intervene therefore are lost at the moment when professional contact could provide both immediate stabilization and bridges to a variety of services.

The collaboration between mental health and police professionals was born out of a common-sense recognition that police officers—who not only make house-calls twenty-four hours a day but are also first on the scene of violent events—are in a unique position to help children and families who are at greatest risk of becoming the psychological casualties of violence. Similarly, when mental health professionals venture beyond the consulting room they are much better able to learn more about the impact of violence on the lives of those who are most directly involved: children, families, and the professionals themselves. Working together, police and mental health professionals have combined their observations and knowledge from the consulting room and the streets in an effort to coordinate an array of responses for children and families whose exposure to violence threatens to compromise their development and functioning.

In beginning discussions between officers and clinicians, the issue of volume and the limitations of our isolated attempts to intervene on behalf of children exposed to violence became a jumping-off point for consideration of ways that they might work together. It became clear that each group felt defeated in their individual efforts to take charge and to intervene in ways that lead to an increased mastery for themselves and for those they hope to serve. Police officers, who are regularly exposed to disturbing scenes of violence, are especially susceptible to feelings of despair in identification with the children they encounter, or to fear

about the dangers that may await *them* at the next call. In this context, it is understandable that officers defend themselves against such feelings by remaining anonymous, distant, and perfunctory, turning a blind eye to the suffering of children or feeling enraged and disdainful toward the adults who have exposed them to terror. Similarly, the clinicians described cases in which children's symptomatic difficulties at school, at home, and with peers brought them to the outpatient clinic at a point when psychotherapeutic intervention alone was no match for the long history of multiple traumatic experiences that had contributed to their compromised functioning. Clinicians were also confronted by the discrepancy between their recognition of the risk factors associated with children's exposure to violence and the numbers of children who would ever actually reach the consulting rooms. It was thought that a shared frame of reference developed out of existing knowledge from the streets and the consulting room could lead to increased understanding of the needs of children traumatized by their exposure to communal violence and the possibility that collaborative action might replace professional immobilization.

To consider their potential roles in responding to the needs of children exposed to violence, police officers would need to learn more about basic principles of development and concepts of human functioning. Similarly, clinicians would need to learn more about phenomena associated with acute incidents of violence and police practices. Both groups would need to learn about the range and limitations of the other's responsibilities.

Thus, a small group of supervisory officers was exposed to a variety of clinical services and liaison activities with social services. Clinicians spent time in "ride-along" tutorials in squad cars with the supervisory officers. Both groups participated in weekly discussions about principles of development and their application to clinical and policing practices. The practical issue of increasing collaborative responses to violence was addressed through the development of a twenty-four-hour on-call service that would allow officers to receive consultation and would provide immediate clinical response to violent crime scenes in which children were involved. In addition, the fellowships for clinicians and supervisory officers were formalized and a weekly meeting was begun to discuss cases referred through the consultation service. However, it was clear that if rank-and-file officers were to participate in this new endeavor, they too would need to establish a conceptual rationale for their collaborative work with mental health professionals, not simply follow orders from supervisors about making appropriate referrals.

Developing a Common Language

In our efforts to increase the attention paid to the children exposed to communal violence it has been essential to establish a regular forum in which officers and clinicians can work out a common ground of concerns and a conceptual rationale for their collaborative work. In weekly seminars, officers and clini-

icians examine concepts regarding basic human needs; development of capacities for self-regulation and mastery; phase-specific sources of danger/anxiety; the link between behavior and underlying psychic processes (that is, the relation between anxiety and defenses); and individual variation with regard to potential life adaptations. It is crucial that the goal of these seminars is to demonstrate how officers' consideration of principles of development and human functioning can enhance the range of strategies in dealing with various situations and can help establish a more realistic appreciation for the impact they can have on the lives of children and families with whom they interact.

A series of ten seminars, co-led by clinicians and supervisory officers who have completed the fellowship, uses scenarios from the streets—ranging from experiences with parents and infants to involvement with adolescent gangs—to illustrate basic developmental concepts. While the discussions proceed according to a developmental sequence, they attempt to link the inner life of the child with manifest behaviors seen at the original phase of development and the ways that these phenomena may be observed throughout the life cycle. In turn, the seminars allow officers and clinicians to think about the meaning of behavior as an effective tool for determining strategies and as part of an effort to develop collaborative interventions between police and mental health professionals on behalf of children and families exposed to violence.

The convergence of principles of development and their application to policing strategies may be best illustrated in a description of a discussion that emerged in one of the seminar series about toddlerhood. Participants were asked to talk about their understanding of the salient features of the phase, and they responded with ideas about the "terrible twos," tantrums, toilet-training, and bossiness. These topics were elaborated in the discussion until participants began to make connections between how physical maturation, mastery, and the child's sense of omnipotence converge and at times clash with parental expectations and the notion of consequences. Issues regarding separation/individuation also entered into the discussion, as the behavioral assertion of strength, power, and well-being could be more broadly understood in terms of the child's developing sense of self-worth and capacity for regulating/expressing urges and feelings. Again, the emphasis of the discussion moved toward the common theme of articulating the relation between observable phenomena and underlying motivation. The central importance of feelings of power, control, and mastery, and the defenses employed when narcissism is injured, was discussed as it applies to toddlers, older children, and adults. Concepts regarding displacement, turning passive into active, and reaction formations were illustrated in material brought from the streets by the officers in the class (Marans et al., 1995).

One of the more powerful illustrations of the relation between anxiety and defense arose after a confrontation that occurred between police officers, a group of young drug dealers, and community members. Several of the officers, including the co-leader who had been involved, described the events. The day after the shooting death of a local drug dealer, a large group of teenagers gathered on a

street corner. When two beat officers arrived, the group began jeering and moving toward them. The officers felt threatened and called for backup. Within minutes squad cars were speeding into the area; the arriving officers formed a line, holding billy clubs at the ready, as the crowd grew more vocal and insulting. Other members of the community joined the crowd and tensions continued to rise until supervisory officers intervened. They first ordered the line of officers to put their billy clubs away and return to their cars. Officers assigned to the neighborhood were asked to wade into the crowd and talk with the most vocal participants they knew—drug dealers and community leaders alike. This group was invited to attend a hastily convened meeting in a nearby church. As the group moved away, the crowd slowly dispersed. Over the next several days, community leaders accompanied officers on patrol as a way of supporting the peace.

Following the description of the events, the officers in the seminar were divided into two groups—cops and crowd members. After meeting separately for several minutes, the groups re-created the standoff. They easily assumed their roles. The "crowd" threw insults at the cops as they moved closer to the cops on the "line." While first remaining very calm, several of the cops broke verbal ranks and began responding to the taunts. While at first they appealed to the crowd to calm down, the replies grew increasingly combative and incendiary. One African American officer replayed with another African American cop on the line an interchange that had occurred when he had been at the original scene. He berated his fellow officer for being a "white man's nigger" and not knowing anything about what it is like to be a "real black man." True to the original scenario, the cop on the line argued that he had grown up in a similar neighborhood and that, unlike his tormentor, he had chosen to work hard and make a better life for himself, and so on. When the crowd member replied that the line cop was a "sellout," the mock pushing began, and the exercise was stopped.

In the discussion that followed officers spoke of intimidation, fear, humiliation, and the experience of being prejudged and insulted by people who do not even know them. In response to questions from the seminar leaders, "crowd members" spoke of their feelings of powerlessness in the face of unemployment and life in a blighted neighborhood—the sense of hopelessness and despair that finds some relief in the excitement and rage that gets targeted on a highly visible enemy. As the discussion continued, displacement and transference were addressed. The argument that developed around the issue of backing down in the face of a hostile crowd versus standing ground and demonstrating power and control were examined in relation to individual and group responses to various sources of anxiety, the degree of perceived danger, and the available capacities to defend against and diminish feelings of helplessness, fear, and humiliation. These themes and others are elaborated as the seminar moves through central concepts regarding the challenges and potential deviations of oedipal, latency, pubertal, and adolescent development.

As the seminars come to an end, officers increasingly refer to the scenes of violence and suffering they confront each day. Themes that commonly emerge in

the discussions include sealing over—"getting used to it" and distancing themselves as best they can—displacing their frustration onto family members or citizens with whom they interact, viewing the world dichotomously (that is, us versus them), and heightening the sense of vigilance. These responses are discussed in terms of the defensive functions they serve—against feelings of fear, inadequacy, sadness, despair, and the like—as well as the interference they may pose in achieving the desired goals of their interventions.

Whereas the seminars on child development and human functioning are intended to develop a frame of reference for officers considering the relation between the child's inner life and manifest behavior, the consultation service provides direct support for officers in the field who are dealing with children and families exposed to violence and tragedy. The availability of immediate consultation has often allowed officers in the field to feel more effective in the face of tragedy. By brokering clinical services and attending to the emotional needs of the children involved, officers have a new way of "taking control" and becoming active in the aftermath of violence rather than simply feeling overwhelmed by it, sealing over, and quickly turning away from the scene. For many of the children and families, the referrals may not only offer accessible and responsive clinical services for the first time but may also reflect a new and different experience of officers and mental health professionals. In many of these situations both police and clinicians are not simply viewed as aloof and disengaged, providing too little, too late, but as *benign* figures of authority who are able to play a role in reestablishing a semblance of stability in the midst of the emotional chaos that often follows children's and families' direct exposure to violence.

Integrating Perspectives and Interventions

In the first thirty-six months of operation, officers and clinicians together have seen more than 450 children through referrals to the consultation service made by community-based officers. The children, who range in age from two to seventeen, have been exposed to murders, stabbings, beatings, maiming by fire, death by drowning, and gunfire. They have been seen individually and as part of larger groups in their homes, in police substations, in emergency rooms, in schools, in community rooms of public housing projects, and at the Child Study Center. Because of the immediacy of the referrals, we have been able to observe children within minutes of a violent event. As each of these cases has been followed in the weekly Case Conference, we have been able to explore the effects of exposure to violence in terms of the specific characteristics of the event and its context within the family, the community, and the inner life of the child.

We have found, as have other investigators (Pynoos et al., 1987; Pynoos and Nader 1989; Terr, 1991; Martinez and Richters, 1993; Pynoos, Steinberg, and Wraith, 1994), that beyond the obvious factors of direct physical injury to children and their parents, the psychological toll that violence takes on children is

determined by an interplay of factors within the child and between the child and his or her surroundings:

- the characteristics of the violence itself—that is, the child's relationship to the perpetrator and victim, proximity to the incident, response of the caregivers to the incident;
- the developmental phase of the child who is exposed—that is, the status of emotional and cognitive resources available for mediating anxiety associated with objective and fantasized dangers—including preexisting vulnerabilities;
- the familial and community context of the violent incident—that is, whether the incident is isolated and unusual or is part of a pattern of daily life; and
- the nature of responses to the possible effects of the child's exposure to violence by family members, school personnel, and community institutions.

In addition, while the configuration of these factors has varied, we have observed common immediate responses to violent events among the children seen through the consultation service. These include disbelief and denial of the outcome or even the occurrence of the violent event; intense longing for the presence of primary caregivers and concern about their safety (especially among children under age seven); concerns about bodily integrity and competence; revival of, and much talk about, previous losses, injuries, fights, and other episodes of violence; repetitive retelling of the events with ideas that might have altered the real outcome of the episode, described by Pynoos as "intervention fantasies" (1993); attribution of blame to those not directly involved in the violence; or, alternatively, reveling in the excitement of the action of the violence with talk of the weapons used—who got "capped," "smoked," or "aired" (Marans, 1994).

Discussions about referrals from the consultation service frequently focus on the extent to which children describe the violent events they have witnessed in terms of the developmental phase—specific anxieties that are aroused. By observing the acute reactions and by listening to the stories from the child exposed to violence, we are able to better see what constitutes the specific danger that overwhelms that child, or what aspects and meanings of the event are experienced as exceptional and overwhelming—and therefore "traumatizing." For clinicians, direct observation of and interaction with children in the community who have just been exposed to incidents of traumatic violence, as well as regular collaborative contact with community-based police officers, has enhanced our understanding of the realities of these children's traumatic experiences, the environmental background against which acute episodes of violence take place, and the potentially therapeutic use that many children can make from their contact with police officers and other adults in the community. Increased understanding

of acute traumatic reactions and environmental variables has, in turn, led to greater flexibility in the delivery of clinical services to families that might not otherwise make use of these resources. For officers, exposure to developmental principles and clinical consultation has expanded the range and specificity of their observations of children with whom they come in contact and has led to an expanded range of possible policing interventions, including referrals for individual clinical services, direct supportive interactions between officers and individual children and parents, and police involvement in community efforts to address neighborhood problems regarding the physical and psychological safety of children and families.

As a result of the ongoing collaboration and the establishment of trusting relationships among police and mental health professionals, both clinical and policing responses are increasingly informed by shared assessments of an individual child's perspectives, needs, and resources, as well as those of the family and community in which the violent events have occurred. In direct response to our increasing understanding of the multiple and interrelated stresses confronting the children and families referred to the consultation service, collaborative responses to acute incidents of violence have increasingly involved the coordination of multiple resources that have impact on the lives of children and families—schools, protective services, medical care, housing, and the like. The following incidents illustrate these observations.

A Street Shooting

Acute responses. At noon on a late spring day, shots rang out. A school bus carrying eight children aged five and six was caught in the cross fire between rival drug dealers. The bus was hit by the gunfire, and a six-year-old boy was shot in the head. The bus went to a nearby middle school, where the children were met by police officers and emergency medical personnel. Officers trained in the CD-CP program were the first to greet the children; they contacted members of the consultation service, whom they asked to join them at the middle school. The boy who was shot was taken to the hospital. (He survived surgery and suffered neurological impairment for which he continues to receive rehabilitative services.) The remaining children were taken inside the middle school building by police officers, who immediately began coordinating efforts to get the parents to the middle school. The officers described their central aim as protecting the children from the excitement surrounding the shooting (camera crews arriving, multiple police personnel, onlookers) and reuniting them with parents. Children were *not* interviewed by officers about the shooting. Officers explained that while this practice used to be part of the standard approach in an investigation, the reality was that any information obtained from the children was not immediately necessary and, according to the sergeant in charge of the scene, would only retraumatize the children, especially when what they needed the most was to be with their parents.

The CD-CP clinicians arrived on the scene within ten minutes of the shooting. They were briefed by their police colleagues and were taken to the gym, where the children were sitting on the floor. Middle school personnel attempted to engage the children in a discussion about what they had seen, but the children remained quiet, clutching their knees and staring into the middle distance. The CD-CP clinicians were introduced to the school personnel, who moved to the background as the clinicians began to work with the children. The clinicians had brought paper and markers. They sat down with two children each and asked them whether they would like to draw pictures. Each child quietly declined, but when asked whether they would like the clinician to draw something, the response was unanimously positive as was the requested content of the pictures: "Draw my mommy." Each child was asked what sort of face the mommy should have and what words might fill the speech bubble that went along with the drawing of the face. The instructions for faces fell into two categories: happy and sad. The words alternated between "I'm so happy to see you!" and "I was so sad and worried about you!" After engaging in the drawings, the children grew more verbal, and each began to make inquiries about where their mothers were and when they would arrive. All of the children expressed concern that perhaps their mothers had been hurt and would not be coming for them. The senior police officer on the scene, a CD-CP fellow, told the children and clinicians that all of the parents had been located and were on their way to the school.

One of the children then asked a clinician to draw a picture of a head. Whose head? "Um, a boy's head . . . that just got shot with a bullet." The rest of the children overheard this question and immediately turned their attention to the picture. The clinician requested details in order to complete the picture and asked whether any of the children wished to add something themselves. Three children scribbled the same ingredient with a red marker—blood, which soon covered much of the page. There were some questions about what was happening to the friend who had been shot, but most of the questions and comments had to do with bodily functions—How much blood does the body have? Can parts of the body fall off?—and talk quickly turned to a more spirited group discussion about the physical feats each could perform. The discussion was punctuated by sidelong glances to the door as parents began to arrive to pick up their children. Each parent was seen briefly by the clinician, given a telephone number to call with questions regarding their child's experiences, and asked whether they could be contacted for follow-up assessments.

While the crime scene was secured and the criminal investigation was begun, similar attention was paid to the emotional needs of the children who were caught up in the experience of violence. All aspects of the response to the shooting—determining how to inform both the middle school and elementary school communities about the shooting; briefing parents and school personnel; consulting with teachers, school administrators, and parents about how to respond to children in the classroom and at home; and making additional clinical

services available—were coordinated and carried out by the Child Development–Community Policing Program in conjunction with the school system. Officers trained in the program were able to communicate information about the shooting in formal briefing sessions with parents and school personnel and informally in their encounters with children who approached them in the streets. They delivered information about the circumstances and background of the shooting, and they communicated their understanding about the meanings of adult expressions of rage and feelings of helplessness in a manner that indicated their sophistication about the complexity of responses to violence. The CD-CP officers and clinicians were able to influence broader community responses to the shooting as well. They successfully argued that, while making some adults feel less helpless, using squad cars to escort school buses the day after the shooting would only exacerbate children's concerns about safety. In a similar vein, officers showed appreciation for children's anxiety and vulnerability by discussing their concerns about the children as they negotiated with the news people who gathered around the children's school. As a result, they helped to minimize the intrusiveness and associated excitement of cameras and the barrage of questions thrown at the children and families. Because of the CD-CP responses to the shooting, the police in this situation were seen not merely as harbingers of tragic news and violence but as sources of effective authority, concerned about the safety and emotional well-being of the children and families affected (Marans et al., 1995).

Clinical follow-up. Five of the seven children received follow-up psychoanalytic psychotherapy because of enduring post-traumatic stress symptoms—disruptions in sleeping and eating; increased separation anxiety; and hypervigilance, generalized anxiety, and avoidant behaviors—that were not part of the premorbid history. Two vignettes offer illustrations of how a child's developmental phase and life circumstances determine the context and specific meaning of a disturbing external event and illustrate the effectiveness of preventive intervention for longer-term emotional and social growth. Each case example is a condensation of material that emerged during two to four months of weekly and twice-weekly treatment.

Beverly, five and a half years old, was sitting across the aisle from her classmate when he was shot. Her previous school functioning was good, as was her adaptation in an intact family (mother, father, and ten-month-old brother). Her developmental history was unremarkable. After the shooting, Beverly had difficulties with sleeping and eating, multiple new fears, and a need to remain close to her mother. These symptoms continued for two weeks before her parents agreed with the clinician's recommendation for individual work with the child in conjunction with guidance for the parents.

In her individual sessions, Beverly repeatedly returned to the scene of the shooting, reviewing an increasing array of details both in play with toy figures and in her drawings. Each narrative ended with Beverly stating that she felt scared or

bad. Over time, the therapist probed these feelings—either within the action of the play or within the narrative that accompanied the pictures. Beverly would elaborate that she felt scared that the bullet might have hit her and very bad because her friend had been hurt. In one session, she drew a picture of herself and her friend on the bus. She drew the bullet tracking around her head on an eventual path to the head of her classmate. She grew quiet and looked forlorn. With the suggestion that there was a connection between her feelings and the story that lay behind the picture, Beverly revealed a secret whose telling spanned many sessions and was accompanied by a dramatic reduction and final resolution of her presenting symptoms.

The first part of the secret was that for several days before the shooting Beverly had been reprimanded by the driver for her behavior on the bus. Beverly thought that perhaps the bullet had really been meant for her as punishment. Later she told the therapist that she had been teasing and poking at the very classmate who was shot. The third part of the secret was about her baby brother. With great anxiety Beverly reported that she teased the baby on numerous occasions and that, in fact, she often wished the brother were no longer around. With this confession, the cause of her worry and guilty feelings became more clear. She was able to articulate her fear that her bad wishes about her brother had come true in the shooting of her schoolmate and that her wishes would be discovered and severely punished. The therapist was able to point out that Beverly was behaving as if the reality of the scary events had somehow been under her magical control. Her hostile wishes toward a rival baby brother and their displacement onto a schoolmate were not unusual. However, for Beverly, the *realization* of these wishes—if only in the displacement—constituted the central source of her overwhelming anxiety and traumatization. In addition, her sense of magical control reflected both age-expectable phenomena augmented by reliance on magic for the purposes of restitution and recovery. That is, a belief in magical control would revise the original experience of traumatization or “absence of control” in the shooting, even if the belief in magic might also lead to a tremendous sense of responsibility for and guilt about the real and imagined events.

Another child, Miguel, age five, presented with multiple symptoms. Miguel was the youngest in a family of six. Both parents and a nineteen-year-old brother worked, one sister was in high school, and the other was in middle school. Prior to the shooting Miguel had no difficulties with sleeping or with leaving home for school or other activities. This changed dramatically after the shooting of his classmate. He insisted on sleeping with the light on throughout the night, departures from home were very upsetting for him, and in the remaining days of school he complained of sickness in order to avoid going. It took several weeks of treatment for Miguel to reveal in his play that he was terrified that the people responsible for the shooting of his classmate would come to shoot him and all of the members of his family. The fact that the shooters were in jail did nothing to

alleviate Miguel's fears or symptoms. But his ability to express his central worry opened the door for further exploration, clarification of his thoughts, and greater mastery over a very frightening experience.

What lay behind Miguel's fear of being shot was his attempt to explain to himself why the shooting had happened and perhaps, with this explanation, to feel more able to predict similarly dangerous events. However, the explanation Miguel developed was limited by condensation and by the concrete thinking typical of his phase of development. Miguel was eventually able to explain to his therapist, and then to his parents, the following ideas: He had learned in school about how bad drugs are—that they do terrible things to the body, that they make people violent and are the cause of fights between drug dealers. When the shooting started and the bus was hit by gunfire, Miguel assumed that the shooting was about drugs and that if the school bus was being shot at, it must somehow be involved with drugs. If the school bus was involved in drugs and he was on the school bus, then he must somehow be connected with drugs, and if he was involved in drugs, then so must his family. If he and the family were involved in drugs, then they too would fall victim to gunfire. While there was no indication that the family was involved with drug use or dealings, the dangers were brought home to Miguel as a powerful response to being shot at and to seeing his friend bleeding. While generating considerable fear, Miguel's explanation relied on the cognitive resources available to him and provided the basis for altering the traumatic episode. In the version of his making, Miguel was able to anticipate the danger—he expected assailants to come after him—and he defended against the danger by staying up at night, staying close to home, keeping family nearby. Understanding Miguel's solution in the context of phase-specific concerns and capacities helped Miguel to clarify the distinction between his fantasy configurations and the factual information and led to a resolution of his developmental crisis and the attendant symptoms.

A Robbery at Gunpoint

Acute responses. Whereas phase-appropriate concerns associated with the body, sibling rivalry, and magical and concrete thinking played a crucial role in understanding and addressing the nature of trauma for Beverly and Miguel, another incident illustrated an adolescent version of overwhelming, disorganizing anxiety. Mark, age fifteen, was robbed at gunpoint on a Friday evening. He'd been walking with friends when two men put a reportedly large-caliber semiautomatic weapon in his face and demanded his money and gold jewelry. Mark had been walking behind several friends, and they were unaware of what occurred in an alley off of the main sidewalk. Mark later reported that men repeatedly shoved the weapon in his face and threatened to shoot him. After taking his valuables, the assailants fled, and Mark ran home. He ran into his room crying uncontrollably, hid on the floor of his closet and, in spite of his mother's urging, refused to come out. After a while, Mark told his mother through sobs what had

occurred, and she phoned the police. Each of the three officers who arrived had been trained in the child development seminars, and the supervisory officer had completed the fellowship. As one of the officers approached the bedroom, Mark began to scream. The officer told him that he had heard what had happened to him and that he realized that the hold-up was terrifying. Mark would not look at the officer and yelled at him to leave the room. The officer was about to leave when the supervisor pointed to his gun and utility belt. The officer then removed his holster and weapon, explaining to Mark that he would leave them outside the room, as he understood how frightening guns might be to him. Mark continued to sob and shake uncontrollably, but he allowed the officer to help him out of the room, and he accepted the suggestion that he go to the emergency room for treatment. The consultation service clinician was called, and Mark was met at the hospital.

Clinical contact. During the interview, Mark was able to look at the clinician only after a comment was made about how fear could make a person feel small and helpless—a very undesirable feeling for a fifteen-year-old guy. Mark began to talk about the events, repeating the scene and the assailants' commands to him over and over. The repetition began to include slight alterations in the details, and Mark protested that he should have "grabbed the gun and kicked each of the [attackers] in the balls." He described the gun muzzle as huge and insisted that he thought the attackers meant to kill him. As his shaking, hyperventilating, and sobbing subsided, Mark began to talk about the earlier part of the evening. He explained that before being robbed he had been "hanging back from his home-boys because they were with their ladies" and he had wanted to "give them space." He shyly told the clinician that he didn't have a girlfriend, and then he exploded with rage and then broke into tears. He wanted to get a gun to kill the guys who "messed with him." He didn't deserve what had happened to him, he said—he was a good student and had just completed an important history paper. He explained that he had bought all of the thin gold chains he wore—emphasizing that he was not to be lumped with "low-life drug dealers." Mark began to cry again as he swore revenge. The clinician commented that it was humiliating to have to feel so terrified and suggested that Mark was wishing he could undo his experience. Mark replied that if he had had a gun or had disarmed his attackers he wouldn't have to feel as though he'd "wimped out." The clinician agreed that feeling powerful would certainly be the opposite of what he had experienced with a gun in his face. Mark brightened and looked up suddenly, exclaiming that now he remembered the gun more clearly—it wasn't a 9mm semiautomatic, it was a BB gun. As the acute terror diminished, he was also able to remember the make of the car in which the assailants drove off, as well as clear descriptions of the two men. His restitution fantasies of revenge began to take another form as Mark talked about helping the police make an arrest. At his request, Mark spoke with the detective involved in the case to offer the information he had recovered in the course of the interview. Two hours after admission to the emergency room, Mark was discharged.

Mark was seen in two follow-up sessions in which he continued to go over the events. The fantasies of what he should have done were intermingled with talk of the mortification of feeling helpless and of the increasing recognition that there actually was nothing he could have done to alter what had occurred. When his sleeping difficulties and hypervigilant feelings abated, Mark declined further clinical contact. However, over the following several weeks one of the three responding officers stopped in on him regularly for brief chats during the course of their usual patrol. In the last clinical follow-up, six months after the incident, Mark had still not bought a gun and, instead of reciting his numerous violent revenge fantasies, spoke of his latest academic demands and of his new friendships with the cops on his beat. While he had not forgotten the terror or rage associated with his experience, Mark added that his good memory had been instrumental in helping the police arrest the men who had attacked him. And, as he said, "that felt really good."

War, Communal Violence, and Therapeutic Implications

In our work with children exposed to communal violence in the American inner city, we hear frequent references in the popular press to "urban warfare" and to the notion that the experience of random, familial, and gang- or drug-related violence is analogous to the experience of violence associated with civil or international warfare. There are important similarities between the experiences of individuals exposed to warfare and to urban violence in terms of the range of acute and long-term physiological and psychological responses. Both in wartime and in violent city neighborhoods, children are vulnerable to the internal and external factors that place them at greater risk for developmental difficulties or, conversely, tend to protect them from the most adverse effects of their exposure to violence. Regardless of the arena of violence, children's healing and recovery are assisted by such internal attributes as cognitive competence, previously developed range of defensive mechanisms, self-esteem and secure attachments, as well as by external factors, including supportive parents and other adults, security of their physical environment, and continuity of interpersonal relationships and social institutions. Both in wartime and in the city, children can be helped to recover from their experiences of violence through prompt reestablishment of physical safety, family ties, and normal routines; through the provision of accurate information that promotes cognitive understanding; through the availability of opportunities to use imagination to take distance from upsetting memories and to try on different resolutions of the events to which they were exposed; and through the calm, sensitive attention of caring adults, particularly the child's parents.

Not only are there general similarities between children's exposure to warfare and to urban interpersonal violence, there are also important distinctions in the cultural context of children's experiences that can have a significant impact on their adaptation. In addition to the strengths that children and families may

find within themselves for coping with exposure to communal violence, there are also protective factors built into cultures. These include a sense of purpose and a feeling of belonging to something greater than one's self. When they function well, ideology and the belief in a larger political or religious worldview justify terrible sacrifices and mediate suffering. In many wartime situations, at least where the fighting does not persist for generations, children are also protected by a sense of continuity with a community not torn by violence. In these circumstances, adults who remember a life of prewar stability can transmit to their children a sense that pervasive violence is not the only possible life experience, and that their own lives will return to normal.

Unfortunately for many poor children in urban America, it is precisely this sense of past stability, historical continuity, and hope for the future that is missing from the family and community environments in which their chronic exposure to communal violence takes place. In contrast with the experience of many children in wartime, children in the American inner city live in a world characterized not by consistent reminders of a more stable past but by multigenerational poverty, academic failure, political and economic disenfranchisement, and a pervasive absence of expectations that the future will be better than the present. In communities plagued by random rather than politically or ethnically driven violence, what is also missing is a sense that the suffering of individual children and families has meaning in relation to their belonging to a larger group. These limitations of socioeconomic security and family and community cohesion are likely to have placed inner-city children in developmental jeopardy before their exposure to violent events, and these same factors are likely to compound children's disadvantage in their efforts at restitution in the wake of violence. For these reasons, traditional modes of conceptualizing and delivering mental health and social services are likely to be inadequate to the psychological needs of the children and families who are most vulnerable to the effects of that violence. Professionals who hope to intervene successfully in these children's lives following their experience of traumatic violence must take extraordinary measures to create new external structures that can promote healing and recovery where existing family and community structure is so limited. We must be prepared to sustain these intensive efforts for a very long time if a new generation is to move beyond their traumatic experiences.

Extending Collaborations

Regardless of their shared concerns, no single group of professionals can address the multiple needs of the children and families subjected to massive environmental stress when the professionals attempt to intervene in isolation from one another. The collaboration between police and mental health professionals in New Haven provides one model of creative interdisciplinary action on behalf of children who are at great developmental risk owing to their exposure to violence and who would be unlikely to receive effective intervention through

traditional models of social service delivery. Other collaborative projects around the country also engage mental health professionals in partnerships with other social service professionals and apply principles of child development to interdisciplinary work with disadvantaged children in community settings. These integrative efforts offer possibilities for more efficient and effective service to vulnerable children and families in spite of the potentially overwhelming volume of children's psychological needs.

In one such project, a group of school administrators, teachers, pediatricians, and clinicians in New Haven developed a model for school-based crisis intervention to follow episodes of violence that affect large groups of children in a particular school, such as a death or serious injury to a student or teacher, or a shooting in the school building. By establishing crisis teams in advance, and by planning for possible crisis responses, schools are in a better position to provide children and their families with the stability and clear authority they need to reorganize in the wake of a frightening event; a sense of chaos can exacerbate feelings of fear and helplessness. School-based responses, utilizing personnel familiar to the students and their families, can provide accurate information about the event, afford opportunities for many children to discuss their experience and reactions and to receive emotional support from peers and teachers, and identify those children who need more intensive mental health intervention (Schonfeld et al., 1994).

The work of Taylor et al. (1994) in Boston and Garbarino et al. (1992) in Chicago also link mental health and educational interventions by providing clinical support and consultation to day care centers, nurseries, and elementary schools in inner-city communities experiencing overwhelming levels of violence. In these settings, thoughtful clinical support for teachers and other school personnel can enable school staff to understand and intervene in the symptomatic behavior of many young children suffering as a result of their exposure to the chronic violence around them. Clinically informed and well-supported teachers are also in a position to identify which of the many children exposed to violence are in most urgent need of direct clinical intervention.

Police, juvenile probation officers, and mental health professionals in New Haven have also begun to work together to address some of the inefficiencies and ineffectiveness of the juvenile justice system in attending to the needs of children and adolescents involved in violent activity. Many children arrested for delinquent acts are known to multiple professionals before becoming involved in the juvenile justice system. Arrest therefore can represent an opportunity for collaboration and interdisciplinary problem solving as an alternative to traditional approaches, which emphasize the independence of the court and associated agencies and which often result in the duplication of efforts or in the assignment of court-ordered treatments that are mismatched to the needs of the child. In a pilot project, police and probation officers have begun to share supervision and monitoring of juvenile offenders by relocating probation officers to community sub-

stations and by engaging neighborhood officers in supervising community service projects for youth on probation. In addition, the CD-CP Program is coordinating a collaboration among local probation, child welfare, and police and mental health services regarding the assessment, disposition, and case supervision of juvenile offenders.

Other collaborative approaches include home-based family support and preservation programs, in which child welfare professionals work to serve children who have been abused or neglected by their families, and children dealing with another war—that of AIDS affecting their caretakers (Adnopo, 1993; Adnopo, Grigsby, and Nagler, 1991)—or which coordinate clinical services for children with substance-abuse, psychiatric, or medical treatment for their disabled parents (Adnopo and Nagler, 1992).

The specifics of these programs vary widely, but they all share a recognition that the volume of children whose psychological development is in jeopardy cannot be served through traditional clinic-based individual psychiatric approaches and that clinicians must move into community settings where the most vulnerable children and families are located and forge new partnerships with other professionals who share their concerns.

Conclusion

In this chapter we have considered the needs of children acutely and chronically exposed to communal violence, which has reached epidemic proportions in the United States. We have discussed some of the impediments that professionals face when responding with grave concern: they run the risk of becoming overwhelmed, much like the children they seek to help. Alternatively, we may face and tolerate the disturbing conflicts that are aroused in the areas of love and hate, empathy and sadism, bodily integrity and life-threatening injury, and the like. When this is possible we are in a much stronger position to admit our helplessness and renew our exploration of the phenomena associated with children's exposure to violence and the range of our potential responses. Recognizing both the complexity of human development and the multiple environmental factors that may impede that development, it is clear that our concerns require multifaceted and sustained responses. Those of us in the fields of mental health, law enforcement, and social and legal services do not have solutions for the multiple social problems that undermine the developmental potential of too many of our nation's children. But when we are able to share the burdens of our tasks, the wealth of our experiences, and the frustrating limitations of our knowledge, we can return together, again and again, to the question: What next? It is only then that the volume will not impede our abilities to listen and to attend to the needs of children and families whose present and future we aim to serve and protect.

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15 Children and Inner-City Violence: Strategies for Intervention

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The riots in Los Angeles in May 1992 brought a dramatic and explosive version of urban violence into the homes of all Americans, just as the riots in Watts did two decades earlier. However, many families that live in inner cities do not need to turn on their television sets to experience the threat of violence. They hear the sound of nightly gunfire, or witness shootings, stabbings, and fistfights in their homes and streets; both the assailants and the victims are their relatives and neighbors.

Community violence in the United States was not born in the late 20th century. However, the gangs no longer fight with fists, knives, and chains, but with semiautomatic and automatic weapons. The stakes are no longer determined by neighborhood pride, turf, and ethnic issues alone, but are driven by competitive market forces of a lucrative drug trade. Gone are the days of zip guns and "Saturday night specials"; they have been replaced by high-tech, 14-shot handguns that can be rented by the hour. The despair of unemployment, multigenerational poverty, and family dissolution contribute to a sense of helplessness and rage; for many urban youth, a measure of relief can be found in the power of fast money and the violent resolution of disputes. The combatants are not the only victims of violence. While ambulances rush the physical casualties to emergency rooms, the psychological victims—the children and their parents—are left to sleep on floors at night and to curtail activities during the day, hoping that these attempts to remain physically safe will help the threatening images, sounds, and thoughts of violence fade away. These images and fears do not fade, however, and the children, in particular, pay a high price for their forced attempts to adapt. Whole communities become captive observers and

experience violence secondhand, always in fear about who the next intended or unintended casualty will be. The reality and specter of violence add potentially overwhelming force to the feelings of impotence, fear, and rage in the face of substandard housing, inadequate education, and the absence of jobs.

CHILD WITNESSES OF VIOLENCE

For children, the experience of acute, isolated, personal episodes of violence is often superimposed on chronic exposure to violence. Specific incidents of violence may lead to a range of emotional reactions, including the circumscribed symptoms of Posttraumatic Stress Disorder (PTSD): disrupted patterns of eating, sleeping, attention and relating, fearfulness, flashbacks, and the like. Repeated exposure to violence may also lead to a variety of persistent patterns of psychological maladaptation. Children may withdraw, turn inward, and appear depressed; they may display difficulties with attention, school achievement, and social engagement; or, they may assume the role of the oppositional, aggressive perpetrator, organizing their sense of self around the active involvement in just that type of experience that was initially so threatening.

The degree of a child's disturbance or traumatization is determined by an interplay of factors within the child and in his or her surroundings:

- Characteristics of the violence itself (e.g., the child's relationship to the perpetrator and to the victim, the proximity to the incident, the response of caregivers).
- The developmental phase of the child who is exposed (i.e., the status of the child's emotional and cognitive resources for mediating the anxiety associated with objective and fantasized dangers).
- The familial and community context of the violent incident (i.e., is the incident isolated and unusual or part of a chronic pattern of experience of daily life?).
- Recognition of and sustained responses to the possible effects of the child's exposure to violence by family members, school personnel, and community institutions.

All of these factors must be considered in developing strategies that may have an impact on the outcome of exposure to and perpetuation of violent behavior.

Children who witness violence do so in the context of developmentally shifting modes of expressing their own aggressive impulses and feelings. Aggressivity plays a central role in development as a means of achieving a

sense of power and competence; it is also a source of conflict between love and hate. Over the course of development, the more direct enactments of the toddler's hitting, biting, and kicking shift to the preschooler's fantasies and play of destructive power, to the competition on the school-age child's sports field, to the vicissitudes of affection and anger that are a part of adolescent and adult relationships (Marans, Dahl, Marans, & Cohen, in press; Freud, 1972). However, this capacity to move from enactment to more sublimated expressions of aggressivity is undermined when the basic preconditions for feeling competent—including physical safety, stable relationships, and success in achieving desired goals—are overwhelmed by poverty, family dysfunction, overstimulation, and threatened or actual physical danger.

Feeling unsafe, helpless, and small runs counter to the developing child's desire and capacity to be in greater control of the self and to achieve increasing mastery of his or her environment. In addition to developing specific symptoms, a child may resort to turning passivity into action to regain the experience of power and control when the dangers of real violence provoke feelings of helplessness and fear. That is, rather than feeling the anxiety and humiliation of being the victim or feeling vulnerable to the aggression of others, the child may become the active perpetrator. Oppositional behavior at home and at school may be a transient means for the child to reassert his or her power at precisely the time when he or she is feeling most vulnerable. However, when the child is exposed to the dangers of violence on a regular basis, identification with the exciting and powerful role of perpetrator may become a chronic hedge against feeling helpless and afraid. When the most powerful models in the home and neighborhood exercise their potency at the end of a fist or gun, aggressive enactments, rather than sublimation, may be an adaptive response to both internal and external sources of danger.

A COLLABORATIVE RESPONSE TO URBAN VIOLENCE

Although New Haven is a small city (with a population of 140,000) and is the home of a major university, it is the seventh poorest city in the United States and is rated as the fifth highest in reported incidents of violent crime (New Haven Department of Police Services [NHDP], 1992). The impact of violence has been experienced forcefully in New Haven, where the marked rise in homicides is one of the clearest social indicators of violence of inner city life. During 1991, there were 35 deaths by gunshot, 490 aggravated assaults, 100 rapes, 1,370 robberies, and 1,400 police dispatches to the call of "shots fired" (NHDP, 1992). New Haven is relatively well endowed with mental health services for children and families, and approximately 1,200

minority, inner city children and families were seen in community mental health clinics during 1991. At least one third of the inner city children receiving care in our outpatient clinic have witnessed or been involved in aggression and its consequences. (P. Armbruster, personal communication, 1992), yet the number of children who receive psychological care represents a fraction of the most vulnerable in the population who are exposed to violence. For example, in a survey conducted in 1992 of 6th-, 8th- and 10th-grade children in New Haven, at least 40% reported being witness to at least one violent crime during the previous year (R. Weissberg & M. Schwab-Stone, personal communication, 1992). By their teenage years, only a small minority of inner city children are free of direct exposure to violence—at home, on the street, or in school. The majority reported being afraid almost everywhere outside of home and many are fearful at home, as well. Studies published in the *Journal of the American Medical Association* reported high incidences of violence, and the characteristics of children and adolescents involved in violence, often with handguns (Callahan & Rivera, 1992; Fingerhut, Ingram, & Feldman, 1992a, 1992b). In addition, other studies have reported alarming rates of children being directly exposed to episodes of violence (Garbarino, Dubrow, Kostelny, & Pardo, 1992; Taylor, Zuckerman, Harik, & Groves, 1992).

The social institutions in the inner city that are involved with children and families—the schools, social welfare and child-guidance agencies, churches, and police—tend to focus on similar problems and, often, on the same individuals. Since the 1970s, clinicians in the Child Study Center have developed models for intervention, representing the application of concepts of child psychoanalysis and child development, that are based in schools and child-serving agencies. Through these programs, principles for collaboration among professionals and families have been developed and demonstrated to be useful in changing the atmosphere and functioning of child-serving institutions, such as the school and child welfare agencies (Adnopolz, Grigsby, & Nagler, 1991; Comer & Haynes, 1990; Comer et al., 1991; Goldstein, Freud, & Solnit, 1973, 1979; Goldstein, Freud, Solnit, & Goldstein, 1986). It is only quite recently that we have begun to understand and focus on the central role of the police in the lives of children and in the functioning of communities.

The police are the major representatives of societal authority in the inner city. With their uniforms, guns, and cars, they present an image of power and control, and they are the most visible governmental response to specific incidents of violence. Police officers have daily encounters with children and families in crisis (those involved in family violence, witnessing crimes, or suffering as victims of aggression), and they are increasingly confronted by very young children who are the perpetrators or victims of aggression.

At their best, police can provide children and families a sense of security

and safety through rapid, authoritative, and effective responses at times of difficulty. All too often, however, children's contacts with police officers arouse far less comforting and more negative feelings. In the psychological lives of inner city children, the appearance of police officers in the context of aggression makes them objects for displacement of children's and families' rage; their arrival "after the fact" strengthens children's view of society as unprotective, and the role of police as symbols of the dominant culture may shape children's views of them as representatives of an alien, uncaring outside world. In fact, the contacts between police and children are sometimes harsh, and police officers, especially in the midst of a crisis, may not have time to be considerate of children's emotional needs. Negative encounters may further reinforce children's view of society as uncaring and aggressive. Thus, these experiences may strengthen a child's concept that hostile behavior—being rough and tough, bullying, and acting strong—is not only appropriate and reasonable in certain situations, but is the normative mode of adult functioning. There are too few countervailing models of social authority available in an inner city child's world.

The Child Study Center Program on Child Development and Community Policing is a collaborative effort aimed at facilitating the response of mental health professionals and police to the burdens violence puts on children, families, and the broader community. Through the application of the principles learned in work with schools and agencies, the program attempts to change the atmosphere of police departments in relation to children and to increase the competence of police officers in their varied interactions with children and families. Fundamentally, the program attempts to reorient police officers in their interactions with children to optimize the psychological roles that they can play as providers of a sense of security, positive authority, and models for identification.

As with other models for social change within institutions, such as schools, the Program on Child Development and Policing is based on the full engagement and philosophical agreement regarding goals and methods of the leadership of the New Haven police and the faculty of the Child Study Center. The program has three major components: the training of all incoming police recruits in principles of child and adolescent development, clinical fellowships for veteran officers who have field supervisory roles, and a 24-hour consultation service for officers responding to calls in which children are either the direct victims or witnesses of violence.

COMMUNITY-BASED POLICING

The Program on Child Development and Policing is closely related to and dependent on the reorientation of the New Haven Police Department,

reflecting the philosophy of community based policing. Community based policing is an alternative to militaristic and highly hierarchical models of policing, which emphasize the response of police to crimes, the pursuit of criminals, and the making of arrests as primary missions. In this model, police officers are dispatched at times of crisis to neighborhoods where they are not known and with whom they have no relationship. In contrast, the concept of community policing emphasizes the major role of police in strengthening neighborhood social structures that deter crime and facilitate social functioning, in early detection of high-risk situations likely to lead to criminal activity, and in interrupting patterns of criminality at their roots. For community-based policing, the pursuit of criminals is seen within this broader context of prevention and early intervention in high-risk situations.

Major strategies of community policing include basing officers within neighborhoods, promoting decentralized functioning by police officers, empowering officers to deal creatively in solving problems, and encouraging regular and close collaboration between officers and community members, social service agencies, and institutions within the community. When it functions optimally, community-based policing integrates police officers into their communities: They become known as individuals, rather than by their role, and they know the people they serve as individuals.

The concepts and methods of community-based policing are still evolving, and each city must find and test its own best approaches. The chief and assistant chief of police in New Haven, Nicholas Pastore and Dean Isserman, have been at the forefront of national efforts to define and evaluate such approaches, with a particular focus on families, the roles of racism, and the impact of inner city violence.

Community policing brings police officers into regular, ongoing contact with children and families in a given neighborhood. This new approach requires a new type of police officer with special training.

CHILD DEVELOPMENT AND COMMUNITY POLICING

The Child Study Center and the New Haven Department of Police Services Program's collaborative model consists of several interrelated educational and clinical components that work toward sharing knowledge between police officers and clinicians.

Education of Police Rookies

In the past, the modal police recruit was 19 to 22 years old, had had some experience in the military or with a security organization, and had a high school or some college education. Increasingly, police officers being

recruited in New Haven are somewhat older, are from inner city and minority backgrounds, and have a broader range of educational and professional experiences. However, there is no requirement that a recruit have any prior education in criminal justice. Academic preparation for police work is provided during 3 months of police academy training, where basic skills are acquired, and then in the field, where recruits receive supervised field training. The education of police officers in most cities (and, until recently, in New Haven) does not specifically and prospectively prepare them for much of the work in which they will be engaged, especially with the demands of community-based policing (i.e., dealing with the psychological impact of family violence, engaging with children and youth in situations of high risk, helping divert possible offenders, collaborating in neighborhood improvement, and assisting those who have been the victims of crime). The seminar for rookie police created by police officers and the faculty of the Child Study Center aims to provide young police officers with both knowledge and a sense of personal empowerment to think about and intervene positively with children and families.

A basic concept of the Program on Child Development and Community Policing is that rookies should be introduced to a mental health orientation while they are beginning to form a sense of their new professional identities. Thus, they attend a seminar that meets weekly during the first 10 weeks of field training. Exposure to child development principles early in their careers introduces young police officers to the importance of thinking about children's development and their own influence on children while they are, for the first time, encountering children and families in their daily work. Also, the course provides officers with the experience of working alongside mental health professionals and with concepts and methods for working cooperatively with other social services on behalf of children.

The major theme of the seminar is how police officers' direct experiences, enriched by knowledge from psychodynamic theory, can lead to useful understanding of the phenomenology of children's development in the inner city: the phases of child development, and how these are shaped by different types of experiences within the family and community; the structure and function of family life; the social structures that influence children's senses of themselves, their families, and social groups; sources of security for children and youth; the types of dangers, trauma, and stress children experience; varying patterns of coping; and how to communicate with and understand young children at different times, including when they are witnesses to and victims of violence and other trauma. In contrast with standard didactic courses, the seminar on children and families is interactive: The instructors try to use active discussion of individual cases and specific scenarios from the streets as starting points for teaching about general principles. In addition, videotapes of children and films about

children (such as "John" by James and Joyce Robertson and "Boyz 'n' the Hood") make the theoretical concepts vivid and relevant to police work.

In addition to the involvement of the co-leaders, who are supervisory officers with 20 years of policing experience each, class discussions are enhanced by the participation of younger officers who have been on the job for at least 5 years. Also, the seminar groups are limited to 15 members to permit active discussion of the emotionally charged ideas and an increasingly rich sharing of personal experiences. During the first academic year of the program, 100 officers completed the course in child and adolescent development.

The knowledge gained in this program improves the effectiveness, positive impact, and safety of police officers interacting with young people in New Haven. It also enhances officers' self-image of serving positive roles within the community.

Child Development Fellowships

Community-based policing requires sergeants who direct substations to be committed to the philosophy of neighborhood policing and to be prepared to translate the concepts into actual practice. These sergeants supervise all the work of the substations, set the tone of police work within the community, and serve as models for younger officers. Especially during the transition to community-based policing, sergeants are faced with challenges in trying to implement goals in relation to prevention; early intervention; work with vulnerable children, youth and families; and collaboration with other agencies. The Child Development Fellowship Program of the Child Study Center aims to provide supervisory officers with special expertise in relation to these tasks.

Child Development Fellows are police sergeants who spend 4-6 hours per week for 3 months in the Child Study Center. With the guidance of a mentor from the clinical faculty, police fellows participate in a range of activities, similar to those of residents in psychiatry, that familiarize them with developmental concepts, patterns of psychological disturbance, methods of clinical intervention, and settings for treatment and care. Their program includes participation in the evaluations of inner city children with emotional and psychiatric problems; visits with a consultation team to community schools to learn about child-school issues and the functioning of Comer School Development Program; meetings with the Family Support Service Program to discuss families in crisis because of AIDS, cocaine, or family violence; participation in clinical discussions of children and adolescents who are brought to the Emergency Service or are psychiatric inpatients because of suicide, aggression, or serious accidents; and attendance at seminars and other teaching activities at the Child Study Center. A

major goal of the fellowship is to establish relationships between the fellows and the child mental health professionals with whom they will be collaborating over the years. An important benefit of the fellowship is the knowledge that officers bring to the other mental health professionals within the Center.

Case Conference

Police officers, educators, and faculty of the Center (child psychiatrists, psychologists, social workers, pediatricians, and lawyers) meet weekly to discuss difficult and perplexing cases that arise from the officers' direct experience and from the Consultation Service (described further on). Cases are discussed by officers and clinicians from many different points of view: in relation to the specific problem of the child and the family, the reasons for their interaction with the police, the types of services they have used or might currently require, barriers to intervention, and specific problems posed to the police officers and other agencies involved. The case discussions emphasize the importance of trying to understand the inner experience and the meaning of events to children and adolescents; how psychological understanding can guide police and clinical work more effectively; the feelings aroused in the professionals by the children, families, or situations; and how the feelings of the professionals might interfere with or be used to inform intervention. Because the case conference often touches on sensitive issues, the format requires a progressively increasing sense of trust and collaboration among its participants. Through the case conference, the sergeants who have been Child Development Fellows are provided with a continuation and elaboration of their involvement with the clinical faculty of the Center.

The methodology for such case conferences that the Child Study Center has developed as part of "continuing education" includes collaboration with different disciplines. For example, one case conference has been functioning since the mid-1960s; it brings together mental health professionals and pediatricians for discussion of emotional issues that arise during the course of pediatric care. We anticipate that the case conferences for discussion of issues that arise in community-based policing will continue, as well, for many years, with a changing set of concerns that will reflect both the development of new collaborative relationships and the problems faced by police officers.

Consultation Service

When an officer comes into contact with a child or youth in great danger or distress, or becomes responsible for his or her disposition, that officer must

make an immediate decision about whether to intervene and what action is in the child's best interest. At times, the path of intervention is clearly mandated, as when a child is believed to be the victim of abuse and the state child welfare agency must be notified. At other times, the critical nature of a medical condition (following an assault or a suicide attempt) dictates the involvement of emergency medical services. Quite often, however, officers are faced with more ambiguous situations or situations where there is no clearly mandated or available service. An officer who finds a child who has witnessed an accident or assault, who has a teenager confide in him or her about being worried about gang membership, or who observes a child becoming truant is offered clinical opportunities for intervention that are broader than those usually considered to be within the province of police work. It is within the officer's discretion as to how to proceed. As police officers work more closely with communities, these situations occur with greater frequency. Where might an officer turn for discussion, guidance, and an immediate clinical response? This is especially critical when the officer is faced with a child who is in great distress, as happens so often in relation to inner city violence.

The Consultation Service of the Program on Child Development and Community Policing (CS/CP) allows the police to make referrals and to have clinicians respond to police officers' immediate needs for guidance, especially following children's traumatic experiences. At the CS/CP, Child Study Center clinicians carry beepers and are on call 24 hours a day to discuss children and youth with police officers. At times, the consultation leads to a disposition to an available clinical program (e.g., the use of the child psychiatric emergency service, referral to the state child protection agency, an appointment at the Child Study Center or other child guidance services within the community, or engagement with the mental health teams within the child's school). At other times, a direct clinical response is needed, because of the urgency of the child's distress. At such times, CS/CP clinicians can respond immediately and see the child and youth at the Center, in the police station, or at their homes.

The first calls to the CS/CP involving children exposed to some form of violence were made by officers who had participated in the child development seminar, by officers who worked in neighborhoods supervised by the clinical fellows, or by the sergeants themselves. These incidents included:

- A 5-year-old girl was caught in the crossfire of a gang shooting and was struck by a .45 caliber bullet that lodged in her lower right mandible. She and her family were seen by a psychotherapist from the moment she entered the hospital and after she was discharged.
- A 12-year-old girl ran away from home when her mother and her mother's boyfriend began fighting at home. When she was 5 years

old, a similar situation had developed between her parents, which ended with the mother shooting the father after he repeatedly beat her. The girl and the mother were referred for psychotherapy, for the first time, by neighborhood police officers. When the mother was able to end her relationship with the abusive boyfriend, the police remained in close contact with the family and assisted the boyfriend in moving out of the home. The girl was able to return home.

- A 13-year-old girl was arrested and charged with murdering her newborn infant. The girl and her mother were referred for evaluation and treatment by the investigating police officers.
- A 16-year-old gang member was referred by the police after suffering a full-blown panic attack while being arraigned for the shooting death of a close friend. Despite his having spent 2 years in a correctional facility, this was the first time the boy had been evaluated by mental health professionals.

CHILDREN AS VICTIMS OF VIOLENCE: COLLABORATIVE INTERVENTION

Through the collaboration between police officers and mental health professionals, the Program on Child Development and Community Police has led to innovative methods for clinical intervention for children who have been victims of violence. Their cases reveal the depth of trauma to which inner city children are exposed, and the ways in which professionals can complement each other in trying to respond effectively.

Case 1: A Boy Shoots Himself

Sgt. Brown, a detective sergeant on the evening shift, called the on-call Child Study Center Consultant Service clinician to report that a 15-year-old boy had shot himself in the head after a fight with his mother. The boy, John Simmons, had been taken to the emergency room of the local hospital and was accompanied by his mother, his 17-year-old sister, and his 12-year-old brother. Sgt. Brown reported that the boy was not expected to live, and that he was concerned about the other two children, especially the sister, Carol, who had a history of psychiatric hospitalizations for attempted suicide. The on-call clinician spoke with the attending physician in the emergency room, who described the boy's status (he had been taken into the operating room) and reported that the mother had remained at the hospital, and the brother and sister had been taken home by a police officer. Given the sister's history, the clinician was concerned about the risk for

another suicide attempt and phoned Sgt. Brown to suggest that an officer go to the family's home to determine whether the two children were adequately supervised.

The clinician and Sgt. Brown had never met, and the sergeant volunteered that he knew little about the collaborative Consultation Service other than that a memo suggested that this was the type of situation in which the Child Study Center should be notified. He added that he would pass on the suggestion of a police visit to the Simmons' home to the next shift, which would come on in 2 hours. The clinician was uneasy about this time frame, but was not in a position to press his concerns with an unfamiliar officer. The clinician contacted Sgt. Stone, a clinical fellow, who agreed that more immediate contact with the family was indicated. The clinician volunteered to go to the Simmons' home immediately, to determine whether there was adequate adult supervision of the children, and to assess their status. At 11:30 p.m., Sgt. Stone phoned the clinician to report that the 12-year-old was asleep and the 17-year-old was stable; she was concerned about her younger brother's condition, but did not exhibit any impulses to harm herself. However, by the time Sgt. Stone arrived, Ms. Simmons had returned home and had been drinking heavily, and was insisting that she would shoot herself with a gun that remained in the home. In consultation with the on-call clinician, Sgt. Stone arranged for a relative to come to the Simmons' home while he took Ms. Simmons to the emergency room for a psychiatric evaluation.

John Simmons survived and was sent to a local rehabilitative hospital following his recovery from surgery. Ms. Simmons was released from the psychiatric emergency room a day after the shooting, and the family was referred to the mental health center nearest their home. Despite Carol's previous brief hospitalizations, this was the first time that all the family members were seen by mental health professionals. Two weeks after the shooting, the on-call clinician contacted the therapists who became involved with the Simmons family at the local mental health center. What emerged was that each of the family members had experienced disruptions in sleeping and eating and were very eager to talk about the difficulties and anxieties that predated and followed the shooting incident. The family expressed surprise that the police had been so concerned about them. Their previous contact with the police had been around the arrests of Mr. Simmons, who was now serving time for armed robbery, and of a 19-year-old son, who had been involved in a gang-related shooting 2 years earlier.

Case 2: A Family Is Witness to a Murder

Martin and Isabel Rodriguez lived in a public housing project in New Haven with their 2½- and 10-year-old sons, Manuel and George. Both Mr. and Ms.

Rodriguez were unemployed and lived on the Aid the Families of Dependent Children (AFDC) payments they received from the state.

On a Saturday morning, Martin's brother, Julio, raced into the apartment and claimed that four men with guns were chasing him. Ms. Rodriguez called the police and waited for them to arrive as the men attempted to batter down the apartment door. Julio tried to secure the door by leaning against it and pleaded with the men to let him come outside and talk, because there were children inside. As Ms. Rodriguez phoned the police again, Julio was shot through the door; he fell into the living room, bleeding profusely from a bullet wound to the chest. The shooter then battered the door down and walked around the apartment pointing his gun at everyone, including the children, who now stood over the body of their uncle. After ripping the phone off the wall, the assailant backed out of the room with his gun trained on Ms. Rodriguez. The police and an ambulance arrived moments later. The shooter and his three accomplices were arrested; Julio died en route to the hospital.

On the day of the shooting two New Haven police sergeants involved in the investigation referred the Rodriguez family to the Consultation Service. Both officers were part of the Child Study Center training program. Although the family initially declined immediate contact with a clinician, they were eager to have the officers' beeper numbers, and in the following days made frequent calls describing fears of further shootings, as well as multiple symptoms that both the children and the adults were experiencing. The officers were in daily contact with the psychiatric social worker assigned to the case, who advised them about gently pressing the idea of meeting with her. Six days after the shooting, Mr. Rodriguez left home, saying that he was unable to remain in the apartment where his brother had been killed. At this point, Ms. Rodriguez accepted the referral for services from the Child Study Center.

Because of transportation problems, the family was initially seen in their home. Ms. Rodriguez and her two sons were having difficulty falling asleep at night and were waking frequently during the night. Two-year-old Manuel was very clingy with his mother, demanding to be held and carried; he searched the apartment for his father and asked frequently where his father was. Ms. Rodriguez described Manuel as having previously been an active and independent child. She reported some success in soothing him by giving him a bottle, from which he had previously been weaned. Ten-year-old George was having nightmares, waking frequently, and checking that doors and windows were locked, and insisted on sleeping in his mother's bed. George also reported that he was nervous and scared all the time, that he couldn't stop thinking about the shooting, that he worried that the shooter would come back, and that he was afraid to be outside alone; this meant that he could not walk the few blocks to his aunt's house. Ms. Rodriguez

reported sleeplessness, nervousness, and jitteriness; preoccupation with thoughts about the shooting; and worries that she and her children were not safe. During the interview, she was unable to sit still and was frequently tearful. Ms. Rodriguez had seen her primary physician, who had given her a prescription for a mild sedative to be taken at bedtime, but she had been afraid to take the medication lest it make her sleep so deeply that she would not be able to rouse herself in case of another emergency.

The family was seen on four occasions in their home. Most of the meetings took place with all three family members present, because there was little private space in the apartment. During some of the meetings, Manuel was either sleeping or was willing to play by himself in another room. It was apparent that Ms. Rodriguez and George had talked a lot about the incident and neither seemed surprised by anything the other said, although they did disagree about some details of the event.

The first meeting focused primarily on a description of the traumatic events and the witnesses' reactions. Both Ms. Rodriguez and George were quite eager to describe what had happened and to show the clinician where all the participants had been and the damage that remained in the apartment. According to Ms. Rodriguez' account, the most prominent details concerned her own helplessness and the helplessness of those around her. She repeatedly told of having been on the telephone trying to get help when the shot came through the door, and also focused on Julio's ineffective plea to the shooter not to come into the apartment, where there were children. Ms. Rodriguez also reported feeling afraid in her apartment but unable to go anywhere else. George's account of the shooting focused more on the gruesomeness of the scene. He was preoccupied with the images of blood on the floor, of blood on his own clothing, and of having been touched by Julio as he fell into the living room. George pointed out what was left of the blood stain on the rug and described feeling afraid to walk on the rug, especially on or near the stain. George was also preoccupied with concrete issues of physical security in the apartment (e.g., whether the spackle patching the bullet hole in the door might fall out). During the first meeting, the clinician responded by agreeing that the events described had really been horrible and overwhelming, and explained that the reactions the family described were expected reactions to a traumatic experience. The clinician discussed with Ms. Rodriguez the boys' experience of losing their father at the same time as witnessing the shooting and urged her to make some arrangement for them to have contact with their father.

In subsequent meetings in the home, Ms. Rodriguez was agitated, but more angry, than she had been initially. Her anger was directed at the landlord, who had not made needed repairs in the apartment and threatened to charge her for the cost of repairing the battered door, and at Mr. Rodriguez, who had not called her on Christmas, had not arranged to see

Manuel, and had chosen to stay with his father rather than her. She was also reexamining his actions during the shooting, and felt enraged that he had not provided any protection or assistance to her or the children, but had hidden himself in the bedroom.

During the later home visits George talked about his vengeful fantasies about what should happen to the shooter, his continuing fears about his own safety, his wish to live in an apartment with a security system, and his fantasies about dangerous and magical properties of the blood stained rug (e.g., its ability to make a battery-powered toy operate without batteries). The clinician encouraged both George and Ms. Rodriguez to differentiate their fantasies of danger and magic from what they knew was real, and recommended that Ms. Rodriguez come to the outpatient clinic with her children so that they could obtain longer term help in coping with this crisis than could be provided in their home.

In the course of this initial evaluation period, George was friendly, verbal, and engaging as he described his sleep difficulties; his anxious, intrusive thoughts about his safety; and his restricted activities following the shooting. He was pleased to be offered the chance for further discussions that might make him feel better; he had already felt some relief from his talks with the evaluating clinician. Although it appeared that George was very attached to his mother and sought comfort from her when he was scared, he was also burdened by her obvious distress and made frequent efforts to comfort her, especially when she cried.

Ms. Rodriguez was extremely anxious and sought constant contact and reassurance from the police and the clinician regarding her family's safety and emotional and physical needs. In spite of the on-call availability of both, Ms. Rodriguez was overwhelmed. She saw herself as passive, dependent, and helpless. She was unable to make realistic efforts to secure new housing for her family, and was unwilling to take prescribed medication that would help to diminish her level of immobilizing anxiety. Reassuring her about the safety of the medication, the clinician capitalized on Ms. Rodriguez' genuine concerns about her children and their need for her optimal stability to help them with the distressing events. In addition, the combined efforts of the clinician and community police officer involved in the case eventually guided Ms. Rodriguez to the appropriate public housing authorities for discussions about a possible change of neighborhoods.

During the clinician's initial contact with the Rodriguez family, it became apparent that George's acute, posttraumatic symptoms were predated by longstanding social and academic difficulties that had never been evaluated or treated. Although 2-year-old Manuel was able to give up the bottle once again and return to his previous good level of functioning on his father's return home, more extensive treatment for George and his mother was

indicated. Both were referred to the outpatient clinic of the Child Study Center for individual and family psychotherapy. Transportation was arranged by the CP/CS clinician and the community-based police officer, who later engaged George in an after-school program sponsored by the police. As the posttraumatic stress symptoms abated for both George and Ms. Rodriguez, the emphasis of the clinical work shifted from the crisis that followed the shooting to longstanding difficulties with self-esteem, mutual dependence, and constriction of more age-appropriate autonomous functioning.

Case 3: A Father Kills Himself In His Son's Presence

Mark Jones was a 14-year-old boy who was spending the weekend with his father when, from a back room, he heard his father arguing with his girlfriend. Mr. Jones and Mark's mother had been divorced for 10 years; Mark lived at home with his mother and stepfather, and visited his father once a month. He had heard fighting on previous visits, and often worried about his father's drinking problem and frequent swings of depressive withdrawal, gregariousness, and volatile rage.

On this particular Friday evening, Mark tried to block the noise of the argument by turning up the volume on the television. When the shouting stopped, Mark was relieved until he heard the sound of the slide being pulled back on his father's automatic handgun. He prepared himself for what he thought would be the sound of the gun being fired into the wall. What he heard instead was his father saying goodbye to his girlfriend before shooting himself dead. Mark emerged from his room to see his father lying in a pool of blood on the living room floor. Mark phoned the police, screaming that his father had been hurt, and then began throwing objects around the room.

When police arrived on the scene, Mark was tearful and subdued. His mother and stepfather had been called, and were on their way to the father's house. The supervising sergeant phoned the CP/CS clinician on call who advised that the mother, Ms. Johnson, be informed that he would be available to meet with the family at their request. Both Mark and his parents asked to see the clinician immediately, and within an hour of the shooting they were seen in a quiet, private office in the police headquarters.

Accompanied by his mother and stepfather, Mark stared into the middle distance and, with tears in his eyes, slowly described what he had seen and heard. He stopped his story abruptly just before telling about the sound of the gunfire and looked around the room at his parents and then intently at the clinician, unable to go on. The clinician then asked if he would prefer speaking without his parents present. Mark nodded and, after the other

adults left, he continued to talk about his wish that he had intervened when he heard the fighting. He sobbed as he acknowledged that he felt he was to blame for his father's death, but quickly composed himself. Again staring into space, Mark recounted his father's long history of difficulties with alcohol, drugs, and violence.

Mark repeated that he should have "done something to stop him" and said, "I wonder if he's all right." He then described feeling numb, as if in a dream that he wished would end soon. The clinician suggested that perhaps Mark knew for a long time that he was unable to control what his father did to himself, but that, especially now, when he felt so awful and overwhelmed, he wished that he could have been in control or only dreaming, or that he could believe that his father was not really dead but only wounded. Mark nodded and spoke of his hatred for his father's girlfriend, now blaming her for his death. "They always fought and she always started the fights . . . and he wasn't supposed to drink. What was she doing buying him alcohol?" His thoughts shifted rapidly as he described getting into trouble at school, including an incident in which he had stolen a hunting knife from his father and slashed a teacher's tires. Mark added, "Maybe that's why this happened . . . because I was bad . . . like this is my punishment." The clinician pointed out that perhaps the hardest person to be angry with right now was his father. Mark again stared out the window and, in a flat tone of voice, said that he always worried that his father might kill himself and that he alternated between getting into fights with other people and feeling miserable and depressed. "The scariest thing was with his guns. Sometimes when he got real upset, he would go and shoot at things in the basement. That's what I hoped he would do when I heard him loading his gun . . . but he didn't." With a deep sigh, Mark said that he didn't want to talk anymore, that he was tired and wanted to go home.

In a brief meeting, Mr. and Ms. Johnson said that Mark had been having troubles in school over the past year and was seeing the school social worker once a week. Ms. Johnson had little contact with her ex-husband, but expressed her guilt about allowing Mark to spend time with him over the years. She said that she knew how disturbed he was but did not want to deprive Mark of contact with him when Mark continued to want to continue the relationship. She blamed herself for what she concluded would be an indelible trauma for their son. The clinician pointed out that this issue of blame, and the wish that some aspects of the events could, somehow, have been controlled were similar to one ones with which Mark was currently, and would continue to be, struggling. In response to the parents' pleas for ways to help their son through this awful event, the clinician suggested that they recognize that Mark's responses would be varied and complicated, that they would need to follow his lead in how and when he wanted to discuss his thoughts and feelings with them. In addition, the

parents requested that the clinician speak with the school social worker and make a referral for additional therapy services.

Meeting briefly with Mark and his parents, the clinician repeated what he had told the parents, and added that they could contact him at any time. During the next week, the clinician was called on several occasions by the family and by school personnel. The latter contacts were requests for ways of discussing Mark's loss with classmates and for input about how much the school social worker should push Mark to talk about his experience. The family wanted help in deciding whether to require Mark to go to a wake that he had no interest in attending. In addition to making a referral for psychotherapy outside of the school setting, the consulting clinician advised school personnel and the family regarding the wake on the basis of his follow-up phone contacts with Mark. Mark told the clinician, "Everybody keeps asking me a lot of questions and trying to tell me what will be best for me. It's as if they think that whether I go to the wake or talk all the time about my feelings, everything will be better. Everything will not be better . . . at least not for a very long time." In the ensuing weeks and months, Mark threw himself into the activities of normal life while pursuing his complicated thoughts and feelings about his life before and after his father's suicide, in the privacy of his therapy hours.

DISCUSSION

As the rate of violence in our inner cities has climbed, so has the number of children who are its direct and indirect victims. Previous work (Friend, 1956; Pynoos & Nader, 1988, 1989, 1990; Terr, 1989, 1991) has focused on the impact of exposure to isolated episodes of violence and the symptoms of PTSD that often follow. Although psychiatric services are frequently available to the victims of the most episodes of violence, children's exposure to random shootings, and to fighting at home and on the streets has not provoked a routine mental health response or suggested an obvious point of entry for intervention. In addition to suffering acute symptoms following observation of a shooting or stabbing death or the nightly sound of gunfire, children may respond to chronic exposure to violence by turning away from the frightening role of victim and, over time, assuming the exciting, but dangerous role of perpetrator.

Often, the families most affected by community violence have limited access to mental health services or are unable to take advantage of those that exist. A self-referral for psychiatric consultation may be low on the list of priorities for the families who struggle with chronic neighborhood violence, in addition to the hardships of unemployment, poverty, drug and alcohol abuse, and the like. Feelings of hopelessness conspire with the

burdens of transportation and wariness of social service institutions to further limit utilization of existing clinical services.

Community-based policing offers a new approach to intervention for children and families exposed to inner city violence and its short- and long-term effects. The philosophy of community-based policing encourages police officers to detect vulnerable and distressed individuals and to help them obtain the services they need, and to collaborate with communities in establishing and making services available. For community-based policing to fulfill its expanded mission, police departments and police officers will need knowledge and methods, as well as a conceptual framework, to guide their interventions with children and their families. If community-based policing succeeds, even in part, police officers will be better able to collaborate with other professionals concerned with inner city children, such as clinicians, educators, and clergy.

We hope that the Program on Child Development and Community Policing in New Haven will increase the effectiveness of the outreach force of the 480 police officers who have the most direct, immediate, and sustained contact with the families hardest hit by community violence. Detecting vulnerable children and families and those in distress, offering referrals, arranging home visits, or providing transportation for appointments with mental health clinicians expand the role of the police officer responding to a call involving violence. This new role not only focuses the officer's attention on the children's experience of violence, but also supports the caregivers' attention to their own children's needs.

In each of the cases referred to the Consultation Service by the police, officers have commented that, in the past, their role would have ended with filing an incident report on the crime or complaint. They have described countless cases in which children may have been on the scene of violence and were never noticed by officers, who were only engaged in interviewing adult witnesses, collecting evidence, or coordinating arrangements with emergency services. In addition, previous police procedure would have viewed the adults only as suspects, witnesses, or subjects of arrest, not as parents or caregivers of the children who had been exposed to violence.

Veteran officers have described how, prior to the institution of the Child Development Program, even "the cops with the roughest edges always felt for the children" who became caught up in the scenes of violence. However, the earlier, more restricted definition of their job—"catching bad guys and making arrests"—and the absence of a resource for discussing the emotional needs of these young victims resulted in the "requirement" to not notice the children or to turn away from the painful and helpless feelings aroused when there was no active role for them to take in this area.

The shift to community-based policing introduces a different, or additional, role for police officers. With permanent assignments to specific

neighborhoods, officers assume a proactive function that augments the traditional reactive one. Officers become known in the community. They are involved with individual families, as well as after-school activities for children, and attend meetings that address neighborhood concerns. All officers carry personal beepers, so that calls need not be routed through a central dispatcher. Instead, members of a neighborhood can now place a call directly to the officer with whom they are most familiar.

The introduction of courses on child and adolescent development for rookie officers, the clinical fellowship for veteran officers, and the Consultation Service are designed to address the needs of a police force seeking to play a more prominent, proactive role in the lives of the children and families in the inner city. In combination, these programs aim to equip officers with a broader frame of reference in dealing with the problems they confront in their daily work, and to provide a triage and referral service for specific cases in which children are the victims or witnesses of violence. Without interventions, the psychological victims of violence run the risk of never fully recovering, and will continue to pay a high price for their exposure. They may be unable to concentrate and learn, unable to feel safe and play, and they may eventually find some degree of safety and power only as the agent of violence, rather than as its victim. The Program on Child Development and Community Policing brings together police officers and mental health professionals who provide informed and consistent attention to the children at greatest risk for developmental difficulties, symptoms, and self-destructive responses, were their exposure to community violence to go unnoticed and untreated.

ACKNOWLEDGMENTS

The authors gratefully acknowledge the support of the Rockefeller Foundation and the Smart Family Foundation as well as the efforts of colleagues at the Yale Child Study Center and the New Haven Department of Police Service in the development of this project.

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Development: Collaborative Interventions

STEVEN MARANS

INTRODUCTION

Dramatic and explosive violence is a staple on the nightly news all over the world. In the United States and elsewhere many urban families, however, do not need to turn on their television set to experience violent acts. Nor can they turn them off with the touch of a dial. They hear the sound of gunfire outside their windows. They witness shootings and stabbings in their homes and streets. Both the assailants and the wounded are their relatives and neighbors. While ambulances rush the medical casualties to hospital emergency rooms, the psychological victims, children and parents who are witnesses, are left to sleep on the floors at night. They stay inside and hope that their attempts to remain physically safe will also reduce the threatening images and thoughts of violence. Too often these images and fears do not fade away, and the children, in particular, pay a high price for their exposure and forced adaptation.

For children, direct exposure to violence provokes feelings of helplessness and fear that run counter to the developing child's wish and capacity for increasing mastery of his world. Children's responses of distress may include specific symptoms of post-traumatic stress disorder—disrupted patterns of eating, sleeping,

The author gratefully acknowledges the support for this work by the Rockefeller Foundation, the Smart Family Foundation, and the B'nai B'rith Women's Organization. Parts of this work are presented in L. Leavitt and N. Fox (1993).

attention and relating, and fearfulness and flashbacks (*DSM-III-R*, 1987). Repeated, direct exposure to violence may lead to persisting patterns of adaptive but problematic behaviors and modes of functioning. The child may withdraw, appear depressed; display difficulties with school achievement and social relationships; or may assume the active role, becoming the agent of aggressive violence rather than remaining its passive victim.

Applications of principles of child and adolescent development to a variety of situations outside of the consulting room have been employed in an attempt to minimize the stress and traumatization that may interfere with children's developmental potential (Marras, 1991). Principles regarding the essential emotional needs of the child, the child's primary tie to the parent, and the potentially traumatic effects of disrupting that relationship have been applied in considering the "best interests" of children requiring hospitalization (Burlingham, 1979; Earle, 1979; Fraiberg, 1968; Freud, 1952; Furman et al., 1968; Moran, 1984; Schowalter and Lord, 1972), institutional care (Provence and Lipton, 1962; Robertson and Robertson, 1958; Spitz, 1945), and involvement in custody/placement decisions (Goldstein, 1973, 1979, 1986). In work with children and families exposed to violence, the development of a program on Child Development and Community Policing addresses another aspect of psychic trauma that occurs when what Freud referred to as the "actual danger" (Freud, 1926) is in the form of gunfire, wounding, and death. In the current collaboration developed between the Yale Child Study Center and the New Haven Department of Police Service, child analysts and analytically informed clinicians have turned to the police as the professionals who have the greatest amount of immediate and sustained contact with the children and families most directly in the line of fire.

TRENDS IN COMMUNITY VIOLENCE

While community violence in the United States by no means began in the latter part of the twentieth century, over the last several years there has been a marked increase in its occurrence. In the period between 1989 and 1990 alone, Boston experienced a 45 percent rise in rates of violence; Denver showed a 29 percent increase; Chicago, New Orleans, and Dallas each had

increases of 20 percent (Surgeon General's Workshop on Violence and Public Health, 1991). During the year ending in December 1991 approximately 22,000 people died from assaultive violence, while 2.2 million people suffered nonfatal injuries from assaultive violence (Surgeon General's Workshop on Violence and Public Health, 1992). It is estimated that homicide is the second leading cause of death among 15- to 24-year-olds in the United States. It would seem that the despair of unemployment, multigenerational poverty, and family dissolution contribute to a sense of helplessness and rage that for too many can lead them to find some relief in the power of a violent resolution of disputes.

While the statistics regarding the incidence of assaultive violence are disturbing in and of themselves, it is important to note that the potential number of children as psychological victims may far outnumber the medical casualties that reach our emergency rooms or the headlines of our newspapers. In a recent study conducted at Boston City Hospital, it is reported that one of every ten children seen in the primary care clinic there witnessed a shooting or stabbing before the age of 6—half in the home, half on the streets. The average age of the children was 2.7 years (Taylor, 1992). In a survey of inner-city elementary school children in New Orleans, 80 percent of the sample reported witnessing violence; 60 percent had seen weapons used; 40 percent had seen a dead body (Osofsky et al., 1992). Similarly, in a study conducted in New Haven schools of sixth, eighth, and tenth graders, 40 percent reported being witness to at least one violent crime in the past year (R. Weissberg and M. Schwab-Stone, personal communication). In spite of the fact that New Haven is well endowed with mental health services for children and families, it is clear that the potential number of psychological victims of violence far outweigh the availability and responsiveness of existing models of intervention. It was out of the shared concerns about these often unnoticed psychological casualties of violence that the collaboration between the Child Study Center and the New Haven Department of Police Service emerged.

CHILD DEVELOPMENT AND COMMUNITY POLICING

The discussions that took place between the leadership of the Yale Child Study Center and the New Haven Department of Police Service occurred in the context of rising rates of violence

and the recognition that previous intervention strategies on the part of police and mental health professionals were having limited impact on interrupting the trends in violence or decreasing the number of medical casualties and psychological victims of violence. The discussions also occurred in the context of a shift to community-based policing within the New Haven police service and to increasing acceptability of clinical services through schools, the home, and community resources. The Child Development-Community Policing Program is a collaborative effort to address these problems through prevention and intervention activities on the part of mental health and police professionals. The program consists of several interrelated educational and clinical components that aim at sharing knowledge between police officers and mental health professionals in the service of ameliorating some of the effects of violence on inner-city children. These components grew out of months of discussions between faculty members of the Yale Child Study Center that occurred in equal parts in conference rooms, on the streets and in squad cars, in outpatient clinics and in hospital emergency rooms, in juvenile courts and detention centers, and in substations throughout the city of New Haven. The components that were developed are:

Child Development Fellowships

Clinical fellowships were established for supervisory sergeants who spend three to four months rotating through various clinical and consultative services of the Yale Child Study Center. Under the guidance of a mentor from the clinical faculty, police fellows participate in a range of educational activities. These experiences were intended to familiarize them with developmental concepts, patterns of psychological disturbance, methods of clinical intervention, and settings for treatment and care. Their program includes participation in evaluation of children with emotional and psychiatric problems, visits with a consultation team to community schools, participation in clinical meetings with the child welfare team to discuss families in crisis, discussions with senior faculty of children and adolescents who are brought to the emergency service or are psychiatric inpatients, and attendance at seminars and other teaching activities within the Child Study Center. Participation of veteran supervisory officers in the fellowship has several aims: (1) the clinical fellowship prepares supervi-

sory officers to provide leadership for ongoing application of developmental principles to police work by officers working under their command; (2) their years of police practice expertise has been essential in developing and implementing all other areas of the Child Development-Community Policing Program; and (3) their visibility and endorsement of the principles and practices of the program have been instrumental in gaining acceptance throughout both the police department and the department of child psychiatry within the medical school. In turn, the visibility of clinicians engaged with police officers in various domains has been equally important to the potential role of mental health clinicians as potential collaborators for police officers.

The Education of Police Officers

In New Haven, as elsewhere in the United States, the education of police officers has not specifically and prospectively prepared them for dealing with the psychological impact of violence on children, adolescents, and their families—let alone the impact on themselves. Nor has there been any particular frame of reference for considering the range of human behavior they confront and must respond to in the course of their daily work. A seminar for community-based officers was created and taught by senior officers who had completed the child development fellowship and faculty members of the Child Study Center. The twenty hours of seminars for groups no larger than fifteen participants aims at providing officers with both knowledge and a sense of personal empowerment to think about and intervene positively with children and families in a range of situations.

The major theme of the seminar is how police officers' direct experiences, enriched by knowledge from psychodynamic theories of development, can lead to useful understanding of the phenomenology of human behavior. Topics include the phases of child development and how these are shaped by different types of experiences within the family and community; social structures that influence individuals' sense of themselves, their families, and social groups; sources of security for individuals, types of dangers, traumas, and stress experienced; varying patterns of coping; and how to communicate with and understand children and youth at different times, including when they are witnesses to and victims of violence and other trauma. The seminars are interactive and

informal and employ both individual cases and specific scenarios from police experience as starting points for teaching about general principles of development and psychological functioning. An essential ingredient to officers' participation in these discussions is the notion and experience that when officers have a broader frame of reference for understanding human behavior, their options for safer, more creative, and more effective interventions are expanded.

Consultation Service

When an officer comes into contact with a child or youth in danger or distress, he or she must make an immediate decision about whether to intervene and what is in the child's best interests. At times, the path of intervention is clearly mandated, as when a child is thought to be the victim of abuse or neglect and the state child welfare agency must be notified. At other times the critical nature of a medical condition, for example, following an assault or a suicide attempt, dictates the involvement of emergency medical services. However, officers are most often faced with more ambiguous situations, situations in which there is no clearly mandated or available service. An officer who finds children who have been witnesses to an accident or assault, who has a teenager confide in him about being worried about gang involvements, or who observes a child becoming a chronic truant may have opportunities for intervention broader than those usually seen as within the province of police work. It is at the officer's discretion how to proceed. As police officers work more closely with communities, these situations occur with greater frequency. Where might an officer turn for discussion, guidance, and an immediate clinical response? This is especially critical when the officer is confronted by a child who is in great distress or who has quietly withdrawn at the scene of horrific violence.

The consultation service allows police officers to make referrals and to have clinicians respond to their immediate needs. Child Development-Community Policing (CD-CP) clinicians and senior police officers are on call twenty-four hours a day to discuss children and youth with police officers. Many consultations lead to a disposition to an appropriate service agency, for example, the state child protection agency, an appointment at the Child Study Center or other child guidance services within the community, or

engagement with the mental health team within the child's school. However, at other times a direct clinical response is indicated due to the urgency of the situation or because of our increased awareness that an immediate response to the child and family at the scene of a violent event can, in fact, set the stage for the clinician's closer understanding of the magnitude of the experience and may enhance the potential for a therapeutic contact being made. At these times CD-CP clinicians and officers can respond immediately and see children and their families in the home, at the Child Study Center, or in the neighborhood substation or police headquarters.

Case Conference

During and after their involvement in the clinical fellowship, police officers and faculty within the Child Study Center meet on a weekly basis to discuss difficult and perplexing cases that arise from our direct experiences through the consultation service. The case discussions emphasize the importance of trying to understand the inner experience and the meaning of events to children, adolescents, and their families, as well as the challenges and difficulties in the path of the service providers. These discussions address the ways in which psychological understanding can guide both police and clinical work. A case conference also offers the clinical fellows and Child Study faculty an opportunity to continue and elaborate their working relationships with one another. Increasingly, as these meetings are held in the substations around the city of New Haven, more and more officers are able to participate in these meetings as a way of continuing their engagement in discussions that are often similar to ones that they may have experienced in their ten-week seminars.

During the first year and a half of operation, the program has trained 150 officers in the seminars on child and adolescent development; 15 supervisory officers, including the assistant chief of police, have participated in the clinical fellowship; and approximately 200 children have been seen through the consultation service.

CHILDREN'S RESPONSES TO VIOLENCE

The children we have seen have ranged in age from 2 to 17 years. Initial contact has occurred from within minutes of a violent event to several days after and has included children's

exposure to shootings, stabbings, beatings, and in one situation, the drowning death of a peer. The traumatic situation may still be described as one in which the individual has experienced feelings of helplessness in the face of a danger whose magnitude outweighs the "subject's estimation of his own strength" (Freud, 1926, p. 166). The children we have seen through the consultation service have responded to the violence they have witnessed with a variety of defensive activities that may best be seen as attempts to regain a semblance of control, strength, power, and predictability; to gain distance from, and better prepare for the images and feelings associated with danger and fear.

Similar to the findings of other investigators (Pynoos et al., 1987; Pynoos and Nader 1989; Terr, 1991) our observations suggest that the degree of a child's disturbance or traumatization is determined by an interplay of factors within the child and between the child and his or her surroundings:

- characteristics of the violence itself—that is, the child's relationship to the perpetrator and victim, proximity to the incident, response of the caregivers to the incident.
- the developmental phase of the child who is exposed—that is, the status of emotional and cognitive resources available for mediating anxiety associated with objective and fantasized dangers.
- the familial and community context of the violent incident—that is, was the incident isolated and unusual, or part of a chronic pattern of daily life.
- recognition of and sustained responses to the possible effects of the child's exposure to violence by family members, school personnel, and community institutions.

In addition, while there is tremendous variation among children seen by consultation service clinicians and police officers, some common observations can be reported. These include: (1) disbelief and denial of the outcome or even the occurrence of the violent event; (2) intense longing for the presence of and concern about the safety of primary caregivers (especially among children under age 7); (3) revival of and much talk about previous losses, injuries, fights, and other episodes of violence; (4) repetitive retelling of the events with ideas that might have altered the real outcome of the

episode, described by Pynoos as "intervention strategies" (R. Pynoos, personal communication); (5) attribution of blame to those not directly involved in the violence; or alternatively (6) reveling in the excitement of the action of the violence with talk of the weapons used, who got "capped," "smoked," or "aired."

While our findings are preliminary, it would appear that two groups of children are most vulnerable to longer term presentation of affective, attentional, and behavioral difficulties in the wake of their exposure to episodes of violence. Not surprisingly, one group includes children whose development has already appeared compromised and whose limited capacity for mediating anxiety led to a range of symptoms prior to witnessing a violent event. The second group of children includes those whose initial responses are quiet and unobtrusive to the adult caregivers or whose gross symptomatology is not seen by caregivers as causally linked to the child's exposure to a disturbing scene of violence. When the child is unable to understand, let alone directly verbalize his or her experience of trauma, adults are often unable to listen to or interpret the child's action or symptomatic language that communicates distress. Additionally, adults may be overwhelmed by the child's feelings of helplessness and fear, so similar to those that accompany their own experiences of violent episodes. Their own inability to listen and to attend to their child's needs may be a natural consequence of their own attempts at restitution and self-protection and feelings of vulnerability—the wish to push away upsetting images and feelings is especially powerful when the events that evoke them are so dangerous and real.

These phenomena have a special bearing on mental health care providers and police officers as well. By personal disposition and training, each is called upon to treat and cure the ills of patients or to "protect and serve" citizens to the best of their personal abilities and the community's resources. In cases involving children who have witnessed incidents of violence, however, the professionals who respond to them are not immune to the horrors that the children have experienced themselves. The urge to act, to make things better quickly for patients or the youngest citizens served, may be an attempt to guard against the discomfort and feelings of helplessness experienced by the professionals, while interfering with the most significant initial intervention that the professionals have to offer—to listen and to attend.

COLLABORATIVE INTERVENTIONS: A FAMILY WITNESSES MURDER

Through the collaboration between police officers and clinicians, the Child Development-Community Policing Program has led to innovative methods for clinical intervention in relation to children who have been victims of violence. Their cases reveal the depth of traumatization to which inner-city children are exposed and the ways in which police and mental health professionals complement each other in trying to respond effectively.

Mr. and Ms. Rodriguez live in a public housing project in New Haven with their 2½- and 10-year-old sons, Manuel and George. Both Isabel and Martin Rodriguez are unemployed and live on AFDC (Aid to Families with Dependent Children) payments they receive from the state. On a Saturday morning in January, Martin's brother Julio raced into the apartment and claimed that four men with guns were chasing him. Ms. Rodriguez called the police and waited for them to arrive as the men attempted to batter down the apartment door. Julio tried to secure the door by leaning against it and pleaded with the men to let him come outside and talk because there were children inside. As Ms. Rodriguez phoned the police again, Julio was shot through the door; he fell into the living room, bleeding profusely from a bullet wound to the chest. The shooter then battered the door down, and walked around the apartment pointing his gun at everyone, including the children who now stood over the body of their uncle. After ripping the phone off the wall, the assailant backed out of the room with his gun trained on Ms. Rodriguez. The police and an ambulance arrived moments later. The shooter and his three accomplices were arrested; Julio died en route to the hospital.

On the day of the shooting two New Haven police sergeants involved in the investigation referred the Rodriguez family to the consultation service. Both officers were part of the Child Study Center training program. While the family initially declined immediate contact with a clinician, they were eager to have the officers' beeper numbers and in the following days made frequent calls describing fears of further shootings, as well as multiple symptoms that both children and adults were experiencing. The officers were in daily contact with the psychiatric social worker assigned to the case, who advised them to gently press the idea of meeting with her. Six days after the shooting, Mr. Rodriguez left

the home, claiming that he was unable to remain in the apartment where his brother had been killed. At this point Ms. Rodriguez accepted the referral for services from the Child Study Center. Because of transportation problems, the family was initially seen in their home.

Ms. Rodriguez and her two sons were having difficulty falling asleep at night and were waking frequently during the night. Two-year-old Manuel was very clingy with his mother, demanded to be held and carried, hunted around the apartment for his father, and asked frequently where his father was. Ms. Rodriguez described Manuel as having previously been an active and independent child. She reported some success in soothing him by giving him a bottle, from which he had previously been weaned. Ten-year-old George was having nightmares, waking frequently, checking that doors and windows were locked, and insisted on sleeping in his mother's bed. George also reported that he was nervous and scared all the time, couldn't stop thinking about the shooting, worried that the shooter would come back, and felt afraid to be outside alone. This meant that he could not walk the few blocks to his aunt's house. Ms. Rodriguez reported sleeplessness, nervousness and jitteriness, and preoccupation with thoughts about the shooting and worries that she and her children were not safe. During the interview she was unable to sit still and was frequently tearful. Ms. Rodriguez had seen her primary physician, who had given her a prescription for a mild sedative to be taken at bedtime, but she had been afraid to take the medication because it might make her sleep so deeply that she would not be able to rouse herself in case of another emergency.

The family was seen on four occasions in their home. Most of the meetings took place with all three family members present because there was little private space in the apartment. During some of the meetings Manuel was either sleeping or was willing to play by himself in another room. It was apparent that Ms. Rodriguez and George had talked a lot about the incident and neither seemed surprised by anything the other said, although they did disagree about some details of the events.

The first meeting focused primarily on a description of the traumatic events and the witnesses' reactions. Both Ms. Rodriguez and George were eager to describe what had happened and to show the clinician where all the participants had been and the damage that remained in the apartment. In Ms. Rodriguez's

account, the most prominent details concerned her own helplessness and the helplessness of those around her. She repeatedly told of having been on the telephone trying to get help when the shot came through the door, and also focused on Julio's ineffective plea to the shooter not to come into the apartment where there were children. Ms. Rodriguez also reported feeling afraid in her apartment but unable to go anywhere else. George's account of the shooting focused more on the gruesomeness of the scene. He was preoccupied with the images of blood on the floor, blood on his own clothing, and having been touched by Julio as he fell into the living room. George pointed out what was left of the bloodstain on the rug and described feeling afraid to walk on the rug, especially on or near the stain. George was also preoccupied with concrete issues of physical security in the apartment, for example, whether the spackle patch of the bullet hole in the door might fall out. During the first meeting the clinician responded by agreeing that the events described had really been horrible and overwhelming, and explained that the reactions the family described were expectable reactions to a traumatic experience. The clinician discussed with Ms. Rodriguez the boys' experience of losing their father at the same time as witnessing the shooting and urged her to make some arrangement for them to have contact with their father.

In subsequent meetings in the home, Ms. Rodriguez was agitated but more angry than she had been initially. Her anger was directed at the landlord, who had not made needed repairs in the apartment and threatened to charge her for the cost of repairing the battered door, and also at Mr. Rodriguez, who had not called her on Christmas, had not arranged to see Manuel, and had chosen to stay with his father rather than her. She was also reexamining his actions during the shooting, and felt enraged that he had not provided any protection or assistance to her or the children but had hidden himself in the bedroom.

During the later home visits George talked about his vengeful fantasies about what should happen to the shooter, his continuing fears about his own safety, his wish to live in an apartment with a security system, and his fantasies about dangerous and magical properties of the bloodstained rug (e.g., to make a battery-powered toy operate without batteries). The clinician encouraged both George and Ms. Rodriguez to differentiate their fantasies of danger and magic from what they knew was real and recom-

mended to Ms. Rodriguez that she come to the outpatient clinic with her children so they could obtain longer-term help coping with this crisis than could be provided in their home.

In the course of this initial evaluation period, George was friendly, verbal, and engaging as he described his sleep difficulties; anxious, intrusive thoughts about his safety; and restricted activities that followed the shooting. He was pleased to be offered the chance for further discussions in order to feel better and had already felt some relief from his talks with the evaluating clinician. While it appeared that George was very attached to his mother and sought comfort from her when he was scared, he was also burdened by her obvious distress and made frequent efforts to comfort her, especially when she cried.

Ms. Rodriguez herself was extremely anxious and sought constant contact and reassurance from the police and the clinician regarding her family's safety and emotional and physical needs. In spite of "on-call" availability of both, Ms. Rodriguez was overwhelmed. She saw herself as passive, dependent, and helpless. She was unable to make realistic efforts to secure new housing for her family and unwilling to take prescribed medication that would help diminish her level of immobilizing anxiety. Reassuring her about the safety of the medication, the clinician capitalized on Ms. Rodriguez' genuine concerns about her children and their need for her optimal stability to help them with the distressing events. In addition, the combined efforts of the clinician and community police officer involved in the case eventually guided her to the appropriate public housing authorities for discussions about a possible change of neighborhoods.

During the initial contact with the Rodriguez family it became apparent that George's acute, post-traumatic symptoms were predated by long-standing social and academic difficulties that had never been evaluated or treated. While 2-year-old Manuel was able to once again give up his bottle and return to his previous good level of functioning on his father's return home, more extensive treatment for George and his mother was indicated. Both were referred to the outpatient clinic of the Child Study Center for individual and family psychotherapy. Transportation was arranged by the CD/CP clinician and the community-based police officer who later engaged George in an after-school program sponsored by the police. As the post-traumatic stress symptoms abated for both George and Ms. Rodriguez, the

emphasis of the clinical work shifted from the crisis that followed the shooting to long-standing difficulties with self-esteem, mutual dependence, and constriction of more age-appropriate autonomous functioning.

DISCUSSION

As the rate of violence within our inner cities has climbed, so has the number of children who are its physical casualties and psychological victims. Often the families most affected by community violence have limited access to mental health services or are unable to take advantage of those that exist. Feelings of hopelessness conspire with the burdens of transportation and the weariness of social service institutions to limit utilization of existing clinical services. Moreover, it is not easy for adult caregivers to attend, listen, and understand a child's efforts at recovering from trauma when the need to push away their own experience of fear, helplessness, and discomfort in the face of violence is so great. When attention is not paid, when there are no interventions for the psychological victims of violence, they run the risk of never fully recovering; they continue to pay a high price for their exposure. They may be unable to concentrate and learn, unable to feel safe in play, and may eventually find some degree of safety and power only as the agent of violence, rather than as its victim.

In the collaborative effort between mental health and police professionals developed in New Haven, the Child Development-Community Policing Program is broadening the potential sites for providing informed and consistent attention to children at greatest risk for developmental difficulties, symptoms, and self-destructive responses that might result if their exposure to community violence goes unnoticed and unattended.

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