Part Two - Section Three

ISSUES OF VIOLENCE AND VICTIMIZATION - 6

Introduction to: Bell CC & Jenkins EJ. "Traumatic Stress and Children," Journal of Health Care for the Poor and Underserved, Vol. 2, No. 1: pp. 175-188, Summer 1991.

On October 2, 1990, we presented "Traumatic Stress and Children" at the "Children at Risk" Third National Conference on Health Care for the Poor and Underserved held by Meharry Medical College. The conference presented CMHC's research team the opportunity to highlight our continued work on the issue of traumatic stress in children in print. The article briefly covered CMHC's study of violence exposure in 536 second, fourth, sixth, and eighth grade students that had caught the attention of Ms. Johnnie Dyson in 1989. As a practicing clinical social worker who was working in a school we surveyed, Ms. Dyson saw first hand the results of the violence we had been accenting. As a result, she went on to publish "The Effect of Family Violence on Children's Academic Performance and Behavior" in the January 1990 Journal of the National Medical Association. She presented two cases of six students, all of whom had extensive histories of family violence, including a murder of a close family member. These cases illustrated the extreme impact of violence in the lives of African-American children. "Traumatic Stress and Children" also highlighted a previously done CMHC research team study on over a thousand school children aged 10 to 19 years done during the 1987 - 1988 school year. The complete result from this study was published in two articles. "Co-victimization of African-American Children Who Witness Violence: Effects on Cognitive, Emotional and Behavioral Development" was published in the March 1991 Journal of the National Medical Association by Bambade Shakoor and Deborah Chalmers. "African American Youth Encounters with Violence: Results From the Community Mental Health Council Violence Screening Project" by Edwina Uehara, Deborah Chalmers, Esther Jenkins, and Bambade Shakoor was published in the Journal of Black Studies, Vol. 26, No. 6, July 1996. When we began the work in the early 1980's, we had no idea how great an impact our work would have.

TRAUMATIC STRESS AND CHILDREN

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NEWS REPORTS, official statistics, and research data indicate that relatively large numbers of inner-city children are exposed to violence on a regular basis. Furthermore, the exposure occurs in such a manner that it and its pernicious effects are often subtle and underestimated. While child victims of violence elicit considerable concern, and rightfully so, many more children witness extreme acts of violence, often perpetrated against family and friends. This direct observation of the violent assault of another person, referred to as "co-victimization" by Shakoor and Chalmers [1], is frequently accompanied by immersion in a violent milieu in which the child is in constant danger if, in fact, never actually victimized. Such exposure to violence has serious consequences for the child's mental health, often resulting in post-traumatic stress disorder (PTSD) symptoms similar to those resulting from direct victimization. In the absence of understanding the symptoms and the circumstances under which they occur, the child's dysfunctional behavior, which often includes poor achievement and acting out, maybe misinterpreted, inaccurately diagnosed, and inappropriately treated.

This paper discusses black youths' exposure to violence, the traumatic effects of such exposure, and some approaches to treating the effects as well as preventing the initial exposure. We conclude with research questions that need to be addressed in order to better serve these at-risk youth.

Children's exposure to violence

Although very little data exist on the actual extent of children's witnessing of violence, there is evidence that such exposure is considerable, particularly for children in the inner city. For example, in Los Angeles county in 1982, 10 to 20 percent of the 2,000 homicides were witnessed by a dependent youngster. [2] An examination of one-half of the homicide cases in Detroit in 1985 found that 17 percent were witnessed by a total of 136 youths age 18 or younger. [3] In about one-quarter of these cases, a family member was the victim. In an informal sample of 10 mothers in a Chicago public housing development, Dubrow and Garbarino [4] found that "virtually all" of the children had had a first-hand encounter with a shooting by age five, and the majority of those incidents appeared to have involved witnessing someone get shot.

Our research at the Community Mental Health Council, a comprehensive community mental health center on Chicago's south side, provides further evidence of the extent of the exposure and the types of incidents that are witnessed. Our first study surveyed 536 African-American school children in grades two, four, six, and eight. [5] A 32-item questionnaire asked about background, involvement in fights and arguments, and exposure to violence. It also asked whether the child had seen someone shot or stabbed. While the study contained many of the flaws that have characterized similar studies [6] elsewhere, most notably that the measures were self-reports, it revealed that a disturbing number of these children had in fact witnessed violence in their environment. Approximately one-quarter (26 percent) of these children reported that they had seen a person get shot and 29 percent indicated that they had seen an actual stabbing.

A subsequent screening of over 1,000 middle and high school students found very similar results. [1, 7] Among these students from relatively high crime areas on the south side of Chicago, 35 percent had witnessed a stabbing, 39 percent had seen a shooting, and almost one-quarter (24 percent) had seen someone get killed. In the majority of cases, the students reported that they knew the victims, and about half (47 percent) of the victims were known as friends, family members, classmates, or neighbors. In addition, 46 percent of the sample reported that they had personally been the victim of at least one of eight violent crimes, ranging from having a weapon pulled on them to being robbed, raped, shot, or stabbed.

Statistics on homicide and data on the epidemiology of violence in the black community also suggest that a considerable number of black children will be exposed to life-threatening violence. After an extended period of decline, the homicide rate among African-Americans has increased dramatically and consistently since 1985. [8, 9] Currently, the homicide rate among black males is seven times that of white males; homicide is the leading cause of death for black men and women age 15 to 34. [10] showing a 39 percent increase for black males since 1984. [11] These statistics will probably worsen. Estimates based on the number of homicides in the first six months of 1990 suggest that 1990 killings will exceed those of the previous year by 2,000 victims, making it, in the words of one national politician, the "bloodiest year in American history." [12] Even more disturbing, the factors fueling this killing frenzy - joblessness, family disruption, drug use - show no sign of abating.

Blacks are more likely than whites or Hispanics to be killed by a friend or acquaintance in the home with a handgun during a verbal argument. [13] This kind of killing - in a residence, unpremeditated, as a result of an emotional outburst - seems quite likely to be observed by family members, including children. In addition, the increase in gang/drug killings, which in many cities is accounting for the dramatic increase in homicides among young black males, points to greater exposure for children as witnesses and increases the chances that the victim will be one of their peers. In Chicago in 1989, one of every five homicide victims was

between the ages of 11 and 20, an increase of 22 percent over the previous year and one which police attributed to gangs and drugs. [14]

What is not captured in the statistics on homicide is the public, random nature of violence that pervades many inner-city communities, turning them into veritable war zones where citizens live under chronic threat. A recent *Wall Street Journal* article [15] chronicled the day-to-day violence in an inner-city housing project, most of it gang shoot-outs out of doors, with bystanders caught in the middle and literally running for their lives:

> Once again the sound of gunfire fills the air. They catch glimpses through the windows of young gunmen waving their pistols about. One youth totes a submachine gun. In an apartment upstairs, other gang members blast away at rivals in a building across the street. In the middle of the battle, the elementary school across the street lets out.

In the previously mentioned Dubrow and Garbarino study at a Chicago housing development [4], all 10 of the mothers, when asked to name the most serious danger confronting them, listed shootings. The most serious concern of a matched sample residing out of the city was kidnapping.

While most killings still occur indoors as a result of arguments between family and acquaintances, a distressing amount of unpredictable, life-threatening violence occurs in public places, exposing innocent bystanders. And although statistics indicate that the involvement of bystanders is the exception rather than the rule, bystanders are killed in the crossfire and occasionally inside their homes, as gang/drug wars are waged with increasingly powerful weapons that penetrate doors and walls.

Effects of exposure to violence

Research and clinical experience indicate that children who witness and are otherwise exposed to violence are deeply affected by the events, often showing symptoms of post-traumatic stress disorder. Pynoos' work with children who witnessed the murder of a parent and who were exposed to community violence [16] found that the youngsters displayed the following classic PTSD symptoms: reexperiencing the event in play, dreams, or intrusive images and sounds associated with the event; psychic numbing characterized by subdued behavior and inactivity; constricted affect and diminished interest in activities; sleep disorders, avoidance behaviors, and startle reactions. In addition, the children are frequently plagued by fears of recurrence of the violence; guilt over their behavior during the incident; a pessimistic future orientation; and difficulty forming interpersonal relationships. These latter symptoms can manifest in a sense of futurelessness [17] characterized by children's belief that they will not reach adulthood, and difficulty with close interpersonal relationships as they hesitate to establish bonds that they fear will be broken.

Violence-exposed children may have lowered self-esteem [18] and show a decline in cognitive performance and school achievement. These school difficulties, which are so easily misdiagnosed in inner-city children, may be a

result of the child being distracted by the intrusion of thoughts related to the trauma, making it impossible to concentrate on school material; the development of a cognitive style of deliberate memory lapses to help control these spontaneous reminders of the event; or simple fatigue from sleepless nights. [16] In a more psychoanalytical oriented explanation, Gardner [19] argues that exposure to chronic violence inhibits development of precision learning by leading to an avoidance of the aggressive-assertive behavior necessary for problem solving. Indeed, a frequently noted characteristic of children exposed to violence is a passive-aggressiveness—difficulty controlling aggressive impulses [20] but also emotional withdrawal and passivity.

While children may experience any or all of the PTSD symptoms, the specific manifestations of PTSD are a function of the age and developmental level of the child, and the event itself may impact on the developmental process. [2, 16, 21] Preschool children are more likely to display passive reactions and regressive symptoms such as enuresis (bed wetting), decreased verbalizations, and clinging behavior. In comparison, school-age children tend to be more aggressive and more inhibited, and have somatic complaints (such as stomach-aches) and cognitive distortions and deficits that show up as learning difficulties. Adolescent trauma reactions more closely resemble those adults, and as Pynoos and Eth note [2], are characterized by a "premature entrance into adulthood or a premature close on identity formation." Children of this age who have witnessed or been exposed to violence may engage in acting out and self-destructive behaviors such as substance abuse, delinquent behavior, promiscuity, life-threatening reenactments, and other aggressive acts. [2, 16, 20] The aggression and other destructive behaviors are viewed as an attempt to protect the self from anxiety and to prevent its fragmentation. [2]

Exposure to violence can be particularly problematic when the violence results in the death of a family member or close friend, and personal reactions to trauma clash with grief and mourning. [16, 21] The trauma/grief connection is most severe when the death is sudden or grisly. [22] So where as reminiscing about the deceased is necessary for grief resolution, the survivors may avoid memories because they trigger anxiety surrounding the event. The grieving may also be complicated or impeded by the child's intense rage and desire to punish the perpetrator. [21]

An issue of considerable concern to those working with inner-city children is the impact of chronic exposure to violence. Whereas seeing even one act of life-threatening violence is a traumatic event that requires intervention, many inner-city children have experienced multiple losses to traumatic violence and are themselves exposed to shootings and other mayhem on a regular basis. After listening to her young classmates in a "grief class" describe the deaths of close family members, one of whom had lost seven relatives, an eight-year-old remarked that "just" three folks in her family had died violently. [23] Lafayette, the 12-year-old subject of Kotlowitz's description of life in the Chicago housing projects, had personally witnessed three shootings during his lifetime and lost two acquaintances during the three months that the reporter observed him and

his family. In two case studies of black adolescent males referred for behavioral problems, a Chicago social worker [20] found that one youth had experienced the violent death of an uncle, cousin, and brother, and the second youngster had lost two aunts, an uncle, and his mother.

Whereas one may argue that repeated exposure will produce an adaptation to the violence, the evidence more strongly suggests an overload. Pynoos suggests that the "effects of each episode can be additive and seriously deplete the child's inner resources." [16] Lenore Terr, a psychiatrist who treated child victims of the Chowchilla kidnappings, [24] noted that while brief traumas have only limited effects on the individual, repeated trauma may lead to anger, despair, and severe psychic numbing resulting in major personality changes. [17]

Violence that touches children has consequences far beyond the individual victim, eventually having an impact on the quality of life in the black community. In addition to the lost resources of a fully functioning member with a healthy mind and body, exposure to violence creates an individual more likely to engage in future violence and other antisocial acts. The PTSD symptoms include such behavior. In addition, social learning theory predicts that observing violence may lead to an acquisition of that behavior, depending on the child's identification with the perpetrator and the outcome of the violence. [25] At the least, violence may be perceived as an appropriate response in much too broad a range of situations. In addition, many children in a violent milieu may resort to violence in order to avoid victimization or in retaliation for prior victimization of self or close others. Eventually, children who are exposed to a steady diet of violence will themselves feed into the cycle of violence, victimization, and fear that is paralyzing many inner-city neighborhoods.

Treatment options

Growing awareness of the extent of violence among black youth has led to the development of numerous approaches and programs. Because most of the concern surrounds homicide and violent victimization, much of the activity has been directed at violence prevention, thus indirectly affecting violence exposure. While anything that reduces violence in the black community (e.g., control of firearms, strengthening black families and improving parenting skills, reducing head injury [9]) will necessarily reduce youth involvement in violence, there are a number of programs designed specifically for the young. Currently, a number of school-based programs [26, 27] teach conflict resolution skills in an attempt to alter behaviors and norms that contribute to the violent encounters in which the role of victim and perpetrator is almost decided by chance. A variety of community-based programs are aimed at reducing youth involvement in gangs, drugs, and violence by enhancing self-esteem, improving conflict resolution skills, and encouraging or providing education and job training. [28]

While programs to prevent violence are much more prevalent, some programs address the impact of witnessing. In an elementary school in South-Central Los Angeles, children who have experienced losses through violence

attend a “grief class” in which they explore their feelings about life and death and their loss. [23] Johnnie Dyson, a school social worker on the south side of Chicago who began traditional group and individual therapy sessions with her “behavioral problem” referrals after finding that all of them had experienced the violent death of at least one close family member, reported a marked improvement in the students’ emotional health at the end of the semester. [20]

Detroit’s Family Bereavement Center provides treatment to child witnesses of homicide based on a model developed by Robert Pynoos and associates at the Prevention Intervention Program in Trauma, Violence, and Sudden Bereavement in Childhood at UCLA. [16, 21, 29] The Pynoos model is one of the most developed approaches to the treatment of childhood trauma. It is based on the principle that the consequences of a violent event - the endangerment of a child’s life, witnessing of injury or death, loss of significant other, worry about the safety of another, or reminders of some previous traumatic event - will determine the child’s symptoms (PTSD, grief, separation anxiety, renewal of old symptoms) and the treatment. An initial assessment examines factors that mediate the impact of the trauma, e.g., degree of exposure, relationship to victim, presence of other stressors. The intervention can occur at the individual, family, classroom, group, or community level, with intervention at each level addressing a particular goal. Workers in this area agree that a key to successful treatment is intervention soon after the trauma occurs even if the child is not showing obvious signs of post-traumatic stress: symptoms will probably emerge eventually, and delayed intervention carries the risk that so-called maladaptive trauma resolution will have taken place in response to the overwhelming anxiety. [17, 21]

At issue in the treatment of children exposed to violence is the identification of these silent victims. While sensational events (such as the 1988 shooting of six children in a Winnetka, Illinois, classroom [30] and the 1989 slaying of five children on a Compton, California, playground [31]) create enormous concern for the children exposed to the violence, children in inner cities where chronic violence occurs often do not receive such attention. [32] Many observers may assume that violence is such a part of these children’s lives that they are no longer affected by murder and mayhem, a position which, as we noted previously, is not accurate. Inner-city school systems and communities may simply have fewer resources to commit to the problem. Less than a year before the Winnetka incident, a high school student in Chicago was shot in the hallway as classes were changing. Crisis workers visited for one day. No crisis workers came to the south side elementary school when a 15-year-old student was killed on the street, even though teachers and students were quite shaken by the incident . [32]

Witnesses of family and community violence can be expected to receive even less attention. In most instances, these crimes are handled by law enforcement professionals whose concern is the event and the actual victims, with the presence of others being of interest only if they have a bearing on the case. When violence occurs in a public or quasi-public place, professionals may not even be aware of the number of witnesses. That a violent event is witnessed

by so many contributes to the perception that the trauma is shared and thus has less impact on the individual than if that person alone had been present when the incident occurred.

An additional complicating factor in the treatment of inner-city victims of exposure to violence is that many PTSD symptoms are considered endemic to the inner city. In many such neighborhoods, poor school achievement, aggression, and the self-destructive behaviors of substance abuse, delinquent behavior, and promiscuity occur with such frequency and in close linkage with other destabilizing factors (family disruption, poverty, poor schools) that the contribution of violence exposure is overlooked. In such instances, the diagnosis of the child's difficulties are inadequate and treatment may be inappropriate or misdirected.

One approach to identifying violence-traumatized children who need mental health services is to screen at-risk children for their exposure to violence. [1, 33, 34] Schools in high-crime areas would be appropriate places to conduct such a routine screening, allowing one to reach a large number of children. In addition, physicians and mental health workers are encouraged to collect this information as part of their patients' medical history and to provide the appropriate referrals or treatment. Our research [34], as well as that of others with psychiatric patients [35], suggests that individuals do not volunteer such information regarding these violent incidents, but will respond honestly if asked directly. In screening for exposure, one needs to examine not only witnessing and identity of the victims but also victimization and perpetration. These three factors seem to be related, with exposure and victimization predicting to perpetration. [7] Any of the three experiences suggests a need for intervention.

The most direct way to identify children who have witnessed violence is to gather this information from police homicide records. The advantage of this approach is that it targets the most severely affected children - those physically close enough to a killing to be listed as a witness. In many instances, the victim will be related to the child witness. This approach will also yield a smaller pool of children in need of services, which for many agencies will be more manageable given their often limited resources.

Regardless of how these youthful co-victims are identified, steps must be taken to make sure that appropriate and adequate services are available for them. Currently, few direct service organizations provide victims' services (and even fewer provide these services for children; most are geared toward adult female victims of sexual assault). Moreover, few professionals are trained in this area. Establishing treatment centers can satisfy both of these needs by providing service and training opportunities for professionals via workshops and internships. Such training centers should grow out of a collaborative effort between institutions (police, schools, child welfare agencies) that can identify co-victims; academics who can provide expertise in grantsmanship, research, and treatment approaches; and service agencies from which the professionals are drawn and which can provide a site for the programs.

Research needs

While there has been some encouraging progress regarding the identification and treatment of child witnesses to violence, there is much more to be learned about and done for these silent victims. There is a desperate need for more research on the circumstances and extent of the exposure and on factors that mediate the impact of the exposure. There is a need to understand the prevalence of children's exposure to violence against family, friends, and strangers. More needs to be known about the impact of witnessing the victimization of close others as opposed to strangers. Very little is known about the impact of the characteristics of the perpetrator of the witnessed event. That is, we know little about how the impact on witnesses differs depending on whether they know or do not know the perpetrator; how the identity of the perpetrator and victim may interact (the impact of a family member killing another family member versus killing a stranger); and how the circumstances surrounding the violence affect the extent or severity of traumatic reaction. Do children respond differently to expressive violence which is marked by anger and impulsivity, and instrumental violence that is more calculated toward achieving some specific goal? Do they respond differently if the violence is perceived as provoked and justified?

Clearly, more research needs to be conducted on the impact of multiple, chronic exposure to violence and the interaction of violence exposure and other stressors in the lives of poor inner-city children. What affect will the recent incidents of bystanders being killed by stray bullets *inside* their apartments and houses have on the emotional health of children who can no longer count on their families and the four walls of their homes to shield them from the violence in the streets?

Clearly, all children who are exposed to violence do not sustain psychological damage. Who are these exceptions? What buffers them against the deleterious effects of violence and victimization? Age and developmental level appear to be important variables; one report on psychiatric patients found that those experiencing their initial trauma before age 10 were about three times more likely than patients experiencing it as teens to develop post-traumatic symptoms. [36] What about family characteristics and relationships and the child's personal values? Does the extended family buffer the child from or facilitate the child's working through the trauma by providing additional adult nurturing? Are middle-class children, with fewer stresses from poverty and with a greater sense of control over their environment [38], better able to cope with violence than are children from poorer backgrounds? Does a strong ethnic identity or belief in religious values buffer African-American children against the impact of victimization or co-victimization, as it apparently does for substance abuse? [36] Relatedly, does a rural Southern background, with its attendant sense of family cohesion, traditionalism, and conservative attitudes [39], buffer children from the impact of witnessing violence?

There is a need for continued research on the symptoms that occur as a result of trauma. Given the relationship between school phobia and anxiety

disorders, are children with a history of school phobia at greater risk for PTSD from exposure to violence via victimization or witnessing? Does witnessing or being a victim of violence in childhood or adolescence increase the risk of attempted or successful suicide as the individual matures without having resolved the anxiety associated with earlier trauma?

Gender differences in responses to violence are a fascinating area of study. In a study [34] of victimization of black psychiatric patients, we found that while young patients (age 17 and under) did not differ significantly in their degree of personal victimization, girls were five times more likely to report knowing of close others having been victimized. Replication and comparison with a medically ill sample found comparable results. [33] In the latter study, both the mentally ill and medically ill male youngsters were less likely than girls in these groups to report that a relative or acquaintance had been murdered. These findings raise interesting questions about denial and other responses of young black males to threatening events, and may have implications for their risk taking, occasionally nihilistic, behavior.

There is much to be done regarding the treatment of and research on children who have been exposed to violence. Physicians, mental health workers, law enforcement officers, and educators should be aware of the circumstances and symptoms of PTSD and of the necessity for quick referrals and intervention. Data need to be collected uniformly so that researchers can make cross-study comparisons. Collaboration among front-line service organizations, universities, and public institutions that can identify co-victims is essential to creating programs that effectively address this problem.

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Post-commentary

Dr. Jenkins and I have continued to refine our efforts in this area. In 1992, Dr. Jenkins designed a study on 203 African-American students from a public high school on Chicago's Southside. After refining some National Institute of Mental Health Child and Adolescent Disorders Research Branch survey instruments, we replicated the study Dr. Richters and his group did a few years prior. Nearly two-thirds of the adolescents surveyed reported they had seen a shooting and 45% reported they had seen someone killed. This research was published in Anxiety Disorders in African-Americans (New York: Springer publications, 1994) in a chapter entitled "Post-traumatic Stress Disorder and Violence Among Inner City High School Students." This research also formed the basis for another chapter entitled "Exposure and Response to Community Violence among Children and Adolescents" edited by Joy Osofsky and published

in Children in a Violent Society (New York: Guilford Publications, 1997, p. 9 - 31). This was the study I alluded to in the introduction on "Stress-Related Disorders in African-American Children" that aided in our realizing that youth could also develop other types of stress-related disorders in response to trauma (see Section One). Our work has recently come to the attention of the American Psychoanalytic Association providing me with the opportunity to present "Impact of Violence on African-American Youth" at the Public Forum: Creation of a Self: Color and Trauma in the Life of a Child of the American Psychoanalytic Association in New York City December 19, 1997. My hopes are that this association will realize the practical value of Freud's empirical work on traumatic stress and begin to apply some psychoanalytic principles toward working with children exposed to traumatic stress.

A more recent development in this line of inquiry deserves special mention. The Anxiety Prevention and Treatment Research Center in the Department of Psychiatry and Behavioral Sciences at the Medical University of South Carolina in Charleston has been advancing our understanding of exposure to violence in children. Drs. Michelle R. Cooley, Samuel M. Turner, and Deborah C. Beidel have written about the difference in reported emotional distress symptoms between high-exposure and low-exposure community violence groups. These authors point out that the "literature on acute (non-recurring) violent incidents suggest that children exposed to community violence manifest psychological disorders, fear and anxiety, depression, helplessness and hopelessness, emotional withdrawal, and somatic symptoms (features associated with internalizing disorders)." However, when children are exposed to high levels of community violence (which was the case in the author's study and our study on "Post-traumatic Stress Disorder and Violence Among Inner City High School Students"), "the focus should be on a broad array of areas including measures of academic, interpersonal, and social adjustment." Simply put: exposure to one event of traumatic violence may cause post traumatic stress disorder while exposure to multiple events of traumatic violence may cause academic, interpersonal or behavioral problems.

As a result of my work I have participated in the Strategy Session on Children, Violence, and Responsibility with President Clinton and Vice President Gore at the White House, May 10, 1999 in Washington, D.C. This was a very interesting meeting as there were only about thirty “experts” in the room with the first and second families. After children who were present got a chance to say something, Mrs. Hillary Clinton introduced Dr. James Garbarino, Dr. Robert Pynoos, and myself as experts on children who where exposed to violence. Garbarino went first and did a great job of emphasizing that, although the recent mass murder school shootings that were taking place in white suburban schools were tragic, we needed to be mindful that the traumatic stress of community violence had been occurring in inner-city schools for sometime earlier. Next, I got an opportunity to talk about the fact that mass murder/suicide was essentially a white male phenomena and was similar to what Dr. Chester Pierce called a

"white male entitlement dysfunction". I also got an opportunity to talk about my work within the Chicago Public Schools on violence prevention. This meeting occurred the same day as the Reno/Shalala Violence Against Women meeting, so, as soon as I left the White House I bummed a ride to the Reno/Shalala meeting with Secretary Shalala. We had a very interesting talk on the way to the meeting, and I was amazed at how White House insiders get to travel around Washington, D.C. I was also invited back to the White House Conference on Mental Health with President Clinton and Vice President Gore, June 7, 1999. Another great personal outcome of being in the Strategy Session on Children, Violence, and Responsibility was that I got my picture taken with President Clinton. The White House was gracious enough to send me a copy, so, now I have a photo to match my father's picture with President Kennedy and my grandfather's picture with President Truman (included in this photo are Mrs. Mary McLeod Bethune, National Council of Negro Women; Dr. Benjamin Mays, President of Morehouse College; A. Phillip Randolph, President of the Brotherhood of Sleeping Car Porters; Dowdal Davis, President National Negro Publishers; Dr. Charles S. Johnson, President of Fisk University; Channing Tobias, Phelps-Stokes Fund; J. Robert Booker, President National Bar Association; Lester Granger, Executive Director National Urban League, and Walter White, Executive Director NAACP).

Right after the Columbine school shootings I made the observation that it was mainly European-American males who were responsible for anger/revenge mass murder/suicide, serial killings, presidential assassination attempts, and murder sprees. Needless to say, when I would compare this phenomena to "white male entitlement dysfunction" several European-American male reporters accused me of "white male bashing" and got quite hostile. The European-American female reporters seems to be more understanding. They explained to me that frequently they had been victims of "white male entitlement dysfunction," and they could related to what I was talking about. I remember outlining those dynamics to a Newsweek reporter, but, when the article came out, my observations had been left out. A couple of weeks later I was at the 1999 American Psychiatric Association meeting in Washington, D.C. During a think-tank on juvenile violence, I remarked to several colleagues how I found it interesting that most of the reporters had missed the suicide component to all of the recent white mass murders. About two weeks later Time came out with a story citing a white colleague, who was in the room with me during the think-tank, who was underscoring the suicide/depression component of all the recent mass murders. I guess the moral of the story is that if an African-American psychiatrist is critical of European-Americans it is not acceptable, but if a European-American psychiatrist says the same thing about European-American, it is okay. I guess the reverse is also true, but it would seem that truth would be truth regardless of the politics of who says it.