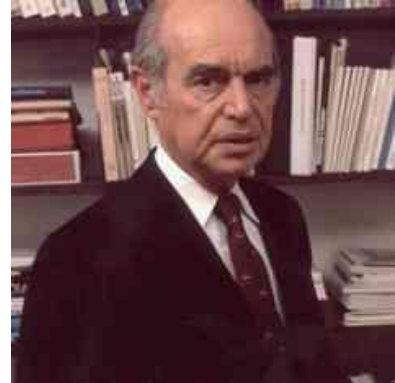


Julius Benjamin Richmond

- Born 09/26/1916 in Chicago, IL; Died 07/27/2008 in Chestnut Hill, MA
- M.D. (1939), M.S. (1939), and B.S (1937) - All from the University of Illinois (M.D. from College of Medicine)



Major Employment:

- University of Illinois - 1946-1953, Pediatrics
- Syracuse University - 1953-1971, Medical School
- State University of New York - 1953-1971, Medical School/Pediatrics
- Harvard Medical School - 1971-1988, Child Psychiatry and Human Development

Major Areas of Work:

- Pediatrics, Child Welfare Policy, Co-Founder of Head Start Program

SRCD Affiliation:

- President (1967-1969)

SRCD ORAL HISTORY INTERVIEW

Julius Richmond

Interviewed by Ed Tronick
At the Children's Hospital, Boston, MA
September 9, 1998

Tronick: One of the areas we'd like to explore is your general intellectual history, things like your family background along with childhood and adolescent experiences that may have been of interest; educational and occupational characteristics of your parents, where you were born and grew-up, what your schooling was like, early work experiences, military experiences? That sounds pretty complete as a question.

Richmond: Well, I was born and grew up in Chicago and the surrounding area. I was born around the time of World War I in 1916. My parents were emigrants from Eastern Europe, from Russia, and fled as many Eastern European Jews did during that time for a better life in this country; I was born shortly after they arrived in this country. They had a very important influence on both my personal and intellectual development in that they placed great value on education and learning. That's interesting in retrospect because neither of my parents were, in a formal sense, educated, but they were literate and self-educated; my father in particular was quite intellectual. And this was combined with a social conscience orientation that put them in the category of what I would now think of as Social Democrats. They weren't radical in any extreme sense, but they were committed to social justice, and I think that commitment certainly rubbed off on me. I think my entire career has been characterized by a kind of commitment to social conscience and activism, a commitment to trying to help those who are less fortunate. So there was that kind of early background with the kind of expectation that their children (I had a brother who was four years older) would go to school, pursue higher education, and do well; so the expectations were high. I think, whether in response or whatever, for my entire academic career I

was always at the top of my class. So my academic record is essentially fairly uniform in terms of the highest level of performance.

The family was disrupted during my tenth year when my mother developed a brain tumor to which she succumbed in that era. Brain surgery was almost inevitably fatal, and she did have to have a neuro-surgical procedure. She probably died from what was complicating Meningitis because in those days there were no antibacterial agents that could be used. So at age ten I went through that rather profound loss, but my father then had to make some judgment about managing the care of my brother and I. My brother was sufficiently older so that he could stay with my father in the city, and my father had identified a small school called the Allendale School, northwest of Chicago, which was essentially a farm school. It's appropriate to say a few words about that school because it was quite unique in many respects; it had been founded in 1897 by a man who had no formal training in social work, but who was deeply committed to trying to help children in an era when there were many dependent children because mortality rates among young adults were still relatively high. He decided that something needed to be done for these youngsters, and he found this farm in a rural setting on a little lake called Cedar Lake. He appealed to philanthropists in Chicago and some of the affluent families in Chicago like the Armour's and the Switt's, and similar names of that era were among the philanthropists who provided him with support.

The school, by the time I arrived there in 1927, had about a hundred boys. Part of the ethos of the school was work so that alone we had our academic program that was rather conventional for a residential school setting, but we each also had to engage in some kind of work. Indeed, the school was largely maintained by the work of the youngsters so that there was a very small child care staff and the teaching staff. But virtually all of the work, including the work on the farm, was done by the youngsters with supervision from adults. The work experience was extremely valuable in sort of preparing one for a life of work. What complemented my formal education there was an opportunity to work on the farm.

The man who ran the farm was a man by the name of William Duncan, and he was a Scotch Canadian who was very interested in the raising of purebred sheep as a hobby. I became affiliated with him in caring for the sheep, and that essentially was the nature of the work. It now gave me, you know, a sense of responsibility, but I actually learned a lot about animal husbandry and farming in the process.

To get ahead of the game later on when I wanted to study separating experiences, it was my knowledge of how the attachment process took place in sheep and goats that enabled me to set up a whole set of experiments. We saw their way into the literature about the bonding process and in attachment and in adoption processes in sheep and goats so that in retrospect I always felt that those experiences were extremely valuable. It also gave me a great sense of how one comes to appreciate individual differences because with his purebred flock Mr. Duncan's ambition was to show them at the various fairs. I quickly learned what the best attributes of these animals were, what the judges would expect to see, and how they would be evaluated so that, I think, in medicine later it helped me understand the important principles of physical and physiological systems. As I later, for a variety of professional reasons, became interested in individual differences, it seems to me that my early training in looking at how you discriminate among individual animals and livestock judging became very, very useful.

I went on from that school, since it was a junior high school. However, I returned every summer to work with Mr. Duncan in sort of taking the sheep to various fairs and helping him in exhibiting them. But since the school didn't have a high school associated with it, I went to high school in Chicago. This required quite a process of adaptation because this school, of course, had very small classes with only a hundred youngsters. My graduating class had thirteen in it, but then I went to Chicago to a huge metropolitan public high school system. Whether it was true or not at the time, I enrolled in the Carl Schurz High School in Chicago, it was said to have the largest attendance of any high school in the world. Nonetheless, there were several thousand students there, and I quickly had to make an adaptation to the setting where you go from being a very conspicuous individual to one of anonymity. I

must say I used my intellectual processes to extract the most I could out of what was a fairly anonymous situation.

I think what reinforced my continuing desire to achieve under those circumstances was the role of individual teachers and that's very striking, incidentally. And I'd add, parenthetically, that these were the Depression years and schools did the best they could, but they clearly had teachers with relatively large classes. At the high school level the teachers were specialized so that they could have five or six separate classes of youngsters. In spite of that, periodically I would get very significant reinforcement from some of these teachers about the fact that I was doing excellent work. Interestingly enough, I was surprised at the time because I was aware of the fact that they would have five or six sections of students and yet single out individual student performance. There were certain teachers, particularly one of American history, who I suppose in better times would have been teaching at the university level. He was a person of remarkable intellect, and he taught our course pretty much like a college course; we had a reading list and he developed a library in the classroom, which students could access and read about. That was one of my great awakenings to how different people viewed historical events because he made a point of sort of indicating how one viewed history critically, and that had a very profound impact on me. The way in which he conducted the class was really good preparation for the university because what happened was at the end of various sections that we were assigned to study, a student then would be assigned to make presentations to the class. It was essentially kind of a seminar in which he was the one who provided the critique, so that was a very good kind of orientation.

Now I mentioned earlier that my father certainly had the expectation that one would go to college; it never occurred to me that one would not go to college. The interesting thing in retrospect, as I have been a faculty member of various universities, was how little counseling I had in that large school system. Nobody ever asked whether you were going to college. Nobody ever asked whether you needed any letters of recommendation or what college would be best for you. You were pretty much on your own and without any guidance. Since it was the Depression, the State University was the least expensive, and so that's where I enrolled, at the University of Illinois in Urbana. At that time there was no liberal arts program at the University of Illinois in Chicago. Now, of course, there's a very large campus. Although the medical school was in Chicago, the rest of the University was in Urbana.

Tronick: So it seems like this early period had a number of very specific individuals who played key roles?

Richmond: Right. Incidentally, I'm glad you mentioned that because I didn't do justice to the setting of this little private school, Allendale. I mentioned the farmer that I'd worked with; he was a kind of charismatic, swashbuckling character. He had a considerable influence on me in terms of his energy and his imagination and his risk-taking in terms of, you know, trying to raise a prize-winning flock with relatively few resources, which incidentally he succeeded in doing because a flock of sheep that he had, the breed was the Oxford-Down breed, were regarded as the best in the country and probably in the world. The founding Director of the school that I mentioned to you, a most remarkable character, had been a Princeton graduate. He was Princeton class of '83, that's 1883, so when I came along in 1927 you can imagine that he was fairly elderly. The interesting thing is that I knew that he was Princeton class of '83 because every spring he would disappear for about a week and come back with a huge orange and black mug saying, "Class of '83," so I learned something about Princeton from listening to him. He had this kind of Brahmin aura about him, but yet in terms of dealing with youngsters he was very earthy and all; But the ivy-league aura that was transplanted to this junior high school in this very isolated area was a very interesting thing that he recreated. I say this in retrospect because the intramural athletic teams that competed were Yale, Princeton, and Harvard. And then later on, because I guess he wanted to give it some local flavor, he reluctantly added the University of Chicago. So I had all the values of Princeton, Harvard, Yale and Chicago, so those became the competing teams and there was a lot of flavor.

Incidentally, I should have mentioned that the living situation he developed there was one of a cottage arrangement. There were 14 to 16 youngsters in each cottage. Each cottage had a housemother who

lived in the cottage, and so it was a decentralized thing, but there was a central kitchen, and again, the boys did virtually all of the work under the supervision of the cook in the kitchen, and the food was transported, but you had sub-kitchens, so there was a bit of a family kind of arrangement in that kind of setting. This Director of the school, we called him Capt. Bradley, he wasn't captain of anything; it was just a nickname that he had acquired. He supervised the school; he picked the school principal, he played the organ and he conducted chapel services every morning, while technically the school was non-denominational. In fact, it was really an Episcopal school because he came out of Episcopal background. The way in which the services were conducted was Episcopalian. When I can walk into an Episcopal church now, I still feel very much at home because of the aura there.

I think I should also comment on the fact that the transition from a kind of Jewish, social Democratic background to this very Protestant ethical background was really quite an abrupt transition, and again I had to make some rapid adaptation. I was the only Jewish youngster at this school and nobody paid any attention to that; it was as though there was nothing like a Jew, so one couldn't make an issue of it. I guess one could have made an issue of it, but the only thing that could result is you'd leave because there weren't any options, and so I sort of adapted. It was very interesting that there was a library in the school building, and so I sort of tried to educate myself by literally using the encyclopedia to learn more about denominations, and also that I knew a little bit more about what the differences were. So at these various stages in my career I had these kinds of abrupt transitions.

Now going back to the college situation, again I was on a large campus although classes were relatively smaller. I had an interest in medicine I guess because it was one of the learned professions and I had intellectual interests. It also offered an opportunity to be of service to people, which was a social conscience kind of outlet. I enrolled with the idea you didn't have to declare a major, but with the idea that I would take the pre-medical requirements. The ambivalence about that that entered in, was that I had this background in animal husbandry, and the whole notion of doing something in the College of Agriculture came up, and I actually had a little pressure to do that because there were faculty at the College of Agriculture that had to do with sheep husbandry, whom I had gotten to know by virtue of going to the fairs. Usually faculty members served as judges because they didn't compete with their animals, even though they bred the animals and there was only one exhibition that they would compete in, that is the International Livestock Exhibition in Chicago, otherwise they wouldn't. Well, when they learned that I was coming to the University they just assumed I was going to enroll in the Agriculture School. There were all kinds of goodies, job opportunities and all, but I kind of stood my ground. And while I'm eighteen, cordial relationships developed and I offered to help them in any way they needed me with the showing of their animals, I sort of figured that I didn't want to quite make a career of it, but I wasn't entirely certain.

The other thing that I had to think about at that time was that one could enter medical school with only two years of collegiate education and get a bachelor's degree at the end of the first two years. Medical school, whether to do that or to go on for four years, and by that point I was becoming quite aware of financial burdens. While my father, incidentally, never complained, and I thought that I probably ought to do the two years and go on to medical school, and again there was no counsel, there didn't seem to be anybody to talk to about this, so--

Tronick: That alone speaks to the differences.

Richmond: --so I did, however, make a calculation. I figured that since after the first semester my grades were again all A's, so I thought, well, if your grades were good you could take extra courses, and I quickly did a calculation that in the two years if I did extra work each semester, if I carried extra courses each semester, I could get about three years of credit in two, and that's sort of how I ended up. And the matter of going to medical school, also I had no counseling, nobody ever suggested that there were any other options, because I knew that I would get into the medical school in the State university, and so I just went ahead and enrolled and went to medical school at Chicago, and at that point lived with my father.

I should back up. I didn't say much about my father other than his intellectual interests. When he came to this country he had been apprenticed in Europe as a cap maker, and so he got a job working in a clothing factory that made caps. As a matter of fact, they made uniforms for police and military and whatever, and the caps he made, and apparently very skilled, because he became the Foreman at a very young age of that kind enterprise. So he had steady employment during the Depression, which is how he was able to afford to have us go to school, but he wasn't a high earner, so for his entire career he was actually working for a salary.

I went on to medical school, and again at that time that medical school had the largest classes of any medical school in the country, and so again there wasn't a great deal of kind of individual attention. The medical education, however, was quite good in terms of that period. This was during the 30's. I entered college in '33, and entered medical school in '35, and graduated in '39, so it was during the Depression years. And the fact that my father was able to provide the support was, of course, a very comfortable situation for me.

Tronick: One thing that strikes me, that sounds so very different than I think contemporary experiences of children, is by the time almost that you're in school, certainly by the time you're in college here, you have both a sense of responsibility in terms of making decisions about your own direction, but you also, I think, had something which may even be more unique, which is a lot of the experience that you had at the school, probably from your father, was for you to learn that you would work and the value of work. So it was okay that you were at a farm and maybe preparing meals, but it wasn't just the functional aspect of it, I imagine, but it was to teach you that this is what you would do to value that. It sounds as if they really--

Richmond: Well, I think that's a good comment and observation, but I think that the issue of work at this little school, Allendale, was important because see I was atypical there, the families that those youngsters came from were generally working-class families, and very few of them -- the Director of the school, I think, recognized that very few of them would go on to higher education, and so I think that the work ethic for them was going to be extremely important. I guess if it hadn't been for my family background and using my own kind of both analysis and intellectual aspirations, I kept resisting, you see, the notion that you only went to work because if I had sort of let myself become homogenized with the others, I think I would have probably just thought of getting a job to get through. I think that's where the paternal, the family influence, maternal and paternal, you see, was so important.

Just again to interject, my mother's influence was quite important because she sort of, I think, intuitively had some notion that I was special. There were just all kinds of little things that she would say, and her expectations that I was going to go on and do some things. And you have to remember she died when I was ten, so all of this had to have occurred and I had to have absorbed this. In reading about Freud and how his mother, you know, because he had the call over his head when he was born that, you know, he was going to be special. I sort of empathize with that because somehow or other I had the feeling that my mother thought--and I always sort of had the feeling because I don't think she quite felt the same way about my brother, although, you know, there wasn't any problem there and I think he was intellectually able too, but somehow or other I had the feeling that I was very special in her mind and that she felt I was going to be an achiever. That's kind of an interesting dynamic.

Tronick: But you didn't experience it as a burden?

Richmond: No. That's interesting. No, I never--you know, it was sort of most of the time subliminal anyway, but I never--I don't know why, but I never had the expectation that I would academically do anything but the best, so that I think I may have gotten a 'B' in one physics course in college or something like that, but other than that it never occurred to me that you would do less.

Tronick: Right.

Richmond: Now medical school, I should mention, is somewhat more competitive, and I think more so in the first year. I think mainly because I was also developing political interest during the Depression with the threat of war and fascism, and at that point I was beginning to spend a lot of time thinking about that and organizing a medical school organization nationally, the American Association of Medical Students, although we had interns. So I think maybe for part of that first year I may not have done quite so well, but again I was at the top and I was in the honors society, AOA, the Academic Honors Society for Medical Students and all of that. So during the course of that period in medical school I was trying to sort out what I might be most interested in, and at that time there was very little specialization. It was about the time I was in medical school that the Boards were formed, so by the time I was in medical school everybody was thought to be headed for general practice, and specialize only later, and so I thought I too would be a generalist. In those days everybody took a kind of a general internship, there were virtually no straight internships, and so I applied, and again, there was no counseling, you see, for thinking of going to some of the more prestigious centers and the most competitive internship at that time was the Cook County Hospital where we had done a fair number of our medical student clerkships; it was very competitive and because everybody was destined at that time to be a generalist, it was regarded as being the best experience because it had more clinical experience than virtually any other kind. In that era it was so competitive. That was a competitive examination; you had to write the examination. I think it was a day and a half and quite an ordeal. I think they did something like a hundred house officers at that time, and then your choice of what rotations you had depended on how high you ranked on the exam, and I ranked seventh, I think, so that was a good example of my competitiveness. It was during the course of the internship at the County Hospital and rotating through the pediatric service that I began to think that was going to be the kind of career I wanted to have. And during the course of that year I then applied for the residency training program, but since infectious diseases were so much a part of the training in pediatrics at that time, there was a separate municipal contagious disease hospital in Chicago (all of the large cities had counterparts), and so I applied, and was admitted for six months of that before taking my pediatric residency. At that time I was really more of an encyclopedist, that is, I was still exploring all of the medical areas. Even though I settled on pediatrics, my interest in child development per se had not yet crystallized because I found medicine, the medical aspect of pediatrics so intriguing. And so, as I say, I really was kind of a walking encyclopedia, and my colleagues sort of regarded me as the one who knew the literature better than they did.

Tronick: It was like the encyclopedia you read at the Allendale School. You were becoming it!

Richmond: So that was an interesting period, and then developed as I was partway through my residency in pediatrics, World War II broke out, that would be at the end of '41, and again the social conscience dimensions of that were such that I felt that I wanted to enlist and join the War effort. And so without consulting the senior attending staff I just went down the day after Pearl Harbor and had applied to be a commissioned medical officer. That created quite the consternation for the medical staff because they didn't want the house officers just running off on their own, they'd be left - it was very interesting because the Chief of Staff, a man by the name of Dr. Blatt, was very ambivalent about all of this because he was a General in the National Guard and he always used to try to recruit us to enroll in the National Guard, and here I was going off to military, but he was trying to protect his flank upon this little -

Tronick: He wanted those attending -

Richmond: -- so for public relations purposes he made quite a point of castigating me, but privately the message was, "I'm really proud of you." So then within a matter of weeks I was off in the military service, and that had a very profound impact in terms of my professional development and channeling of my interests and all.

When I entered the military I was assigned to what then was called the Army Air Corp, and as the War went on this was then made a separate service, as it is now, the Air Force. I was assigned to a field in Texas, Wichita Falls, Texas, which was the reception center bringing huge numbers of young draftees

into the service. They would be processed there and then sent onto other fields for training. So during one month, for example, at its peak we were putting a hundred thousand people through that field, so I was doing a lot of physical exams because these people were brought in very quickly because of the organization there were a lot of medical problems. Even though I had the pediatric background and I knew a lot about infectious diseases, I was assigned to the orthopedic service that was in keeping with the ethos of the time, particularly the military, they didn't want anybody to be a specialist; they wanted people to be generalists. That was very interesting, because as the War went on they recognized the importance of specialization and they developed the category MOS, Military Occupational Specialties.

Early in the War because I was so young, relatively, as a medical officer they thought that I ought to go to flight surgeon school, which was at Randolph Field Texas at that time. During that first year many of them in the psychosocial sense were not well prepared, and the physical part it seemed to me wasn't as significant. I then began to develop an interest in the psychology and social development of young people, and I then began to develop a feel that we ought to be able as a nation to rear children more adequately, more effectively as young adults. Then as time went on, I started reading more and thinking more about this, although I still have very general medical responsibilities, I kept up with reading and all in the general context, but more and more I found myself thinking about psychological issues and psycho-social development, so that at the end of the War I came back to my pediatric residency because I needed to complete my credentialization for pediatrics and I found that there wasn't anybody at a hospital like Cook County Hospital that really knew anything other than intuitively about psychology and social development. I would ask questions on rounds about the Gesell writings and evaluations of development with the attending physicians, they sort of disregarded it; that was very irrelevant. And particularly when we would see youngsters on the wards who had some degree of retardation, their attitude was, 'the quicker you get them out the better,' nobody really wanted to spend much time, so again, I found myself sort of charting my own course.

Then, fortuitously, the Chief of Pediatrics, the Professor of Pediatrics at the University of Illinois where I had graduated, who had been a faculty member but not the Chief when I left, by then had become the Chairman of the Department at the University of Illinois. He recognized that I had some academic interests, and incidentally I was becoming aware of the role of full-time clinical faculty. You have to remember that at the time I went to medical school there was no clinical faculty full-time; they all earned their livelihood in practice, essentially volunteers. So I became aware of the fact that there were places like Harvard and Yale and Hopkins where there were full-time faculty members. I began to think about this and he came along and offered me this opportunity at that time. He knew that my interests were developing. His name was Henry Poncher, and he was a significant figure in academic pediatrics at that time, even though he was the only full-time person there, he was articulate and bright and so nationally he was a well-recognized figure. He sort of gave me the opportunity to sort of develop psychosocial dimensions of development in any way that I could, so I began to develop reading lists for students and tried to begin to teach some dimensions to students, and it was all kind of self-taught in terms of my background because I'd never had any formal coursework in this arena. At this time there was a new school of social work that was developing at the University of Illinois in Urbana, not in Chicago, and they wanted somebody to teach the medical aspects of social work, and I don't how they found their way to me, but somehow or other there was a woman by the name of Florence Hosch, who worked with the then Dean of the school, incidentally her name was Marietta Stevenson, she was Adelai Stevenson's first cousin, and so they convinced me to go to Urbana once a week in the evening, taught this as an evening course, and I would make that trip in one day. The point of this was it enabled me to consolidate my background in psychosocial development and blend that with what I thought social workers needed to know about medicine.

Tronick: And it must have been unique at that time in terms of their program and your being--

Richmond: University of Chicago, which had a school of social service administration established much earlier, did have some of the medical faculty that came over and gave some medical lectures, but I think they were straight medical lectures and didn't try to combine these developmental issues. Yes, it

was unique. Then one of the ways that I also expanded my horizons was, I began to make some liaison with the people in child psychiatry in the Department of Psychiatry and they had relatively few teaching hours, but I had proposed to them that they rotate their psychiatric residents through the pediatric clinic where they find some opportunities --

Tronick: And that was something that wasn't done?

Richmond: Oh, no. Well, in most training programs don't even do that today. I think that was very unique, mostly at the time and forever more, because of it being a great experience, but most pediatric ambulatory care facilities don't want to clutter their teaching program with people from other disciplines. I remember George Pollick, who later on went on to become the Director of the Institute for Psychoanalysis in Chicago, while he was a resident he was very ambitious fellow. I was seeing some cases of iron-deficiency anemia that were very unique and nobody had ever written these up, and we did a little paper on these cases. These were infants who clung to bottle feedings and who had grown adequately, but then were beginning to develop severe anemia and ceasing to grow any longer. And because this came on very gradually their parents didn't recognize how pale they were, usually a neighbor would come in and say, "Gee the baby is very pale," and usually there was some stressful situation in the family that caused the mother to prop the bottle. We know that milk is an adequate source of protein and can be an adequate source of calories, the one thing it doesn't have is an adequate source of iron; so these babies were gradually becoming anemic. So he and I published, I think it was in the *Journal of Psychosomatic Medicine*, a series of cases.

We began to have these relationships and then, of course, this was a period in American Psychiatry, there was a great popularity in psychoanalysis and I became very curious about psychoanalytic theory and practice, and I began then to explore whether I could become a student at the Institute for Psychoanalysis. Now in this process during this period I had also encountered children on our wards with what we then thought of as psychosomatic disorders; so we had children with bronchial asthma, ulcerative colitis, rarely peptic ulcer, neurodermatitis, and these children we had in the hospital. I had convinced the then head of psychiatry, because they had a separate neuro-psychiatric institute, to establish a unit in that institute for children with psychosomatic disorders, which we did. We then attracted a number of very, what were locally outstanding child psychoanalysts; Irene Joselyn (I think she may have been the Founding Editor of the *Journal of Child Psychiatry*) and George Mohr were very senior psychoanalysts. In my view the most talented in that group was Dr. Margaret Gerard, who was married to a neuro-physiologist, Ralph Gerard. We took care of the medical part and she added the psychosocial dimension, and so as a consequence of that, I began to learn more and more about child psychiatry. And then I did manage to have a training analysis at the Institute and I had enrolled in some coursework there as well, but I never completed the formal training because I then went off in a different direction, becoming Chairman of Pediatrics in Syracuse. I did complete most of the formal coursework, but I didn't complete the actual analysis that was required to do before qualifying.

Tronick: So there is this aspect of your seeing in some way a whole portion of pediatrics being left out, and in a way being fortunate enough to have access and exposure to other disciplines where this was more the -

Richmond: Right. So what I was beginning to feel a need to do was to incorporate more psychological and social development in the pediatric practice because I saw that as the future. But the mainstream academic pediatricians didn't see that, and Milton Senn was sort of the pioneer in trying to do this, and I watched carefully how he was being regarded and all, and I established some communication with him, and it was very clear to me that they thought that that approach would "dilute" pediatrics.

On the broader arena in terms of communications with the public, Ben Spock had just published his book and was beginning to have an impact, so there were these currents; Milton Senn in academic pediatrics, Ben Spock more broadly had a broad influence on the public. And I was trying to figure out, how can you really incorporate this? I then began to think about the fact that within pediatrics, if you didn't have all the usual academic credentials of research and formal training in research, that you

never really could be accepted in pediatrics. So at that early point I began to conceptualize that one had to do something different from what anybody had been doing, and up until that point the general kind of intuitive notion among those who were interested in doing this, like Bill Kessen, was to try to get a liaison with child psychiatry. And I began to recognize that that wasn't the way to go because you don't develop your own discipline clinically by borrowing exclusively from another clinical discipline, you had to have a basic science. And so I began to then conceptualize in my own mind that you had to really develop the basic science for what I was then calling 'developmental pediatrics.'

I should back up and say that a very important mentor in this connection was the Head of Psychology at the University of Illinois, fortuitously, he had more of a national reputation than anybody else had, David Shakow, who was sort of the Dean of the development of clinical psychology in this country, he and Carl Rogers at the same time. I think they're the only two people who had both the Basic Science Award and the Clinical Award from the APA. I had gotten to know him because I was asked to Chair the Curriculum Committee at the University of Illinois. It was after the war, a period of ferment beginning in medical education, and the notion then was well, you ought to have some young Turk's thinking about this, so they appointed me.

I was still wet behind the ears, you know, appointing me to chair this committee, and a lot of these very senior distinguished persons, and low and behold there was David Shakow on this committee. And so I got to know him personally, and essentially I had a tutorial during this period in psychosocial development, and it was largely by brown-bagging lunch. Here was this very distinguished psychologist, yet he was easy to get to know, so I would offer to come and have lunch with him, and here he was surrounded by all of these books, and all so we'd start talking and no matter what we talked about it would remind him of this book or that book and he'd just reach onto his shelves, and I never went away with less than about three books. And by the time I came back I was supposed to have read all of these. And so it was really, you know, a very liberal education. I did have that kind of tutorial and that also enabled me; my interactions with him enabled me to understand the importance of having a basic discipline.

So much later when I received the Aldrich Award, I tried to crystallize all of this in one of the papers that you know became somewhat of a classic, and that is 'Child Development, a Basic Science for Pediatrics,' where I was sort of going counter the current of what was conventional in both child psychiatry and in pediatrics, that all you needed to know, what more of child psychiatry in order to do a job I was not negative about child psychiatry, and indeed the most supportive group at that time made me through first the American Ortho-psychiatry Association, and then secondly after the Academy of Child Psychiatry was organized in those early post-war years, was a cluster of people in child psychiatry but who had been pediatricians. And I think in retrospect, what was missing in their analysis of what they were doing was that they really wanted to be child psychiatrists and pediatrics had been just one vehicle. What they didn't understand was why they had run away from pediatrics, you see, and embraced child psychiatry. Once they did that, what I found lacking was that they always wanted to teach pediatric residents in the same context that psychiatric residents were taught, you see a patient for an hour, you discuss for an hour and I - we keep emphasizing to them, if that's what pediatric residents wanted they would have enrolled in training in child psychiatry. You had to find that out the hard way. So I found that very few of them really, even though you'd think they were the ones who should have had the skills to teach this in the pediatric context, usually they didn't because they wanted to use the same kind of techniques of information gathering.

Tronick: But how did - when you say basic science, you understood the complexity of the idea because you are now starting to think about a science of normal development in terms of child development as opposed to just pathology and disease?

Richmond: Right. Well, see I played both sides in connection, for example, with trying to teach about mental retardation. It was part of my life because people were becoming more aware of retardation, developing a knowledge base, but you used to say that you studied that so you can learn more about the normal. And about the normal, I said you study the normal so you can understand the deviations

better. Basically what I was developing was the notion that whether it was psychology or sociology or anthropology, you had to develop some research skills in some social science area if you were going to teach psycho-social development to pediatricians effectively. And that rather than emphasizing -- this is where I think Milton Sen, and I don't say this critically because he really pioneered at a time that was very difficult, my thesis was not to emphasize the fact that this was different from the rest of pediatrics, but to emphasize the likenesses. If you wanted it to be accepted, you have to have some research tools. And I was always critical of my colleagues who said, "Well, we're different, we don't have basic research," and all. So I kept saying, "No, we shouldn't be different." They would complain that our papers aren't accepted, they want us to be quantitative, and I said, "Well there's no reason why we shouldn't be able to compete in the same way, and if we write papers that are empirically sound, you know they'll pass mustard," and indeed over the years I think that's proven to be the case. And as people have learned some methodological approaches and applied them in the clinical setting, that their research passed mustard just as well as anybody else's.

And as a matter of fact, later on this gets a head of the game, some of my colleagues like Earl Lipton, when we were at Syracuse he became more skilled at research design than most of the people in the biomedical research - in the basic science departments. Since we didn't have senior statisticians in the school at that time, he sort of became a consultant to the young researchers because he knew more about quantitative analysis of data than they did in the early days of computerization and all. He was earlier to get this than people in the biomedical disciplines. So that sort of sets the stage for what I was trying to do in terms of building the knowledge base of child development into pediatric training and to emphasize the similarities. My thesis over the years has gotten to be, if you're trying to pioneer and you want to gain acceptance in traditional circles, emphasize your similarities. Once you're established, emphasize your differences. Well, I mean -

Tronick: Yes. So it's October 1st and we're resuming this interview, and we - well, you know, in terms of - we did a lot of the family background and your work experiences, and even some of your collegiate experiences. I think there's the political and social events which you even touched on that around World War II, and so, you know, the next set of questions that I think you can sort of maybe pick up on the narrative, because maybe it leads in in a way, have to do with the questions about the personal research contributions, your primary interests? You've actually started to talk about that some and continuities in your work? And you have the questions, maybe how you'd like to feed off with that?

Richmond: Well, my early interests were in becoming a very effective clinician. I was not in a situation where a lot of active research was ongoing and the emphasis was on good clinical care and teaching clinical care, but I recognized that there were other settings in which research was taking place, and because I was curious I began to record clinical observations in the literature, and so some of this was clinical investigation in a very traditional sense; collection of cases and case reports. And I became pretty well known as an astute clinician and a clinical teacher, and the clinical observations even though I had this interest in what makes children develop, what makes human beings human and reinforced in part by my World War II experiences, my clinical interests were such that I began to write on a variety of clinical subjects. So early in my career there were actually several clinical observations that we made that were fairly unique. I can think of, for example, calling attention to what Sterling Gerard, one of my younger colleagues and I, referred to as 'psychogenic megacolon' at that time because it had not been identified as an entity, and ultimately psychogenic megacolon and encopresis, that came a well-defined syndrome. Even though a disorder like rumination in infants could be clinically described, the association with the psychosocial component had not been made until we described that and emphasized it.

The other interesting observations that I can think of would relate to some studies that I did with an orthodontist on the growth of the mandible. Until we had made these observations most babies who had these very underdeveloped mandibles would die largely from dysphagia and/or pneumonia. And with the advent of antibiotics it was possible to tracheostomize these children and keep them alive. Since the orthodontists had very well developed techniques for quantifying the growth of the mandible

and cranial facial bones, we were able to document that if you could get these babies to survive, the mandible would ultimately grow. The critical question was, "Would the mandible grow at all, or was it a defect in the growth center of the mandible?" So we established that. That led to many interesting and amusing anecdotes later in my career when the Chief of Ear, Nose and Throat at Children's Hospital came to me one day and said, "There's a fellow by the name of Richmond," I was then Chief of Psychiatry at Children's, "fellow by the name of Richmond who wrote an article on the growth of the mandible, did you ever know him?" So that was an interesting clinical contribution. And then the Chief of my service, Henry Poncher had an interest in childhood hematology, and so we were seeing a number of patients with childhood leukemia, and at that time it was inevitably fatal and we were just beginning to get some glimmers that some of the anti-metabolites like folic acid antagonists might have some favorable effects and we were able to get some of these. So we actually observed early on for the first time some favorable effects of the treatment of childhood leukemia, of course, that's now gone forward on a large scale and in very interesting ways. As a consequence of that, we had so many children coming on our service that I summarized our experiences with the families in a paper that we called, 'A Psychological Aspects of Inevitably Fatal Disease in Children', and so it was an effort to pull together what was my growing interest in psychiatry and child development into clinical observations.

Tronick: And again this was in part -- this still comes out of the wartime experience and in this driving interest in -

Richmond: Yes. Then over the same period of time when I was publishing these clinical papers I was also then beginning to work with the child analysts in Chicago and we developed a psychosomatic unit that stimulated my interest, Franz Alexander, who is one of the leading analysts interested in psychosomatic disorders. He developed some theoretical notions about specificity in psychosomatic disorders that there were personality characteristics that predisposed to asthma, ulcerative colitis, peptic ulcer; these were the kinds of psychosomatic disorders that we were thinking about. So I became more and more curious about those disorders and began to think about how one would study the predisposition of these disorders, and he had this notion about personality specificity, but he recognized that that didn't explain all of psychosomatic disorders, because you could identify patients who seemed similar in background and characteristics. He then postulated what Freud had postulated, an X-factor, a constitutional factor, and I began to be curious about that, and I thought if one had constitutional factors as predisposing factors, wouldn't one be able to identify differences in reactivity and typically autonomic reactivity in early life, and that led to a whole series of studies with one of my young colleagues, Earl Lipton. The model that we used, because one wanted to make sure that we weren't traumatizing babies, of course, we wanted to make our observations as early as possible, we then began to look at heart-rate, when one could record with the cardio tachometer heart rate responses, and also the stimulus we felt would mean it to be atraumatic -- recognizing the skin sensitivity of the newborn we used an air puff and sort of standardized that observational situation and further sort of standardized the state in which the baby was by using this swaddling technique that the nurses in the newborn nursery used, so these weren't tightly swaddled babies, some loosely swaddled. That was our standard technique, and that resulted in a whole series of papers on individual differences and autonomic reactivity.

Tronick: One is that some of the first sets of studies of yours that I came in direct contact, so I know them really quite well, and Lipton then went on to Yale, isn't that right? Didn't he go to work with Sally Provence --?

Richmond: No that's another -

Tronick: Oh, that's a different - okay.

Richmond: Yeah, that was Rose Lipton. As a matter of fact, that was a tragic occurrence when we were sort of at the peak of this work; he committed suicide. He went into a depression and was suicidal.

Tronick: You know, and I'm sure you're aware of it, because now with the group over at Judge Baker who were doing vagal tone on infants and individual reactivity, to the best of my knowledge those studies that you did were the first studies looking at autonomic reactivity in infants.

Richmond: Right. Earl Lipton moved to Syracuse with me, and then at Syracuse, Al Steinsneider, who had his Doctorate in Psychology had just come into medical school and began to work with us. He had more of a statistical competence to help us with the kinds of analytic work that we needed to do to look at the data, but while we were doing that I was also interested in the other facet of psychosomatic disorders and that was, you know, are there personality traits in the parents or in the children as they emerge, and could we begin to study these in a longitudinal study? So after I got to Syracuse we set up a longitudinal study where we were observing the development of children, and we picked these pregnant women and families out of our obstetrical clinic that served the very low-income community around the medical school, and there was a lot of social disorganization in these families, before the whole notion of studying socially disorganized families and very low-income families became fashionable, so we had this sample. And by this time, I should also mention, Betty Caldwell had come to Syracuse and I had known her somewhat from her days at Washington University. She had moved to Syracuse because her husband was a surgeon and had taken a position in the Department of Surgery, and so I recognized she had a lot of talent. So she then began to work with us, observing these children early up in this very low-income neighborhood, that we began to observe what I came to call 'developmental attrition,' as you got to the end of the first year of developmental tests these babies went into a sharp decline. We then became concerned about whether one could really do something about that and we faced the ethical dilemma at that time of, you know, if we developed an intervention program, families hadn't come to us for any intervention and it wasn't necessarily the appropriate thing to do, and if we did intervene there were, of course, the two options, should we do it in a daycare kind of setting or should we do it in the home? She and I debated this back and forth, and I finally prevailed because I wanted this done in a daycare setting. My concern was if we did a home intervention, and in those days nobody had really done that kind of work systematically, I was concerned that we'd never know what the children really experienced, so I knew that if we had gotten positive results we would have been in good shape, but if we got negative results we wouldn't know, so we decided on a daycare program.

Well, that turned out to be a difficult thing to do because it's very difficult to get funding for that kind of program because at that time, particularly because of the impact of John Bowlby's WHO Monograph on Maternal Care and Mental Health, the American social work community had an absolute taboo on any kind of group care for young children. And I was on the Board of the Child Welfare League of America, which had that as a matter of policy, so here was I in this dilemma, I'm on this Board of this organization that says this is bad for children, yet seeing what was happening we knew that the better environment for several hours of the day might be beneficial and certainly wouldn't hurt. So we did ultimately succeed in getting some funding from a Children' Bureau, and a person that deserves a lot of credit, a psychologist by the name of Charles Gershenson, who was then the Director of Research, and he was willing to sort of face up to any critics. And so we set this program up and then what we found was that we could indeed prevent the developmental attrition in the daycare programs. I published this later in the Yale Journal in Biology and Medicine, which wasn't the most auspicious place for this kind of publication, so I think that paper never got a whole lot of attention in all of the literature on the impact on poverty on young children.

Tronick: You know you and I have talked about this, but, you know, now in the literature on infants exposed to things like cocaine, but also it's been showing up in poverty, there is the citation and discussion of these phenomena, because that's what's seen still in these children.

Richmond: Well, that sort of gets me to a point in about the mid 60's, when as a consequence to the civil rights revolution and the focus on doing something about the impact of poverty was beginning to become more prominent, that the Office of Economic Opportunity was established and Sargent Shriver was appointed. He had been heading the Peace Corp, which was started, of course, during the Kennedy administration. This was a couple years beyond Kennedy's assassination, and the legislation was passed

and the Office of Economic Opportunity established, and he was the Director. He had been the Executive Director of the Kennedy Foundation and, as you know, it had its interest in doing something about mental retardation, and their focus was heavily on organic causes of retardation, but being a very bright and able person, he recognized this, he learned more and more about retardation, that there were environmental issues too, and as a matter of fact, he and his wife Eunice had been curious about our daycare program in Syracuse and had visited it. So when he became the Director of OEO, he talked to people like Jerry Bruner and others as to whether it was feasible to do something about this, and he then established a committee; Ed Zigler, Uri Bronfenbrenner, many others, Mitch Ginsburgh from social work, and Bob Cook, who was then Chairman of Pediatrics at John Hopkins and was close to the Kennedy family, chaired that committee. They thought that it was feasible on the basis of the knowledge they established such a program, and so Shriver then contacted me to see if I would be willing to come to Washington to start it. And while I'd had thoughts about what one could do on a large scale, I had never really thought the opportunity would ever arise, and so low and behold, here was an opportunity not only just potentially there, and so I found that we could try to apply what we were learning in Syracuse on a small scale, on a large scale. So there were a lot of ramifications to how we did that, but I ended up going to Washington, and in February we made a judgment to mount a summer program that summer, and to do this all over the United States.

So we had that window of opportunity and relatively few months to contact communities all across the country and ask them to generate applications, and all in the course of those few months we had about thirty-three hundred applications for community-based programs submitted, of which we funded twenty-seven hundred for a total of about five hundred thousand children. And it was, I think, good to start as a summer program because we had teachers who were willing to work during the summers, and with intensive training we could help them adapt. There were a lot of interesting decisions that had to be made, like what age group? And we felt that with the funding that would be available if we targeted it at all of the preschool years that we might not be able to see any major impact, so I pretty much made the judgment that we would start the year prior to school entry, and I say that rather than a four or five year age group, because at that time half of the states didn't require kindergartens; so in some states there were five-year-olds and other states four-year-olds. We had to make judgments about adult to child ratio, and I made the judgment that we would have, based on our experience in Syracuse, one trained teacher for fifteen children and two teaching assistants; so there would be one adult for every five children. That created quite a flap because people in Washington said, "Well, you're using up all the money for that rich ratio," and I said, "Well, I don't know whether we'll succeed with this ratio, but I know we'll fail with the one to thirty ratio that somebody was proposing," so we went ahead and it was fortunate. We knew what to ask and things to do, we didn't tell them precisely how to do it, but we did tell them that you had to include health and oral health and nutrition, early childhood education, social services, parent involvement, volunteers, then probably the most important thing was community involvement and governance. So Head Start was just about the only federal program where federal funds flow directly to local communities without intervening bureaucracy in the states. I think it's largely in the sense of ownership that people in communities locally have then enabled the program to survive.

Tronick: So this is almost in a way a move. This is really quite a big move for you once you start doing this?

Richmond: Yes.

Tronick: You're not doing autonomic studies anymore?

Richmond: That's right. Some of the papers kept coming out, but I was no longer able to. I should mention in connection with the autonomic studies that one of the more interesting things that we did was to do a study of swaddling and what physiological affects it had, and it was very interesting. It really does have a quieting affect in terms of heart rate and motor activity and crying, I think, also. So we did a monograph. For a time, I got very preoccupied with the impact of swaddling, and Earl Lipton and I went to the Soviet Union to see what they were doing in terms of this kind of research, of course,

there we saw swaddling on a large scale. We visited the laboratories of Professor Koltsova at the Pavlov Institute in what was then Lenin graph. So, it's true I didn't get back when I - I was sidelined for a time because I developed a bout of Tuberculosis, and so I had to leave Washington and pretty much stay at home. Incidentally, during the time I was doing it, I didn't completely leave all of my university responsibilities; I was commuting back and forth. So during the time that I was sidelined with Tuberculosis, by then, of course, we had pretty effective drugs for the treatment of tuberculosis, so I didn't need to be hospitalized. But while I stayed home, I had always had an interest in doing a book on healthcare in this country and so I used that time to write a book of which was titled 'Currents in American Medicine, a Developmental View of Medical Education and Medical Care.' I then became more and more involved in public policy interests, and so as time when on I had given up some of my responsibilities at Syracuse, that is at the administrative level, as I had served as Dean of the Medical School for a time, and then the opportunity came to come to Harvard as Director, the Judge-Baker Children's Institute and Chief of Psychiatry at Children's in '71, and so that too set me off on a whole new track and interest in training people in psychiatry and the other clinical disciplines.

Tronick: This is actually when I first meet you.

Richmond: Yeah, that's right. I guess that was during that time. Yeah that's right, and you were working with Berry at the time. And then as time went on, while I was trying to develop programs and develop the services at both Children's and the Judge Baker, I was asked if I would come to Washington to serve as Assistant Secretary and Surgeon General during the Carter Administration, so in '77 I went off to Washington to do that, and as Surgeon General I certainly had all the opportunity to get all involved in the anti-smoking efforts and sort of focusing on what are the public policy issues around habituation, and the habituations not alone related to smoking, but drinking and drug use. The more I thought about those issues, the big public health issues, the more I realized they were behaviorally determined and that we had moved from the era of controlling the infectious diseases into the era of dealing with non-infectious and often chronic disease, but also dealing with what are the health promotional issues that were important. So during the course of my tenure there we published a Surgeon General's Report on health promotion and disease prevention. And as I began to look at those issues I began to be more and more concerned that we really didn't know enough about the developmental antecedents of habituation. And I preferred to use the term 'habituation' rather than addictions because I thought we ought to think about studying how children develop sound health habits as well as unsound health habits. So when I got back to Boston at the end of that period I then began to try to interest people like Bob Selman in looking at how one could study the developmental antecedents of habituation and that's sort of where my more recent interest led me, and so there were studies that--

Tronick: So that that was a movement in a way. I mean, that went beyond the high risk models that had been in place because if I recall isn't it somewhere in the 60's that the article on the continuum of risk by--I can't remember their names. It was an important article by people at John Hopkins, you know, that morbidity has an entire range and has a continuum of morbidity --

Richmond: Yeah.

Tronick: --but that was all risk factor oriented, and no one considered anything about the protective factors or resiliency.

Richmond: A positive resiliency and a positive approach.

Tronick: Right.

Richmond: That is, what are the promotional factors that one could learn more about and reinforce, you know, what makes more resiliency? And those are some of the things that Bob Selman is pretty much involved in looking at. Now I have developed over the course of those years, I suppose it's worth mentioning, some conceptual models and one early on in relationship to child development in

particularly, but I was thinking about issues related to the mental retardation, both the biological as well as psychosocial point of views. I began to think of a functional capacity of the organism as really being determined by three large categories: one is what I call the biological or the internal environment, the other was the physical environment, and the third was the psychosocial developmental environment. And it's the interaction of these that is important, and I use that as an explanatory model for psychosomatic disorders as well. I had several papers in which I sort of explicated that, and--

Tronick: Wasn't one of those papers also that I remember about eczema and either respiratory--

Richmond: Yes, asthma. I particularly developed a series of diagrams and what I called the central circle, which is functional capacity. In order to give it a dynamic character, we arbitrarily assigned a surface area factor of a hundred to that, and then any encroachment from any one of these factors would then represent a reduction of the functional capacity of the individual. So in the model with an asthmatic child, one could have, because of the allergic diathesis, allergens in the environment that would trigger a reduction in the functional capacity of an individual by an attack of asthma. But also since one of the environments was the psychosocial environment, sibling rivalry might trigger an equal kind of diminution in functional capacity, so it was a very dynamic tripartite diagram. Later on when I got to Washington as Surgeon General, I then began to think of public policy in that tripartite model, and then I began to think about public policy as being formulated by, you know, three major factors; our knowledge base, that's, of course, the importance of the research because one should be able to generate better policies as one gains more knowledge, political will, which provides for the resources, and the third is a social strategy; what is the social strategy by which you use political will and the knowledge base to formulate public policy? I found that useful, and it seems to be useful in teaching, because in a pluralistic society like ours people ordinarily think of public policy as sort of informal, some very amorphous way, and this at least provides a systematic way to look at this.

Tronick: This is a period of time, at least in my recollection, where there was a great deal of political will about many of these issues.

Richmond: Yes.

Tronick: Certainly poverty. And any thoughts about the political will now, because it seems to me it's changed quite radically?

Richmond: Well, that's right. We've gone through a period starting in the early 80's with Reagan's election, a lot of constraints of various social programs, and I think people lose sight of the fact that in his first budget sharply reduced, say the maternal child health budget by virtually fifty percent, and it was a very interesting technique politically, because once that sharp reduction took place in subsequent budget years people never went back to what would have been before, they would always go back to the prior year. So unless you were experienced in looking at budgets you wouldn't realize it took ten years to get back to the maternal child health budget that we had at the end of the Carter administration. A lot of people are just totally unaware of how devastating those early and very abrupt cuts were. I think politically the whole notion that government couldn't do anything well and effectively seemed to some way have taken hold because, you know, there was a tendency to say that none of the programs of the 60's and 70's worked, and that really wasn't true, because programs like Head Start, Community Health Centers and a variety of educational innovations worked very well, just that we never did them long enough and extensively enough to cover the entire population in need. And, of course, historically one needs to go back to the late 60's when Head Start and Community Health Centers, which I had a lot to do with during the OEO days, they were making a tremendous difference in low income populations all across the country and rural and urban areas, we have developed some models that really worked very well. Well, as Vietnam came on the scene it was clear that you couldn't have guns and butter both, and so the constraints then began to set in, and I often think about how different this country might have been if we had continued that momentum and hadn't gotten so deeply involved in Vietnam and, of course, what Vietnam did was take a lot of the

attention away from the social programs as well and became a paramount political issue. So I think if you calibrate for Vietnam and then later on, well first, not quite at the end you have the Nixon administration, which, of course, had no great faith in these social programs. We then come to the Carter administration, and I came back into government. We were trying to revive some of that interest in broader social programs. Then with the election in '81 you then had to reinforce the notion that government couldn't do these things well, shouldn't be doing them anyway, and I think the country is just beginning to emerge now, particularly since the '94 elections when the Republicans gained control of both Houses. Getting majority of both Houses of Congress, people recognized that, at least this was my interpretation, that they didn't want the kind of extremism that was represented by cutting all of these programs in what were virtually mindless ways. And so I think the debate more recently has been cast in terms of who cares about what happens to people, and I think the focus around Medicare has linked itself to that because people can understand in this television era, Medicare is a sound byte and they can understand that very, very readily, and I think we've had now in connection with other social programs a kind of balancing, and people are now trying to figure out what it is that government can do well, so I think that's sort of where we are now.

Tronick: Well, that's helpful.

Richmond: Well, I think it is the case.

Tronick: I think part of where we can go depends in some sense on really what you would most like to comment on. I know you've had very much involvement in funding agencies. You had tremendous involvement in SRCD and certainly that has to be touched on?

Richmond: I've had the opportunity from quite early in my career to sit on NIMH study sections, so I sort of followed to development of NIMH and it's movement outside of NIH and then now back into NIH, and I think the research support, while never enough, nonetheless has had a pretty good balance it seems to me between basic and applied research over the decades. It seems to me that consonant with whatever dollars are available, that both the study sections and the advisory council have rendered a kind of nice balance of how the resources are allocated. I also, particularly since I was in Washington during the Carter Administration, had a lot of contact, some before but a lot since with various foundations, so I played a role as a consultant to the Foundation for Child Development, the Robert Johnson, Carnegie and Pew Foundations, occasionally McArthur, and I think those foundations by and large have tried to identify directions where their modest resources, that is modest as related to research support from federal sources, they've tried to identify where they can make some impact, and I think in general they have done fairly well. I think that in more recent years what I see is a tendency particularly during the more conservative period for the foundations to try to play it safe, so it seems to me they're not tackling the bigger issues of society, but they're putting their money into small research and demonstration programs. In my view they're not taking large enough risks, because it seems to me that's what foundations ought to be about is taking risks. It's somewhat understandable, and I suppose to some extent the consultants that they use largely from the academic community of course don't mind being the recipients of the grant support of those foundations. So I think in the -

Tronick: So where would you see them?

Richmond: Well, I think that I would want to see them trying to support groups that would look more poignantly at social strategies. See what I'm concerned about is we have a pretty good knowledge base now that we didn't have thirty years ago of what it takes for good child development, optimal child development, and yet we have large populations living in environments where you know they're not going to have the opportunities to develop to their fullest potentialities. And what are the inhibitions? That is, why are we as a society not really applying the knowledge that we have for those populations? To one extent, for example, should we be moving toward Head Start for all of the eligible children, we're reaching only about a third of those that are financially eligible, and we now have begun the initiative that because again of budgetary constraints of moving Head Start down to earlier periods,

that is emerging as early Head Start. And the foundations it seems to me by sort of demonstrating that in small well-integrated saturation programs for small populations you can be effective, it seems to me they're demonstrating what we already know. And on the other hand if you asked me, "Well, what should the foundations be funding by way of studies to develop those social strategies?" I'm not sure that I have any easy answers, but it's what I tend to call "going to scale" since we know it works. Why is it that on a statewide base why don't they say move into one state and say we'll work with the Governor's office and the state legislature to do something like this for all children? And so I think there hasn't been that kind of bold and innovative thinking. On the other hand one of the things in terms of pluses for research and training point of view that I would say is he's more than fulfilled my expectations because when I started thinking about bringing child development into the mainstream of pediatrics thirty years ago and pediatric academic community resisted, they thought—diluting.

Tronick: I know about that --

Richmond: And Milton Senn before me, you know, I don't claim priority in this, but I think he really was the person par excellence who sort of tried to get pediatrics to move in this direction. And one would have despaired at that time, but gradually I think by virtue of persistence, developing training programs that worked, after all I had no training, I sort of had to train myself as I went on along, that's something that I didn't comment on earlier. You know, I never had a research fellowship or had an opportunity to really learn anything except discipline, but by virtue of my contacts with David Shakow started looking at what Milton Senn was doing and was able to do this. But now in the thirty year sweep, I had in the 50's written papers about the fact that I had hoped that we would someday have all the departments of pediatrics teaching child development. It was sort of a pipe dream, but then in fact it's happened. In fact, the Society for Research in Child Development now has a lot of pediatricians and an organization like the Ambulatory Pediatric Association now, every department of pediatrics across the country has some activities in teaching and research in this area, so I think what could count that to some extent is there's a great success. The interesting thing there is that there wasn't any one policy that one would point to, but I think it was a persistence of a small group of people, and it was very interesting in pediatrics I think early on we made the mistake, as I said in the first session of thinking we were going to get this from child psychiatry, but child psychiatrists had no research discipline of their own either, so we learned, and I learned particularly through my contacts with David Shakow that we would need to look to Child Development, psychology and the other social sciences more and more. Now across the country there are a variety of training programs, fellowship programs that I must say I feel very gratified about. I think this does come back to the role of SRCD, where I think the openness of a lot of people in SRCD and their eagerness to include people from medicine, in particularly pediatrics, impressed me very early in my career, and I can recall very vividly people like Frances Graham wanting to get me involved in committees and then scheduling me to give the invited lecture, I think at the biannual meeting in '61, I think it was, when the meetings were still held on university campuses. This one was at Penn State and the meetings, of course, were smaller and there was a lot of intimacy involved, and I was one of the few pediatricians involved, but I think she saw this as an entree to getting more pediatricians involved. I think that that proved to be the case because I had started encouraging people who were interested in research in child development and pediatrics to join.

I think the other impressive thing to me about SRCD at that time, was how much fun the meetings were. There wasn't really any kind of politicking about the meetings; people just came to hear papers and present papers and to have a lot of informal discussion. And I think of all of the organizations that I've ever belonged to, it was sort of a more fun organization of any. And then, of course, again another manifestation, trying to get pediatricians involved. I was ultimately elected to the Presidency succeeding Harold Stevenson. I should say one other very pleasant thing about the meetings was that it does meet every other year, and I think that even though people constantly raise the question as to whether it ought to be annually, I think it's a very nice characteristic that you don't have to start thinking of next year immediately after meetings. I think that that's been another fun aspect. One of the interesting developments in SRCD I think has been the growing awareness of the importance of child development as the knowledge base for public policy related to children and families, and that is

quite a switch, I think, in the ethos of the group. I remember, I think it may have been at the meeting when I gave the invited lecture, Bill Krogman, a physical anthropologist who was at Penn was the President, and I think his Presidential address was devoted to sort of cautioning against getting involved in anything practical or applied, and particularly policy that that sort of wasn't our business. But over the years there were various members who got interested and there's been a committee on public policy, which I have always thought was a very important development of SRCD. We even had the public policy fellowships with people working in various congressional offices to apply that knowledge base. So I think over the years SRCD has evolved pretty much in the way that I would have hoped it would evolve, and it seems to me it has grown as a consequence as the field has grown in numbers -

Tronick: I think if we were successful in policy and strategy over the past thirty years as we have been and acknowledged them -

Richmond: Well, I think that's a very important point that goes back to what I was commenting on earlier. I think we haven't yet figured out how to be the kinds of social strategists that we need to be. We had opportunities like Head Start, which, you know, has to move forward on a large scale, but we didn't complete the job, that's where I think we currently are. We constantly need to refine our knowledge base and I think all of the research that's ongoing becomes important in building the knowledge base, but I think the other arm is how can we apply what it is we know. I think we just haven't been as ingenious about that as we are in terms of personal research agendas.

Tronick: Well, I think the last few comments really were--

Richmond: Well, I think we've covered the SRCD sheet.

Tronick: And the issues of--well, in any of these areas it could go on quite a bit.

Richmond: I guess it might be worth adding another comment or two about SRCD governance. I haven't been close to the governance process in recent years, but when I was active it seemed to be--again there was a good deal of emphasis on identifying officers who hopefully made significant contributions in child development and who had a lot of commitment to turn the field forward, so I would come back to the fact that the various organizations that I belonged to--I think whatever political processes there are within the organization that worked more for moving the field forward, I think, that it's been a good deal of statesmanship among the officers of the organization.

Tronick: Well, you must have brought even your perspective to some tension between the research side and the policy side each to the organization, Krogman was saying no policy, let's stay away from that?

Richmond: Well, I think you know it was beginning to dawn on more and more people, and you have to remember at the Presidential address he gave came before Head Start, see and I don't want to make Head Start the focal point of all of this, but there was a growing awareness of the fact that we ought to take what knowledge we have about child development and use it to improve the lives of children and families on a larger scale. So I think that people like Harold Stevenson began to have an awareness of this, and as I came along later, by then it wasn't really all that much of a debate because people pretty much accepted the fact that we ought to figure out how to do this better. And Burt Brim, who had been very active in SRCD when he became President of the Foundation for Child Development to help get the funding for SRCD fellowships, and also by then there wasn't a lot of resistance, but as I keep pointing out we still haven't figured out how to really do it as well as we might. Now a lot of that is because we have to influence the political process in this country as much as the knowledge base we have is still not as well understood as it might be. And here I think I would say this self-critically, we haven't really engaged policy makers as fully and as technically as we should, and putting it another way I think we've been too timid about entering that policy arena. I think that we need to figure out how to get the knowledge base applied on a larger scale. I suppose in the light of political events in

these years we have to recognize that whatever we formulate isn't going to happen exclusively, because there are federal resources. I think we need to figure out how local community schools and whatever large scale expenditures we already have, how can we improve what happens as a consequence of those expenditures, so at the local level, at the state level and then with private resources level, I think we just need to figure out how to do that better.

Tronick: And would you like SRCD to be thinking at that scale?

Richmond: I think the Public Policy Committee at SRCD should be thinking about how one might make those sacrifices; after all we've got the richest, in the organization, the richest intellectual resources to bring to bear on these issues. We are citizens, so I think we shouldn't be timid about entering the political arena because we need to be heard just as any other group does as we bring expertise, perhaps more right to be heard, so yeah I think we intended to think in smaller terms rather than in larger terms.

Tronick: Well, you know, arguably it might be said that your involvement during the initiation around the Head Start--that with your involvement in that Head Start is possibly arguably one of our most successful social programs at some level of scale that this country has ever seen, and there are others, of course, and your involvement with--you know, you watched the transition of more children were being moved out of poverty than is currently the case, mortality rates were going down instead of going up for some groups, and there certainly was a momentum in it; seems to me that the 50's and 60's, as you pointed out, has dissipated.

Richmond: Right.

Tronick: How do you see us recapture or creating a new --?

Richmond: Well, I think, one by being much more explicitly engaged in coming back to a committee like public policy ought to be thinking large scale in terms not all in small demonstrations. I have nothing against that, but how do we go to scale with the knowledge that we have? What are the options? And the '90's aren't the 60's, and we can't recreate all of the enthusiasm that prevailed in the country for social programs as a consequence of the civil rights revolution and all of the social ferment that took place then. So in the 90's, and as we go into the next century, are we going to have to do this more incrementally? Are we going to have to do this in a more patchwork fashion, or are we going to be able to create some new institution? And I go back to thinking about the Mondale Brademas Child Development Bill, it was thought of as a Daycare Bill in '71, passed both Houses of Congress and was vetoed by Nixon. That would have created citizens councils somewhat comparable to school boards all around the country, and it wasn't a totally novel concept because the Scandinavian countries have had some analogs of that sort of thing. Well, we didn't get it then, we tried to resurrect something that's the analog of that, but again, I'm not sure that we would get large scale federal funding, although I don't think that's unfeasible either. How would one put state, local and federal resources together in the service of children everywhere? I do have the strong conviction that people of this country really do care about children, but they need to have some example of how you can care, that is, they need to have some programmatic vehicle for caring. Head Start, again, was a good example. We had volunteers coming out of the woodwork for Head Start; we couldn't use all of the volunteers in the first year. What we did was we succeeded in converting what was a latent interest in children and to a manifest interest, and I think if we could provide the right kind of vehicle, that we might convert what I think is the real interest in communities all across the country and to better care and educate our children. And I think nothing short of some kind of movement like this is going to do it. We still haven't invented that to get organizations like the Children's Defense Fund that are sort of examples of how this might happen, but they're not making it happen on a large enough scale, I don't think it's out of the realm of possibility that we can do this.

I come back to the fact that a few years ago we did some calculations indicating that to really provide for good childcare for all of the children in need for all of the preschool years, not just the Head Start

years, that you could do that for about twenty billion dollars, you know, I think that's not an unreasonable expenditure and it may well be that some of that's already being spent in appropriate ways. So I think that we've got to figure out how to really help citizens across the country understand that we can do more and better for children, but we haven't been creative enough, and sort of casting this in some programmatic terms, that's what Head Start was able to do. Of course, we did have dollars, we had come into a few million, so if you do a comprehensive program you have the dollars with which to do it, but you can't do it at the school-age level because there the schools are predominantly state and local funded, so you've got to figure out how to convert those dollars into more effective programs, and so it's going to take some real creativity.

Tronick: Thank you.

Richmond: Well, thank you.

Those who inspired and were influenced by Julius Richmond:

Mentors

Henry Poncher

David Shakow

Colleagues

Franz Alexander

Burt Brim

Uri Bronfenbrenner

Betty Caldwell

Bob Cook

Margaret Gerard

Sterling Gerard

Charles Gershenson

Mitch Ginsburgh

Frances Graham

Florence Hosch

Irene Joselyn

Bill Kessen

Bill Krogman

Earl Lipton

George Mohr

George Pollick

Carl Rogers

Bob Selman

Milton Senn

Sargent Shriver

Ben Spock

Harold Stevenson

Marietta Stevenson

Ed Tronick

Edward Zigler