Fig 1—Life expectancy and income inequality in post-transition eastern Europe

such an effect,¹⁷ although the overall contribution to changing life expectancy seems to be comparatively small.

Taken together, the mechanisms that have been advanced could account for greater mortality changes than have actually happened. This is probably because we are in some cases double counting—for example, the psychosocial effects of social disintegration will be expressed in increased alcohol and tobacco consumption and decreased self care. Direct psychological mechanisms, are, indeed, unlikely causes of mortality trends: the reduction in mortality in Britain since the late 19th century has hardly been accompanied by improved social support and social networks. Happiness, life satisfaction, and job satisfaction in Britain have changed little over the past 30 years, while death rates have continued to plummet.^{18, 19} The causes of death responsible for rising mortality in eastern Europe—coronary heart disease, lung cancer, and accidents¹⁴—are those that increased during a period of generally declining mortality in western Europe and the United States. As these diseases can increase while overall mortality is falling and economic progress is being made their accompaniment by a general worsening of health or increasing social disintegration is not inevitable. A mainly psychological attribution may be as one sided as earlier attempts to consider these conditions, which affect poor people, as diseases of affluence. At that time coronary heart disease was considered by many to be caused by type A behaviour—the rushed, time pressured businessman was the paradigmatic coronary case. This association, which soon stopped being apparent, was generated by socially conditioned perceptions of associations, which were then reified into pathophysiological mechanisms. As many plausible biological

pathways between type A behaviour and coronary heart disease were produced as is now the case for the currently fashionable psychosocial factors.

The problems psychosocial explanations have with accounting for trends and geographical differences in mortality are also seen with respect to the other categories of explanation. Consider (among many others) these paradoxes: low overall and cardiovascular disease mortality in Japan, a country with high smoking rates; the decreasing overall death rates during increases in smoking and dietary fat intake that occurred in many countries; and the low international correlations between past infant mortality rates or current birth weight and mortality from coronary heart disease. For different causes of death, and in different temporal and geographical situations, the determinants of mortality patterns will be distinct. Extrapolating from the past to the present and from one place to another is necessary for broad theorising on the underlying determinants of mortality trends but, in the end, this can only be the start of the more difficult empirical task of understanding the particular factors which act together to produce the patterns seen in any one specific instance.²⁰

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And God will fill the bullet holes with candy

Barbara J Genovese

Do not weep for them, madre.
They are gone forever, the little ones,
straight to heaven to the saints,
and God will fill the bullet-holes with candy.

NORMAN ROSTEN, *In Guernica* from *The Fourth Decade and Other Poems*, 1943

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I wish I could be very far from here—pretty much. I am secretly afraid of a lot of things—very much. I feel alone even when there are people around me—pretty much. I worry most of the time—very much. I worry about what my parents will say to me—very much. Often I have trouble getting my breath—very much. I have trouble swallowing—very much. My feelings are easily hurt—

very much. It is hard for me to go to sleep at night—very much. I feel someone will tell me I do things the wrong way—very much. I often feel sick in my stomach—very much. I worry when I go to bed at night—very much. I often worry about what could happen to my parents—very much. I get tired easily—very much. I am nervous—very much.

These answers were given by a 9 year old as he responded to questions on a psychological battery of tests that measured the mental health of children. Another section had to do with emotional support: "Who do you talk to when you're upset?" An innocuous enough question, as was his answer: "My brother." Then I asked, "How old is your brother?" "4."

In 1991 I moonlighted as a research assistant on a study to look at the mental health of children between the ages of 6 and 12 living in homeless shelters in Los Angeles County. The objectives of our study were threefold: to describe the mental health and academic problems among sheltered homeless children—depression, behaviour problems, severe academic delays, witness to violence; to identify which homeless children have more problems; and to relate the use of health services and mental health interventions to children's needs.

In our sample of 169 children, the following emerged in the battery of child mental health problems: depressive symptoms—37%; total behaviour problems—28%; receptive vocabulary delay—47%; reading delay—39%; and witness to violence—42%.

Fifty six per cent of the children were between the ages of 6 and 9; 44% were between 10 and 12. They were evenly divided between male and female. The ethnic breakdown was 44% black, 35% Hispanic, and 21% white. The mean age for the onset of homelessness was 7.6 years; 28% had been homeless for more than one year; 36% had been homeless for more than two months in the past year; and 48% had had two residences in the past year.

Of the parents we interviewed 61% had an income of less than \$10 000 (£15 000) and their mean age was 34.

Where home is the car

On my first day I sit in a church shelter in Venice, California, where I watch a child left in a corner of the sanctuary, wrapped in his shelter swaddling clothes. The woman who drops him there puts a bottle at the sleeping child's feet and shuffles off. When the apartments on the periphery of this shelter fill the overflow sleeps in the church. On the second day I interview a mother with six children, all of whom at one time or another interrupt for the car keys she keeps on a shoelace around her neck because her family lives in their car.

In a shelter in a Los Angeles barrio, there is a boy of about 7 whom the psychiatrist concludes is a victim of fetal alcohol syndrome. As his mother attempts to tutor him with his homework, I watch as he cringes under her

touch. The mother divides her attention between him and his 6 month old brother. She insists that her son has potential: "I know he can do it," she says, her voice raised in a kind of protest. Against what? Her present circumstances? The past? An uncertain future? It becomes obvious to me that the boy is going to be hit, has been hit, that the mother is preoccupied with the younger child who is thin and not breathing properly. I ask if I can help the boy with his homework. The mother acquiesces, then informs me that she is scheduled to see a doctor for her drug problem. But her words turn into a discontinuous babble of rage, as the boy comes over to his brother and winds up the musical toy in his hand.

I sit with the boy for an hour. His attention span is limited, his comprehension of simple maths abysmal. When I place my hand in comfort on his tiny shoulders, he is still and unyielding, his body armoured, at his tender age, against the belligerence and bullets of life. This image is strong, as the talk that day in this shelter is about the driveby shooting of a boy that some of the children witnessed the night before.

"Ugly. Sorry!!"

In another shelter on the eastern outskirts of the county a 9 year old girl becomes increasingly agitated as her mother talks about her in the interview. The girl notices the writing on my left hand. I write there to remind myself of things I have to do. The girl's actions are swift and impulsive as she begins writing on her arm. Hard. Deep. To break her obsessive, hurtful scripting, I scramble for paper and ask if she can write with her left hand, the hand she does not usually write with. She ravages the paper like a hungry child a loaf of bread, then runs out of the shelter, "away from home," as she has done countless times before.

After her return, she attacks her younger sister. She has done this before, even when the mother holds the child in her arms. I do not find her crumpled words on the floor until I am ready to leave: "I am stupid, I am ugly, I am crazy, I am trash, I am not special, I am not." Self deprecation colours another of the drawings one of the girls did for us. It is a picture of herself, captioned, "Ugly. Sorry!!"

Often I find that I do not want to think about what I am witness to, but I am pursued in a way I do not anticipate in that I take the homeless home with me: they invade my dreams and ask if they can sleep in my study. They speak in Spanish, capturing me in a language I do not comprehend. Images, sounds, smells, dreams of children who have no voice, who believe they have no rights, whose innocence is wounded daily, where overcrowding, for example, contributes to abuse on all levels because families cannot protect their children.

Happy with her feet in the air

There is a girl at the Salvation Army shelter who can tell her biggest secret to no one, who can talk to no one when she is really upset. She feels alone even when there are people around her. She was last in school five months ago. She does not get to wear what she wants and thinks her clothes are disgusting. She has to sleep under the heater so she always feels hot. She is in the shelter with her mother and sister and tells me she "takes care of them," yet when asked about how her family gets along says, "My mom and my sister are together but I'm always to the side." She likes to do her homework: "It makes me happy because it makes me feel like a teenager." This is because she gets to lie on her stomach [on the bed] and put her feet up in the air.

After she correctly identifies a picture of a marriage ceremony as an example of the word "ritual," she begins to improvise abstractly: "I don't much like funerals. I had to go to a funeral once. It was the funeral of my

friend. And I didn't really want to go. She had one of those things around her neck [a brace], and she was in a wheelchair. And she couldn't walk. Her father, he drinks sometimes, he's a drunk, but he wasn't drinking this time. And one night he comes home, and he wasn't drunk, but somehow he accidentally knocked my friend out of her wheelchair and she fell over and died." There is a momentary silence before she continues: "My father cries sometimes. And sometimes he fools me and only pretends to cry. And it makes me so angry when he does that because I can't tell when he's fooling."

I discover later that she was sexually abused at the age of 18 months by her mother's boyfriend, that she has seen a man shot. But for now, what I see is a young girl facing womanhood, who, like any teenager, likes to do her homework on the bed, her feet up in the air.

In a Watts shelter I interview two brothers. The younger speaks of his brother in adoring, stuttering words. He describes his coat to me (it is dirty and ugly), as "lovely." When his brother comes in his eyes are red.

After I read the consent form to him his words come out in a flood. He talks about a fall he has had in the bathroom and is quick to say that his mother does not hit him, except when he is bad. His talk becomes animated and fevered. He asks me if he would be taken away if he told. He is direct, frightened. When his mother comes into the room he stiffens, as do I. She is loud and abrasive, she does not have the time for the interview, she wants to do it tomorrow. The boy is restless, cannot focus or concentrate, and seems short of patience. He complains that his back hurts during the interview, and pulls up his shirt to show me—the bruise is halfway up his back. I report this to the psychiatrist, who, after questioning me, decides to file a suspected child abuse report with the county's social services.

Differences between surviving and flourishing widen

The litany of stories and the barrage of images begin to coalesce; the differences between surviving and flourishing widen. I see a woman haphazardly toss her child on to a sofa. The child's asthmatic cries are unrelenting, and his mother takes many minutes to return to him. She has had other children taken from her and placed in foster homes. She does not know where they are.

At some juncture the homeless stop asking to sleep in my house and the dreams in Spanish subside. I am left with the voices of children who will have no voice unless it erupts in violence or into the underbelly of our society. When you see the homeless, when you read about shelters, there is a stratum you do not see: invisible crisis children staring at you from the other side of statistics.

And I keep seeing the animation and fear on the faces of those children in east Los Angeles. These children of tender age, vulnerable spirit, wait for an advent of healing that will allow them to seal the bullet holes. Their stories are ones of violated innocence. And violated innocence is a crime against the spirit, a crime against our common humanity. As Emily Dickinson wrote: The Things that never can come back, are several—Childhood—some forms of Hope—the Dead.

Dances of death, occupational mortality statistics, and social critique

Johan P Mackenbach

In the late middle ages and early renaissance dances of death were a popular art form. Despite important differences in outlook, the moral messages of these art forms and of modern analyses of socioeconomic inequalities in mortality overlap considerably. This theme has survived in modern dances of death, which are popular in certain parts of Europe, especially in Germany and other German speaking countries in central Europe, and are clearly inspired by the late medieval and early renaissance examples. In the modern dances of death, however, unlike their historical counterparts, social critique (criticism of social inequality) is almost absent, although they include representations of differences between people in social position. Remarkably, references to socioeconomic inequalities in mortality, which have been documented extensively, are also uncommon in the modern examples. This raises important questions about public perception of social inequality in general and socioeconomic inequalities in mortality in

particular, and it suggests that modern Western society has not developed the cultural means of conveying the moral message that follows from research into socioeconomic inequalities in health.

Dances of death were once an immensely popular art form throughout Europe.¹⁻⁷ The two most common types were mural paintings in churches or cemeteries and wood cuts in books. Some of the mural paintings can still be found, especially in France (where they are called *danses macabres*) and in the German speaking part of central Europe (*Totentänze*). The most important British example was a mural painting in Pardon Churchyard, near St Paul's Cathedral in London. This was an imitation of one of the earliest and most famous dances of death, the now lost *danse macabre* of the Saints Innocents cemetery in Paris, which was painted in 1424-5. The London version was executed by an unknown painter around 1430 and destroyed in 1549. Only the poems, translations from the French by

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