73 NAMING MALE AND FEMALE GENITALIA, Betsy Lozoff, Israel Weisberg, (Spon. by Marshall Klaus), Case Western Reserve U. School of Med., Dept. of Peds., Cleveland.

To document the clinical impression that young girls in the U.S. are given little or confusing information about their external genitalia, families were interviewed and preschool books and toys evaluated. 30 highly educated mothers were asked by their pediatrician about the terms for genitalia they used with their 25 female and 31 male children between 1 and 18 years of age. Mothers used words for male external genitalia with 100% of their boys, and words for testicles in addition to penis were reported for 39%. Only 8% of the girls were given a specific label(s) for their external genitalia; vagina was the sole sex organ term for 88%. Women reported with regret that they had learned words for their own external genitalia only in adolescence or adulthood. Yet they had not provided their girls with a different experience.

Of the recent books on sex and reproduction for children grade 1 or below available in local libraries and bookstores, the few which dealt explicitly with anatomical sex differences were similarly misleading. Of these 11 books, only 1 used a term for female external genitalia, but all labeled the male. "Anatomically correct" dolls showed male genitalia, penis and scrotum. So-called female dolls had no genitalia. Neither parents, books nor toys help the young girl identify and understand her major sex organs. This avoidance or omission may reflect a persisting intrapsychic and societal discomfort with the external female genitalia and may interfere with the little girl's pride and pleasure in those genital parts most interesting and important during toilet training and the preschool years.

74 THE CHOOSE PROGRAM: INTEGRATED OUTREACH TO COORDINATE HEALTH AND SOCIAL SERVICES. A. Harold Lubin, Janet L. Kasler, Audre J. Mixon, Shirley A. Randolph, The Ohio State University College of Medicine, Children's Hospital, Columbus, OH

Eight years of outreach experience for a community children's categorical lead screening program have documented unmet health and social needs in Columbus, Ohio. These needs prevail despite the existence of available public health services including: WIC, Food Stamps, C & Y Clinics, and a variety of other community health services. Outreach workers have observed that many people either are unaware of available local resources or of their own or their family member's needs for such services, or have been frustrated by their own inability to understand the mechanisms required for enrollment for and utilization of services. The CHOOSE (Comprehensive Health Outreach Organized Service Effort) Program has been devised to implement organized preventive health measures, to monitor effectiveness of such programs, and to provide active coordinating and follow through mechanisms. Experienced outreach workers, in step vans, will contact individuals door to door. They will administer a brief questionnaire to determine level of prior health care and involvement with any health delivery system. Workers in the van will screen for adequacy of prior immunizations, nutritional and dental status, and developmental, iron, and lead status. Children with problems will be referred to the nearest facility. Ongoing contact with the facility personnel and the referred child's family will monitor effectiveness and provide consistent follow through. Demonstration of effectiveness of such a comprehensive integrated outreach concept may have significant application for other cities throughout the United States.

75 CIRCUMCISION: THE EFFECT OF INFORMATION ON PARENTAL DECISION MAKING. M. Jeffrey Maisels, Barbara Hayes, Sarah Conrad and Ronald A. Chez. Penn State Univ College of Medicine, M. S. Hershey Medical Center, Depts of Pediatrics and Obstetrics and Gynecology, Hershey, PA.

Circumcision is performed routinely on virtually all male infants in the U.S. although there are no valid medical indications for this procedure and parents rarely are informed about the operation or its risks. At 30-34 weeks, we randomly assigned prenatal patients to receive or not to receive written information about, and a description of, circumcision. The information was based on the report of the American Academy of Pediatrics (1975). 39 healthy term male infants were delivered; 15 of their mothers received the written information (Group A) and 24 did not (Group B). 14 of 15 Group A infants and 23 of 24 Group B infants were circumcized. A questionnaire was administered to the parents after circumcision was (or was not) performed. There were no significant differences between the groups with regard to the following: parental age, education and occupation; understanding of the circumcision procedure and its benefits and risks; reasons for wanting circumcision; satisfaction with the amount of information received. In Group A, 5 of 15 did not know what circumcision was and 11 said the information did not lead to further discussion and played no part in their decision. We conclude that providing this information to mothers has no role in the decision for or against newborn circumcision.

76 A COMPARISON OF THE PATTERNS OF BEHAVIORAL RESPONSE DECREMENT IN PRETERM AND TERM INFANTS DURING SLEEP. Kay Malee, Mary Dernbach, William Burns (Spon. by Carl E. Hunt) Northwestern University Medical School, Prentice Women's Hospital, Dept. of Pediatrics/Psychiatry, Chicago.

The responses of preterm and term infants to visual and auditory stimuli during the sleep state were compared and their capacity for self-organization as reflected in the pattern of their inhibition of behavioral reactions to disturbing stimuli was analyzed. A light, rattle, and bell were repeatedly presented (10 in a series according to Brazelton Scale) to preterm infants (n=10) at a mean conceptual age of 34 weeks (S.D.$\pm$0.6) and 36 weeks (S.D.$\pm$0.6). Term infants (n=10) were also administered the same response decrement measures on the second postnatal day. The level of response decrement to light, rattle, and bell was significantly higher ($p < 0.05$) for term infants than for preterm infants. However, differences between 34 and 36 week old infants were not statistically significant. Throughout the presentation of visual and auditory stimulation, term infants exhibited less ($p < 0.05$) physiological and motoric disorganization than did preterm infants; they maintained greater state control, exercised better self-regulation and required less consoling. Preterm infants often reach appropriate weight criteria for discharge from intensive care nurseries by 36 weeks conceptual age. The findings of this study suggest that the capacity to disregard disturbing stimuli is significantly reduced in preterm infants. Adjustments in caretaking practices are indicated if such differences exist.

77 SOCIAL FACTORS RELATED TO CIGARETTE SMOKING IN CHILDREN: THE MUSCATINE STUDY. James L. Massey, Ronald L. Akers, William R. Clarke, and Ronald M. Lauer, Departments of Sociology, Preventive Medicine, and Pediatrics, University of Iowa, Iowa City, Iowa 52242

Children (n=2194) ages 12 to 18 years were surveyed for cigarette smoking practice. A questionaire validated by a randomized question response, "bogus pipe-line", and salivary thiocyanate analyses was administered. Regular smoking was present in 9.6% of children 12-15 years; 20% in children 15-18 years. A strong relationship of smoking behavior was observed between the number of significant others smoking:

	Significant Others Smoking (%)					
Smoking Behavior	None	One Parent Only	Two Parents	Best Friend Only	One Parent and Best Friend	Both Parents and Best Friend
never	75	68	62	28	21	16
regular	1	3	6	26	30	44

Of children not smoking 84% viewed smoking harmful to their health; of children regularly smoking 72% viewed smoking neither harmful nor beneficial. Parents and friends were thought to be permissive of smoking by regular smokers and discouraging by non-smokers. These data suggest that children's smoking habits strongly reflect the attitudes and behaviors of their parents and friends.

78 SOCIAL SUPPORT AND STRESS IN MOTHERS OF ASTHMATIC CHILDREN: RELATIONSHIP TO MORBIDITY. Fernando S. Mendoza, John A. Martin, Ruth T. Gross, Iris F. Litt, Norman J. Lewiston, Joann Blessing-Moore, Stanford University School of Medicine, Department of Pediatrics, Stanford, California

Social support and stress have been shown to modify the course of chronic illness in adults. This has not been examined in the pediatric population although clinical observations suggest that maternal social support and stress may affect the outcome of a child's chronic illness. This study examines the relationship between these maternal factors and the asthmatic child's morbidity.

A group of 35 mothers of asthmatic children seen at Children's Hospital at Stanford completed a questionnaire assessing their social support, stress and compliance with medical care. Baseline morbidity data were collected by maternal recall of emergency room visits (ER) and hospitalizations for the child's asthma over the past year, type of medication used and the mother's perception of the severity of the asthma.

Chi-square analysis of the data showed: 1) mothers with low social support perceived increased severity of their children's asthma, 2) children of mothers with small social networks had more ER visits per year and 3) while maternal stress alone was unrelated to morbidity, mothers who had both high stress and small social networks had children with more ER visits per year than other groups. Neither social support nor stress were related to the degree of asthma, seasonality or type of medication used.

These data suggest that measures of maternal social support and stress can delineate a subgroup of mothers whose children have higher morbidity and who may derive maximum benefit from supportive care by health professionals.