AMERICAN CIVIL LIBERTIES UNION FOUNDATION
New Jersey

P.O. Box 32159
Newark, NJ 07102

Tel: 973-642-2086
Fax: 973-642-6523

info@aclu-nj.org
www.aclu-nj.org

ALEXANDER SHALOM
Senior Supervising Attorney

973-854-1714
ashalom@aclu-nj.org

October 1, 2018

VIA ELECTRONIC FILING
Honorable Chief Justice and Associate Justices
Supreme Court of New Jersey
25 Market Street
Trenton, New Jersey 08625

Re: State v. A.M. A-76-17 (080744)
App. Div. Docket No. A-2090-13T2

Honorable Chief Justice and Associate Justices:

Please accept this letter brief in lieu of a more formal submission from *amicus curiae* the American Civil Liberties Union of New Jersey (ACLU-NJ) in the above-captioned matter.

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PRELIMINARY STATEMENT

This case raises the question of how a court should evaluate instances where police officers fail to elicit critical information when seeking to have defendants waive their constitutional rights. The law is clear: because the State bears a heavy burden of establishing that a person knowingly waives his or her rights, courts cannot excuse the State for its failure to develop a robust record proving the validity of the waiver. (Point I).

In the interrogation at issue, police properly advised the Defendant of his rights, but failed to properly obtain a waiver of his rights. Because those are each critical portions of the *Miranda* process, the trial court erred by focusing exclusively on Defendant's understanding of his rights, rather than his waiver of them. (Point I, A).

New Jersey's jurisprudence instructs reviewing courts to defer to the factual findings of lower courts, assuming that they are supported in the record. However, appellate courts owe no deference to trial court's legal conclusions (such as allocation of the burden of proof) nor their factual findings that are not supported by sufficient credible evidence. (Point I, B).

The trial court's determination that Defendant would have asked clarifying questions had he not understood the printed waiver reflects both a legal error – this constitutes improper burden

shifting – and is not supported by the record. (Point I, B. 2). Indeed, all of the trial court's assumptions about how Defendant would have proceeded had he not understood the written waiver instructions (that were never read to him) reflect a profound misunderstanding of the well-documented coping mechanisms of people who are illiterate or have low literacy. (Point I, B, 2).

STATEMENT OF FACTS/PROCEDURAL HISTORY

Amicus ACLU-NJ adopts the facts and procedural history contained in the Appellate Division's opinion, *State v. A.M.*, 452 N.J. Super. 587 (App. Div. 2018). For clarity, *amicus* recounts the following facts: Police sought to interrogate A.M., who was more comfortable speaking in Spanish than English. *Id.* at 591. One police officer asked questions and another officer, who grew up speaking Spanish, translated the "questions to defendant from English into Spanish and [D]efendant's answers from Spanish into English." *Id.* The interrogating detective gave Defendant a *Miranda*[1] rights waiver form written in Spanish. *Id.* at 592.

The Spanish-speaking officer read aloud in Spanish each of the *Miranda* rights. *Id. See also* DA[2] 123-124 (informing Defendant of the rights to remain silent, to refuse to answer questions, to speak to an attorney, to have an attorney present, to obtain an

[1] *Miranda v. Arizona*, 384 U.S. 436 (1966).
[2] DA refers to the Appendix to Defendant's Appellate Division brief.
P.Cert. refers to the State's Petition for Certification.

assigned attorney if indigent, and to stop questioning at any point and explaining that anything he chooses to say can be used against him). After the list of *Miranda* rights, the officer told Defendant to write his name and sign the waiver form. *Id.*

According to the Appellate Division, "[t]he video record shows [D]efendant appearing to read to himself the waiver part of the *Miranda* form that was written in Spanish." *Id.* at 593. But no law enforcement office ever read the waiver paragraph in the *Miranda* form aloud, as they had with the recitation of rights. *Id.* Instead, the Spanish-speaking officer "pointed to the sections in the waiver form and told [D]efendant: 'Write your name in the line -, complete. And you have to sign here, the line is not there, but you have to sign.'" *Id.*

The State's witness at the hearing conducted pursuant to *N.J.R.E.* 104(c) acknowledged that no one asked Defendant about his level of education; no one determined whether he was literate in Spanish; no one asked him to read the waiver provision out loud; and, indeed, the word "waiver" was never mentioned. *Id.* at 598.

Notwithstanding this, the trial court denied Defendant's motion to suppress his statement. The court held that Defendant "was given an opportunity to read the waiver paragraph and signed the waiver portion, and did in fact review the waiver portion before signing it." *Id.* at 594. The trial court described Defendant as "alert and cognizant while the [*Miranda*] form [was] explained

to him and while he signed the form, stopping the officers on multiple occasions to ask questions, repeatedly acknowledging his comprehension of the process, and correcting the officers when they misunderstood what he [had] said." *Id.* (alterations in Appellate Division opinion). A review of the interrogation transcript belies the trial court's assessment: During the *Miranda* process, Defendant asked no questions and never corrected the officers. DA 122-124.

The Appellate Division reversed, holding that the trial "judge's analysis improperly shift[ed] the burden of proof to [D]efendant to alert the interrogating officers about any difficulty he may be having understanding the ramifications of a legal waiver." *A.M.* 452 N.J. Super. at 599. The Appellate Division concluded that "the State did not prove, beyond a reasonable doubt, that [D]efendant knowingly and intelligently waived his rights under *Miranda*." *Id.* at 600. Judge Fuentes filed a concurring opinion in which he discussed what he found to be "inherent constitutional flaws associated with relying on untrained, presumptively partial police officers to act as interpreters during custodial interrogations of limited English proficient suspects." *Id.* at 600 (Fuentes, J., concurring).

This Court granted the State's Petition for Certification. The ACLU-NJ filed a Motion for Leave to Appear as *Amicus Curiae* contemporaneous with this brief.

ARGUMENT

I. THE STATE DID NOT SHOULDER ITS HEAVY BURDEN OF PROVING THAT DEFENDANT WAIVED HIS RIGHTS UNDER *MIRANDA*.

To establish a waiver of *Miranda* rights in New Jersey courts, prosecutors must meet a greater burden than in federal courts. *State v. O'Neill*, 193 N.J. 148, 168 n. 12 (2007).[3] "Under our state law, the prosecution at a *Miranda* hearing must prove beyond a reasonable doubt that a defendant's waiver of the privilege was knowing, intelligent, and voluntary[.]" *Id. quoting State v. Presha*, 163 N.J. 304, 313 (2000). The State failed to prove, beyond a reasonable doubt, that Defendant's *Miranda* waiver was knowing, intelligent and voluntary.

A. There Exists A Difference Between Understanding Rights and Waiving Them.

There exist two stages to the *Miranda* process: warning and waiver. During the warning stage, a suspect "must be warned that he has a right to remain silent, that any statement he does make may be used as evidence against him, and that he has a right to the presence of an attorney, either retained or appointed." *Miranda*, 384 U.S. at 444. After having been given the warnings, a "defendant may waive effectuation of these rights, provided the waiver is made voluntarily, knowingly and intelligently." *Id.* But,

[3] Under federal law, prosecutors must establish a valid waiver by a mere preponderance of the evidence. *O'Neill*, 193 N.J. at 168 n. 12 citing *Colorado v. Connelly*, 479 U.S. 157, 168 (1986).

"a valid waiver will not be presumed simply from the silence of the accused after warnings are given or simply from the fact that a confession was in fact eventually obtained." *Id.* at 475.

The State contends that Defendant implicitly waived his rights. P.Cert. 16-18. The United States Supreme Court, utilizing its lesser standard of proof, has held that a defendant needs to make an unambiguous assertion of the right to remain silent and his failure to do so, could constitute an "implicit waiver." *Berghuis v. Tompkins*, 570 U.S. 370, 381-82 (2010). And although it is true that "[t]he test is the showing of a knowing intent, not the utterance of a shibboleth[,]" *State v. Kremens*, 52 N.J. 303, 311 (1968), New Jersey courts have never suggested that a defendant's answering of questions after having received *Miranda* warnings relieved the State of the burden of proving waiver. Indeed, in *Kremens*, the Court relied on the defendant's "words and conduct" to find a valid waiver. *Id.* at 310. In other cases where appellate courts have found valid waivers in the absence of a written waiver, they have deferred to trial courts' findings that examined the totality of the circumstances. *See*, *e.g.*, *State v. Faucette*, 439 N.J. Super. 241, 262 (App. Div. 2015) ("We determine the facts support the conclusion that defendant knew and understood his rights, which he intelligently, knowingly and voluntarily waived in admitting his culpability."); *State v. Warmbrun*, 277 N.J. Super. 51, 61-62 (App. Div. 1994) (noting reasons for

deference to trial court's well-supported factual finding of a valid waiver). As discussed below, that deference is required only when the trial court's factual findings are supported by sufficient credible evidence.

B. Appellate Courts Do Not Owe Deference to a Trial Court's Legal Conclusions or to Factual Findings That Are Not Supported By The Record.

As the Appellate Division acknowledged, this Court's decision in *S.S.* governs the standard of review in cases where a defendant seeks to suppress an inculpatory statement:

> Generally, on appellate review, a trial court's factual findings in support of granting or denying a motion to suppress must be upheld when "those findings are supported by sufficient credible evidence in the record." In the typical scenario of a hearing with live testimony, appellate courts defer to the trial court's factual findings because the trial court has the "opportunity to hear and see the witnesses and to have the 'feel' of the case, which a reviewing court cannot enjoy."
>
> We have cautioned that a trial court's factual findings should not be overturned merely because an appellate court disagrees with the inferences drawn and the evidence accepted by the trial court or because it would have reached a different conclusion. An appellate court should not disturb a trial court's factual findings unless those findings are "so clearly mistaken that the interests of justice demand intervention and correction."
>
> [*A.M.*, 452 N.J. Super. at 596-597 (*quoting State v. S.S.* 229 N.J. 360, 374 (2017)) (internal citations omitted by Appellate Division).]

The panel below was also mindful that the deferential standard of review applied equally where the trial court's factual findings relied exclusively on video or documentary evidence. *Id.* at 597 (*citing S.S.*, 229 N.J. at 379).

Notwithstanding that, the panel correctly acknowledged that it did not owe deference to the trial court's legal conclusions or its factual findings that were not supported by sufficient credible evidence in the record. *Id.* at 579. In this case, the trial court's determination that Defendant knowingly and intelligently waived his *Miranda* rights relied on both significant legal errors and factual findings not supported by sufficient credible evidence. The Appellate Division panel properly showed those errors no deference.

1. Failure to Raise Questions About Waiver Does Not Constitute a Knowing Waiver.

The trial court acknowledged that officers never read Defendant any language about waiver, but concluded that "it is clear from reviewing the video tape that [D]efendant was given an opportunity to read the waiver paragraph and signed the waiver portion, and did in fact review the waiver portion before signing it." DA 97. This conclusion – although unassailable on its face – proves nothing. Whether a person reviews critical information is of no moment: the critical inquiry is whether he understood it.

The State adduced no information about Defendant's literacy or comprehension.

The trial court relied on the fact that Defendant "appear[ed] alert and cognizant while the form [wa]s explained to him and while he signed the form, *stopping officers on multiple occasions to ask questions,* repeatedly acknowledging his comprehension of the process*, and correcting the officers when they misunderst[ood] what he [] said.*" *Id*. at 97-98 (emphasis added). The transcript of the interrogation belies that conclusion. Indeed, during the *Miranda* warning and waiver portions of the interview (*Id.* at 122-124), Defendant asked *zero* questions and never corrected anything the officers said. The only answers Defendant gave during that portion of the interview were "Uh-huh," "Okay," "Yes" and "Yes, I understand." *Id.* The last answer was provided only when officers asked Defendant to turn off his cellphone. *Id.* at 124. Put simply, the trial court's conclusion that Defendant was an active listener, giving cues about his comprehension finds no support in the record and is not entitled to deference.

Worse still, the trial court concluded that "If [D]efendant had any problems reading the waiver portion of the form, written in Spanish as he had requested,[4] it is clear to this court that he

[4] Defendant did not request a written form in Spanish. He indicated that he was more comfortable conducting the (spoken) interrogation in Spanish. Defendant never indicated that he could read Spanish or any other language.

would have voiced such difficulty." *Id.* at 98. The State describes this conclusion as a "common sense observation" and "reasonable" "factual inferences[.]" P.Cert. 16. In contrast, the Appellate Division described the trial court's legal conclusion as "improperly shift[ing] the burden of proof to [D]efendant to alert the interrogating officers about any difficulty he may be having understanding the ramifications of a legal waiver." *A.M.*, 452 N.J. Super. at 599.

The State's "heavy burden" to demonstrate valid *Miranda* waivers, *Miranda*, 384 U.S. at 475, requires proof beyond a reasonable doubt, *Presha*, 163 N.J. at 313, based on the totality of the circumstances. *State v. Yohnnson*, 204 N.J. 43, 59 (2010). Put differently, defendants are not required to demonstrate their lack of understanding: the State must prove knowledge and that the waiver was also intelligently entered into and voluntary. Here, other than Defendant's failure to convey his lack of comprehension, there exists no evidence that Defendant understood the waiver instructions – indeed, there is no evidence that those instructions were ever meaningfully conveyed to him. In its Petition for Certification, the State relies on the officer's testimony that Defendant "'physically' read the *Miranda* form." P.Cert. 14 (*citing* 1T46-8 to 9; 60-21 to 25). Such reliance is meaningless: one does not "physically" read anything. Perhaps the officer intended to reference the fact that Defendant kept his eyes trained on the

Miranda form for some period of time – a fact also relied upon in the Petition for Certification. *Id.* at 15 (*citing* video of interrogation). But that simply proves that Defendant saw words on a paper, not that he could comprehend them. On the critical inquiry – whether Defendant understood that he was being asked to waive his rights – the record was devoid of any evidence to indicate that he did.

2. *The Trial Court's Conclusions About People Who Cannot Read Were Clearly Erroneous*.

As noted, the record is bereft of any information about Defendant's literacy. But the trial court's conclusions about how a person would behave if he were unable to read are also not supported by research regarding behavior of people with limited literacy skills. As noted above, the trial court's conclusion that "If defendant had any problems reading the waiver portion of the form, written in Spanish as he had requested, it is clear to this court that he would have voiced such difficulty[,]" DA 98, improperly shifted the burden to the Defendant. It also misunderstands how people who struggle as readers cope with that limitation.

There exists a strong correlation between difficultly reading and shame. Nina S. Parikh, et al. "Shame and health literacy: the unspoken connection" *Patient Education and Counseling*, V. 27,

Issue 1 (1996), p. 36; AA04.[5] In the context of medical care, researchers have concluded that shame "actually inhibit[s] low literate patients from admitting their reading difficulties, seeking help to comprehend and complete medical forms, or asking questions regarding their healthcare." *Id.* at AA06. The details are even more illuminating:

> Only two-thirds of the patients with low functional health literacy admitted that they had trouble reading. Even among those who admitted difficulty reading, complete disclosure was unusual. Of the 40% who admitted both difficulty reading and shame, two-thirds had never told their spouse, one-half had never told their children, and 19% had never before told anyone.
>
> [*Id.*]

These stark conclusions apply beyond the medical realm. Psychologists have noted that "stigmatization of the illiterate induces them to feel shame and guilt regarding their lack of reading and writing ability. They often engage in elaborate ruses or avoidant behaviors to disguise their inability to read. Family members are, in many cases, not informed regarding their shameful secret." Robert N. Sollod, "Behavioral Science and Adult

[5] The article, although publicly available, cannot be found in full text online. As a result, it is appended to this letter brief. Citations to the Appendix are listed as AA.

Illiteracy: becoming Part of the Solution" *Behavior Analysis and Social Action*, V. 6, No. 1 (1987), p. 23; AA09.[6]

This is not a problem small in scope: According to the U.S. Department of Education and the National Institute of Literacy, "Approximately 32 million adults in the United States" cannot read. Valerie Strauss, "Hiding in plain sight: The adult literacy crisis" *Washington Post*, Nov. 1, 2016, available at https://www.washingtonpost.com/news/answer-sheet/wp/2016/11/01/hiding-in-plain-sight-the-adult-literacy-crisis. Even more troubling, the Organization for Economic Cooperation and Development found that half of American adults cannot "read a book written at an eighth-grade level." *Id.*

Given the prevalence of illiteracy and low literacy, and given that many people cope with reading difficulties through denial, the trial court's observations about Defendant's likelihood of speaking up if he had comprehension concerns cannot be fairly characterized as "common sense observations." The State's contention that "the judge's factual inferences were reasonable," is not supported by social science. Put differently, even if the trial court had not improperly allocated the burden of proof, and even if the trial court's recollection of Defendant's conduct during the warning and waiver portions of the interrogation had

[6] This article is also included in the Appendix for the reader's ease.

been correct, the trial court's conclusions about the implications of Defendant not voicing concerns about the waiver were improper.

CONCLUSION

For the foregoing reasons, this Court should affirm the decision of the Appellate Division.

Respectfully submitted,

ALEXANDER SHALOM (201162004)
JEANNE LOCICERO
AMERICAN CIVIL LIBERTIES UNION OF NEW JERSEY FOUNDATION
Counsel for *Amici Curiae*

Dated: October 1, 2018

AMICUS ACLU-NJ'S APPENDIX

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PATIENT EDUCATION AND COUNSELING

Shame and health literacy: the unspoken connection

Nina S. Parikh, Ruth M. Parker,* Joanne R. Nurss, David W. Baker, Mark V. Williams

Department of Medicine, Emory University School of Medicine, 69 Butler Street, Atlanta, GA 30303, USA

Abstract

Illiteracy is a well known national crisis, yet relatively little research has focused on how low literacy affects patients' health care experiences. The purpose of this study was to determine the relationship between shame and low functional literacy in the health care setting. It hypothesized that many patients with low literacy may not admit they have difficulty reading because of shame. Patients who presented for acute care at a large, public hospital in Atlanta, Georgia were interviewed. A total of 202 predominately indigent African-American patients completed a demographic survey, the Test of Functional Health Literacy in Adults (TOFHLA) and answered questions about difficulty reading and shame. Of the 202 patients interviewed, 42.6% had inadequate or marginal functional health literacy. Patients with low literacy were more likely to be male ($P < 0.05$), have less than a high school education ($P < 0.01$) and be over the age of 60 ($P < 0.01$). Of those patients with low literacy, 67.4% admitted having trouble reading and understanding what they read. Almost 40% ($n = 23$) of patients with low functional literacy who acknowledged they have trouble reading admitted shame. Of the 58 patients who had low functional health literacy and admitted having trouble reading, 67.2% had never told their spouses, and 53.4% had never told their children of their difficulties reading. Nineteen percent of patients had never disclosed their difficulty reading to anyone. Many patients with reading problems are ashamed and hide their inability to read. Shame is a deeply harbored emotion that plays an important role in understanding how low literate patients interact with health care providers. Further research is needed to understand how providers should deal with the shame associated with low literacy.

Keywords: Functional health literacy; Low literacy; Shame

1. Introduction

Illiteracy is one of our nation's major social problems. The recent National Adult Literacy Study conducted by the National Center for Educational Statistics found that 40–44 million people perform at the lowest literacy skill level [1]. Of note, 66–75% of adults in the lowest level describe themselves as being able to read 'well' or 'very well'. Lack of adequate literacy may be an important barrier to receiving high quality care. Patients are routinely expected to read and understand medication labels, appointment slips, consent forms and health education materials. Prior studies in the health care setting have

* Corresponding author. Tel.: (+1-404) 616-6627; Fax: (+1-404) 616-5485.

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shown that medical information given to patients often is above their reading level [2–8], and that a significant number of patients are low literate [9,10]. As a result, current patient educational materials are inaccessible to millions of Americans. In addition, the shame and embarrassment felt by some low literate patients may pose an important psychological barrier to asking for help or requesting low literate materials, even when they are available.

In 1992, we began the Literacy in Health Care Project sponsored by the Robert Wood Johnson Foundation to measure the prevalence of functional literacy in the health care setting and examine the impact of low literacy on the health care experience. The Test of Functional Health Literacy in Adults (TOFHLA) was developed to assess patients' functional health literacy using actual materials from the hospital setting, such as prescription vials, appointment slips, and an informed consent [11]. In our initial work, we used focus groups and individual interviews of low literate patients to determine perceived problems in obtaining medical care and patients' coping mechanisms for these problems. Among the results from this qualitative research was the finding that low literacy is a tremendous source of shame. Many patients said they tried to hide their reading problems, and some patients even recounted times when they did not seek care because of embarrassment about their illiteracy [12]. This background research led to the hypothesis that shame may actually inhibit low literate patients from admitting their reading difficulty, cause them to delay seeking help when needed to comprehend and complete medical forms, or prevent them from asking questions regarding their health care.

Shame has received increased attention over the past decade. Shame is very personal and often times unspoken; it is a very complex and painful emotion of individuals who feel inadequate and exposed. Nathanson, a leading expert on shame has stated, 'There may be no emotion that wounds as deeply as shame, no pain so searing' [13]. Because shame is so painful, its source is often denied or disavowed. This leads to a profound secrecy about shame and the perceived defect giving rise to it.

Comprehensive Medline and social science literature searches revealed discussions about the stigma of illiteracy [14] and poor self-esteem of low literate individuals [15]. There were no articles dealing specifically with the impact of shame among patients who are low literate. The goals of this study were to identify a group of patients with low functional health literacy, assess their disclosure of their difficulty reading, inquire about coping mechanisms, and question them in a limited interview about shame.

2. Methods

A sample of 202 patients was recruited from the emergency department and the walk-in clinic at Grady Memorial Hospital in Atlanta, Georgia between March and May 1994. Grady Memorial Hospital is an approximately 1000-bed public hospital; the vast majority of its patients are African-American, indigent residents of Fulton and DeKalb counties. The non-appointment acute care clinics are the site of more than 250 000 patient visits yearly. The study and survey design were approved by the Human Investigation Committee of Emory University and Grady Memorial Hospital. The survey consisted of a demographic inventory, the Test of Functional Health Literacy in Adults (TOFHLA), and questions regarding difficulty reading and shame.

The survey was performed by research assistants, each of whom had at least 15 h of training, which focused on interviewing techniques, administering the survey and the TOFHLA, and being sensitized to low literacy and shame. Accuracy of the results was verified by the project coordinator.

The TOFHLA was developed using medical or health related texts, not just isolated words [11]. Previous work has shown the TOFHLA to be a reliable and valid measure of patients' functional health literacy in the health care setting [11]. The test consists of two parts: reading comprehension and numeracy. The reading comprehension portion is a 50-item test using a modified Cloze procedure; that is every fifth to seventh word in a

passage is omitted and four possible options are provided. Passages include the Rights and Responsibilities section of a Medicaid application form, and a portion of a standard informed consent document. The numeracy section is a 17-item test using actual hospital forms and labelled prescription vials. It tests a patient's ability to read and comprehend directions for taking medicines, monitoring blood glucose, keeping medical appointments, and obtaining financial assistance. The numeracy score is multiplied by a constant, 2.941, to create a score from 0 to 50, the same range as for the reading comprehension section. The sum of the reading comprehension and the numeracy scores yield the TOFHLA score, which range from 0 to 100.

Item difficulties (*P*-values and bi-serial correlations) for each TOFHLA response have previously been calculated to obtain median difficulties of 72% for the reading comprehension section and 64% for the numeracy section [11]. Based on the difficulty and clinical importance of individual items, the total TOFHLA score is divided into three categories: inadequate, marginal, and adequate. A person scoring 59 or less is considered to have inadequate functional health literacy and understands less than 60% of standard health care information on the test. Scores between 60 and 74 are considered marginal, and a score of 75 or greater indicates adequate functional health literacy. For the purposes of this paper, we combine inadequate and marginal scores (0–74) into the category of low; patients scoring between 75 and 100 constitute the group with adequate functional health literacy.

Patients who were waiting to see a physician were asked by a research assistant to participate in the study. Exclusion criteria included: previous enrollment in the study, age less than 18 years, unintelligible speech, overt psychiatric illness, lack of cooperation, English as a second language, too ill to participate, visual acuity greater than 20/100, and refusal. Patients were told participation was voluntary and confidentiality was emphasized to each individual. All questions except the TOFHLA were read to the patient, and responses were recorded using an interview instrument. After obtaining informed consent, research assistants gathered demographic data, administered the TOFHLA, and finally asked questions about difficulty reading and shame.

Questions regarding difficulty reading and shame began in a hypothetical format. In other words, the first series of questions asked the patient about people in general and what the patient thought about their responses and behaviors. Patients were then asked if they thought people would hide trouble reading and understanding what they read, why they thought patients would hide their difficulty reading, how they thought it would make someone feel if they had to tell someone in the hospital about it, and if they thought people are ashamed when they have trouble reading. A five-point Likert scale was used in questions related to disclosure of reading trouble and shame. Next, we asked more directly personal questions. We began with asking if they, themselves, ever have trouble reading or understanding what they read. If the patient responded no, the interview ended. If the patient's response was yes or sometimes, we asked four additional questions: who other than the patient knows they have trouble reading, how often they bring someone to the hospital to help them read things, whether they feel ashamed about having trouble reading and understanding what they read, and how they feel about having trouble reading and understanding what they read. The entire interview took approximately 30 min. Upon completion, the patient was escorted back to the waiting area. The patient's care was not interrupted nor was his or her waiting time extended as a result of the interview.

Data were analyzed using Epi-Info [16]. Responses to open-ended questions were reviewed and response categories defined based on the most common themes. Responses were assigned to these categories by one of the investigators (NP). Unadjusted chi-square tests were performed to assess whether differences existed between groups. A *P*-value of 0.05 was used to show statistical significance.

3. Results

A total of 309 patients were approached, of whom 202 (65.4%) agreed to complete the entire

survey. A total of 21 (6.8%) patients refused to participate, and 86 patients (27.8%) were excluded because they were too ill [21], English was a second language [14], they previously had been interviewed [11], inadequate vision [5], overt psychiatric illness [4], and other reasons [31], such as uncooperative. The patients ranged in age from 18 to 88 with a mean age of 41.4 ± 15.8. The majority were African-American (92.1%) and female (51.5%), nearly half (49.5%) had less than a high school education. Patient characteristics are listed in Table 1.

After completing the TOFHLA, all patients ($n = 202$) were asked about their perceived reading skills (Fig. 1). Using the TOFHLA as a measure of functional health literacy, 86 of the 202 patients (42.6%) had low functional health literacy skills. Fifty-eight (67.4%) of these low literate patients admitted they had trouble reading or understanding what they read and were classified as low literate. When these 58 patients were asked about shame, 39.7% ($n = 23$) admitted shame. Results will be presented for all patients ($n = 202$), patients with low TOFHLA test results ($n = 86$), patients with low literacy

Table 1
Patient characteristics (N = 202)

Characteristic	Percentage
Age (years)	
18–30	26.2
31–45	42.6
46–59	14.4
>60	16.8
Gender	
Female	51.5
Race	
African-American	92.1
Caucasian	7.4
Latino/Other	0.5
Education	
<6 Grade	6.9
7–11 Grade	42.6
HS Grad/GED	36.6
>12 Grade	13.9
Socioeconomic indicators	
Own a car	24.8
Own a phone	58.9
Receive financial assistance for food	42.6

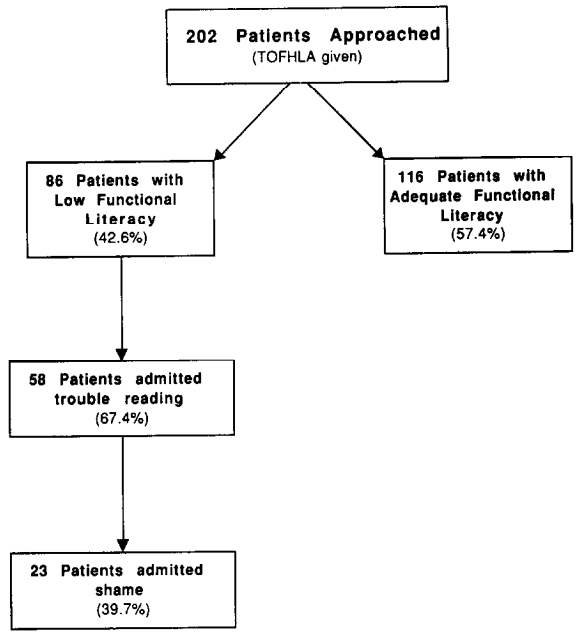

Fig. 1. Flow diagram of patients admitting shame and trouble reading among those found to be low literate.

they have trouble reading ($n = 58$), and low literate patients who admit their reading difficulties and acknowledge shame ($n = 23$).

There were significant differences with regard to gender, race, age, and educational level between the groups of patients with low and adequate functional health literacy. Patients with low literacy were more likely to be male ($P < 0.05$), have less than a high school education ($P < 0.01$), and be over the age of 60 ($P < 0.01$). There were no differences between the two groups with regard to indicators of socioeconomic status.

All patients ($n = 202$) were asked questions about the potential association of shame and low literacy. Approximately half of the patients in both groups, i.e. 49.1% of those with adequate literacy and 51.2% of those with low literacy, said they would feel very bad or so bad they would never tell anyone they have trouble reading. Sixty percent of both groups thought patients would feel very ashamed or so ashamed they would not talk about it to anyone if they had difficulty reading. Patients were asked if they feel people hide trouble reading and understand-

ing what they read. Almost all (93.9%) of those with adequate literacy said patients would hide their illiteracy compared to 77.9% of those with low functional health literacy ($P<0.05$).

All patients were also asked about potential use of various coping mechanisms for patients who have trouble reading medical forms and instructions (Table 2). Patients with low and adequate literacy skills both suggested frequent use of similar coping mechanisms: bringing along a surrogate reader, making excuses, watching others, asking staff or other patients for help. More than sixty percent of all patients felt that those with reading difficulties never ask for help. Ninety percent of patients with adequate literacy felt that patients cope by pretending they can read; a statistically significant lower portion (77.9%) of those with low literacy skills felt patients cope by pretending they can read ($P = 0.01$).

To gain more insight into patients' disclosure of difficulty reading, we further questioned the 58 patients with low literacy who also admitted they had difficulty reading about the extent to which they hide their literacy problem. When asked, 'Who knows you have trouble reading?', over two-thirds (67.2%) of the patients had never told their spouses and more than half had never told their children, relatives, or friends of their problems with reading and understanding what they read (Table 3). The vast majority had likewise never told co-workers or supervisors. Nineteen percent of patients with inadequate functional health literacy skills stated they had never disclosed to anyone their problems reading and understanding what they read. Finally, we asked patients how often they bring someone to the hospital to help with reading. More than three-fourths (75.9%) of the patients stated that they never brought anyone to the hospital with them. All of the eleven patients who revealed to the interviewer they had never told anyone about their trouble reading stated they never bring anyone to the hospital to help them read and understand what they read.

Table 3
Lack of disclosure of reading difficulty by patients with low literacy ($n = 58$)

No Disclosure to:	Percentage
Spouse	67.2
Children	53.4
Relatives	56.9
Co-workers	86.2
Supervisor	91.4
Friends	62.1
No one	19.0

4. Discussion

Shame is a deeply harbored emotion that plays an important role in understanding how patients with low functional health literacy feel. Illiteracy carries a stigma and creates feelings of inadequacy, fear, and low self-esteem [14,15]. In the confidential setting of our study, with interviewers who were sensitized to the emotion of

Table 2
Postulated coping mechanisms associated with literacy levels

Coping mechanism	Percentage suggesting	
	Patients with adequate literacy ($n = 116$)	Patients with low literacy ($n = 86$)
Bring someone who can read	92.2	97.7
Make excuses	93.1	87.2
Watch other people and do what they do	90.5	86.0
Ask for help from the staff	82.8	89.5
Pretend they can read	90.5	77.9*
Ask other patients	75.9	80.2
Never ask for help	65.5	62.8

* $P = 0.013$.

shame, we were successful in asking patients about shame. Even though shame is often hidden, we believe we were able to obtain honest responses about patient's feelings of shame resulting from their difficulties in reading. Some patients admitted for the first time that they had trouble reading and felt shame.

Our hypothesis in beginning this study was that shame might actually inhibit low literate patients from admitting their reading difficulties, seeking needed help to comprehend and complete medical forms, or asking questions regarding their health care. Indeed our findings suggest that such is the case. Only two-thirds of the patients with low functional health literacy admitted that they had trouble reading. Even among those who admitted difficulty reading, complete disclosure was unusual. Of the 40% who admitted both difficulty reading and shame, two-thirds had never told their spouse, one-half had never told their children, and 19% had never before told anyone – including those who were providing their health care. Indeed they do keep their low literacy well hidden – so well hidden that they do not get needed help in reading and understanding prescriptions, follow-up appointments, recommended health care instructions, or informed consent documents.

When asked hypothetical questions, 98% of the low functional health literacy patients postulated that persons with reading difficulties would bring someone who can read with them to the hospital. They were significantly less likely than patients with adequate functional health literacy to propose that people would cope with their difficulties by pretending to read. However, in reality, the low functional health literacy patients who admitted difficulty reading do not bring anyone with them nor do they ask for help. In fact, they pretend – to themselves and others – that they read and understand health documents, potentially jeopardizing their own treatment and well-being. It may be that patients with low functional health literacy keep the fact they have trouble reading so hidden or feel so much shame about their literacy difficulties that they cannot even admit to hiding it. In fact, one-third of the patients with low functional health literacy did not admit that they had difficulty reading, and three out of every five patients who did admit they had difficulty reading denied feelings of shame. We believe that the effectiveness of their health care is limited by their shame about their low literacy.

What can or should health care providers do about this situation? If high quality health care is to be provided to all patients, changes need to be made in the health care delivery system to accommodate low literacy patients. These changes need to be available to everyone, with no stigma attached, since health care providers cannot depend on patients to ask for help. The stigma society places on illiteracy is one of the main reasons patients hide their reading difficulties [14]. Creating a shame-free environment where patients receive help without feeling stigmatized, exposed, or humiliated will require a strong partnership with all active staff in the hospital. Hospital personnel should be informed about the problems that low literate patients have in different areas in the health care setting, including understanding registration, medication bottles, and other written materials, and they should be sensitized to the shame and embarrassment patients may harbor. Programs that educate the entire hospital staff can help to create a more shame-free environment for patients who seek health care and who help to sensitize the staff to the prevalence of low literacy and its associated shame. The nature and effectiveness of such programs need to be the focus of further research in order to remove the stigma of low literacy in the hospital and to ensure adequate health care for all patients.

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Behavioral Science and Adult Illiteracy: Becoming Part of the Solution

Robert N. Sollod[1]
Department of Psychology
Cleveland State University

Abstract

The adult illiteracy problem in the United States has deep historical, social, economic, political and psychological roots. The level of illiteracy in The United States is a serious problem for the society as a whole and is connected with issues such as delinquency, poverty and unemployment. Illiterate adults have multiple significant problems associated with their inability to read. Behavioral scientists and professionals, along with the remainder of United States society, have largely ignored the problem of adult illiteracy. A number of steps for behavioral scientists to take to help remedy this situation are presented. These include introducing literacy programs within mental health settings, augmenting existing literacy programs with empowerment modules, enabling current programs to be more accessible to the illiterate, facilitating employment of the illiterate by identifying and measuring their job-relevant competencies, and developing college courses which involve tutoring illiterate adults. Additional activities and areas of research to which behavioral science expertise could contribute are also suggested.

Although largely ignored by behavioral scientists for the past half century, literacy skills are instrumental in producing reinforcers associated with happiness. Luria (1976), who conducted his field research in 1931 and 1932, was among the first to study the human impact of the development of literacy skills. He concluded, based on studies of Russian peasants in the midst of collectivization, that adult illiterates are condemned to a world of the most simple, concrete mentation. Their cognitive responses, such as imagination, are impoverished and, further, are constrained by the proximate discriminative stimuli that they encounter in their daily existence. Luria's thesis was that the acquisition of reading, writing and comprehension skills fundamentally affects cognition and perception and has consequences for the society as a whole.

Whether or not normal development of the cognitive skills repertoire may occur without the acquisition of literacy skills (D'Angelo, 1982), it is unambiguously clear that — in contemporary Western societies — an increasingly high level of literacy is required for effective adaptation to economic and social realities. Entry into the job market is extremely difficult for the functionally illiterate. Even those jobs which do not require literacy skills as part of job functioning often necessitate that the applicant fill out written forms at the 6th or 8th grade level. Welfare departments, food co-ops and driver's license bureaus, for example, require that citizens fill out forms. Assistance for the illiterate is either not available or provided very reluctantly in most such instances.

In addition to the practical problems of functioning in our society without the ability to read, the illiterate are stigmatized (Kozol, 1985). Even though widespread literacy is a recent phenomenon in historical terms, our current stigmatization of the illiterate induces them to feel shame and guilt regarding their lack of reading and writing ability. They often engage in elaborate ruses or avoidant behaviors to disguise their inability to read. Family members are, in many cases, not informed regarding their shameful secret. Furthermore, the illiterate — by virtue of their limitations — are barred from readily and effectively participating in the political process. Along with mental patients and the prison population, they are not able to draw attention to their own concerns and needs in a largely literate democratic society.

One of the most peculiar aspects of the illiteracy problem in the United States has been the widespread ignorance of the endemic nature of illiteracy. The *1987 Information Please Almanac* (Johnson, 1987), for example, indicates a 99% literacy rate. Such a statistic is based, in part, on studies of percent completion of various grades of elementary school. This 99% literacy rate confirms the invisibility of the illiterate in our society. Current realities are far different. Estimates for varying degrees of *functional* illiteracy range from 20 million to 60 million Americans. According to Kozol:

> *Twenty-five million American adults cannot read the poison warnings on a can of pesticide, a letter from their child's teacher, or the front page of a daily paper. An additional 35 million read only at a level which is less than equal to the full survival needs of our society. (Kozol, 1985, p.4)*

[1] *The author is grateful for the encouragement and assistance of Dr. Richard Rakos in the preparation of this article.* *Reprint requests may be addressed to: Robert N. Sollod, Ph.D., Department of Psychology, Cleveland State University, Cleveland, Ohio 44115.*

In addition, the problem by no means seems to be disappearing.

According to Kozol (1985), 15 percent of recent high school *graduates* read at lower than a sixth-grade level. This is in addition to the large percentage of youngsters who drop out of the school system. There are currently about one million teenage children in the United States between the ages of twelve and seventeen who cannot read above the third grade level. Furthermore, the problem of adult illiteracy is concentrated in precisely those minority groups with the greatest poverty and unemployment. Sixteen percent of white adults, 44 percent of black adults and 56 percent of Hispanics are functionally illiterate (Kozol, 1985). Language and dialect may be contributing factors. Although there has been attention paid to bilingual education, significant dialect differences have largely been ignored in American education (Davis, 1982).

Behavioral science responses to adult illiteracy.

Surprisingly, behavioral scientists and professionals have done little to study and remedy the problem of adult illiteracy. Presumably, this lack of attention is in part a reflection of national indifference to the problem. Traditional disciplinary boundaries may also be a contributing factor. The area of the acquisition of literacy skills has fundamentally been viewed as an educational specialty — off limits for behavioral science. There are, however, a number of areas in which behavioral scientists and professionals have an opportunity to make a significant contribution to resolving the problem of adult illiteracy in contemporary American society.

Literacy training and the mentally ill.

One area is the development of literacy programs for both inpatient and outpatient services as a means of empowerment of the "mentally ill" or those with major psychological problems. Patients cannot fully extricate themselves from the sick role without the acquisition of skills necessary for gainful employment. Chronic psychiatric patients are by no means immune to the feelings of helplessness associated with unemployment. Kilbourne and Kilbourne (1983) indicated the existence of a vicious cycle in which welfare status for psychiatric patients increases feelings of dependency that, in turn, are related to eventual rehospitalization. In a recent study (Perrotta & Lyons, 1986), it was ascertained that only 14% of 132 chronic psychiatric patients seeking community treatment had full-time employment, and another 14% were employed part-time. No doubt, illiteracy is one of many factors contributing to this unemployment problem.

Literacy programs should be part of the therapeutic regimen of mental hospitals as well as of community mental health centers. In addition, such efforts to develop literacy skills in psychiatric populations should be accompanied by more extensive social-skills training (Liberman, et al., 1984), additional remedial education and vocational training (Beardsley, 1984). Such programs could well be based on behavior-analytic principles, since this approach has been successful in teaching other basic adaptive behaviors to a variety of populations characterized by inadequate rudimentary skill repertoires [e.g. mental patients, mentally retarded adults, withdrawn children, delinquent children, autistic children (Martin & Pear, 1983; Sulzer-Azaroff & Mayer, 1977)].

Additional empowerment of the illiterate.

A related area for psychological intervention is the development of empowerment modules among adults who are enrolled in literacy programs. The goal of such activities, unlike those emphasized by Tünnerman (1987), would be primarily that of *individual* economic and personal empowerment. Literacy is a usually necessary but not sufficient precondition for obtaining satisfactory employment. Other behavioral competencies such as asserting oneself, identifying appropriate jobs, letter-writing, interviewing and grooming are also very helpful. A comprehensive program that shaped these skills and, in the process, provided generous contingent reinforcement, would provide participants with an expanded adaptive behavioral repertoire and an increase in cognitions related to positive self-esteem. The development of literacy skills along with the acquisition of other important abilities, by enhancing an individual's experience of effectiveness and competence, should have a significantly positive impact on his or her life (White, 1959, 1966).

Accessiblity of public services.

The 25 to 60 million functionally illiterate adults in the United States may be presumed to emit a much higher than average level of maladaptive and deviant behavior and to experience a greater amount of distress. According to Kozol (1985), for example, 85 percent of juveniles involved in the court system are functionally illiterate. He also indicates that half of the heads of those households categorized as below the federal poverty line are unable to read at an eighth-grade level. Mental health agencies working with the public should examine their programs in light of their accessibility to the illiterate, who underutilize such services (Riessman & Scribner, 1965). These mental health centers should develop pre-therapy training activities (Heitler, 1973) for the illiterate to enable them to benefit from psychotherapy and other mental health services. Many public agencies rely heavily

upon written applications and tests, which are intimidating to persons lacking literacy skills. These organizations have not provided necessary training for staff to work with the functionally illiterate and to ensure that they will obtain reinforcement for participation. Most agencies have also failed to develop discriminative stimuli in their community outreach attempts that would indicate to the illiterate that the agencies are enthusiastic about working with them and that participation in the program will produce reinforcement.

Employment Rights of illiterate adults.

An additional area for consideration by behavioral scientists is the rights of the illiterate — particularly regarding equal employment opportunity. In spite of a variety of efforts to remedy the problem of adult illiteracy, there is little doubt that there will continue to be a large number of adult American illiterates well into the next century. It is much more difficult for adults to learn to read and write than it is for children. In addition, adults often do not have the time or resources to enable them to participate in literacy programs. Nevertheless, many illiterate Americans are able to contribute to the society's well-being through their employment activities. Such employment opportunities could also lead to participation in on-the-job literacy programs.

Unfortunately, credentialism has extended even to the level of unskilled or semi-skilled jobs and trades. Many jobs, which themselves do not require reading and writing skills, are awarded on the basis of written applications or competitive written tests. Additionally, there are jobs which could be suited for the illiterate with slight modification. Unfortunately, since illiteracy is considered as a lack of ability rather than as a disability, there seems to be little or no attempt to modify current jobs so that they could be satisfactorily performed by illiterate employees. Behavioral assessment (i.e. functional analysis) of job-related skills of the illiterate and job modification for the illiterate are also areas which could be performed by behavioral scientists within commercial, educational, governmental and industrial settings.

College courses involving student tutoring.

An additional area open to those behavioral scientists and professionals working in academia is the development of college level courses on the topic of illiteracy that also include a fieldwork placement for college students to work as volunteer tutors within community-based literacy programs. Such a program was first carried out at the University of Miami from 1969-1973 (Manasa, 1984)[2]. The author developed such a college course[3] at Cleveland State University in conjunction with Project: LEARN[4], a private, nonprofit Laubach Literacy[5] program located near the university. This course, entitled, *Literacy Seminar and Practicum*, requires a student's commitment to tutor for at least two trimesters of ten weeks each. This course is categorized as a Social Science course within First College, an undergraduate college at Cleveland State University. Its multidisciplinary syllabus includes readings from psychology, linguistics, history, literature and the political sciences. This year's class activities included a visit to view a touring exhibit of the *Magna Carta*, a guest lecture on black dialects and a film on illiteracy. In addition to their participation in tutoring and completing reading assignments, students are expected to complete a term paper on some facet of the adult illiteracy problem.

Aside from the fact that the mobilization of college students is one potential key to solving the adult illiteracy problem, students have reported that the course has provided a variety of positive reinforcers for them. Wallach and Wallach (1983) have concluded that individuals may obtain major benefits from being engaged in altruistic activities. In addition to course credit, reinforcers include the increase in literacy demonstrated by their pupils, as well as social reinforcement provided by these adult students. Such reinforcers for the college students' tutorial behavior lead to associated cognitive and attitude changes. Students note an increase in self-esteem, diminished anomie, and a greater understanding and acceptance of those who have grown up in impoverished and severely limiting environments. In addition, the reinforcers for tutoring and completing course requirements are powerful. Some of the students appear to have begun a long-term commitment in their own lives to address the problem of illiteracy. About one-third of them have continued to tutor illiterate students — even without continuing course credit — thus indicating the extent of their reinforcement for participation. Their term papers and diaries of their involvement in the literacy project demonstrate that many of their stereotypes about the illiterate had been effectively challenged by their personal experiences in the course.

In addition to the areas indicated above, there are numerous other areas in which behavioral science expertise could be applied in order to study the illiteracy problem and to facilitate its remediation. These areas include program evaluation of current literacy programs, research on the effects of literacy training on self-esteem and mental health in adults, research on the relationship of literacy to mental health and psychological well-being, development of more effective literacy training programs, research on motivating illiterate adults to obtain training, and research on factors encouraging volunteer participation in literacy programs.

Behavioral scientists and professionals should add their efforts to the struggle against adult illiteracy in the United States. Their expertise can provide an additional dimension to the understanding and remediation of this major contemporary human problem.

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[2] *Inquiries to The Washington Education Project should be addressed to: Mr. Norman Manasa,* Director, *The Washington Education Project, 224 Third St. SE., Washington, D.C. 20003.*

[3] *Inquiries about this course may be addressed to the author at Cleveland State University.*

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[4] *Project: LEARN is a voluntary adult literacy program sponsored by the Interchurch Council of Greater Cleveland. The project provides free, private, basic reading and writing lessons for adults who read at the 3rd grade level and below.*

Project: LEARN may be contacted by writing to: Ms. Nancy Oakley, Director, *Project: LEARN, Interchurch Council of Greater Cleveland, Cleveland, Ohio 44115.*

[5] *Laubach Literacy is the largest privately supported literacy training program for adults in the United States. It may be contacted by writing to:* Mr. Peter Waite, Executive Director, *Laubach Literacy Action, Box 131, Syracuse, New York 13210.*