



## An Overview of Primary Prevention

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*The historical antecedents of primary prevention are found in the methods of public health, counseling, and psychotherapy. Primary prevention is defined as being proactive and is aimed predominantly at high-risk groups not yet affected by the condition to be prevented. Its success is measured in a decline in the incidence of a condition that is compared with controls. Only through prevention can we reduce incidence, and it seems that it is the only feasible way to deal with the unbridgeable gap between the enormous number of individuals at risk for emotional disturbance and the limited availability of treatment resources.*

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In this article we present strategies for implementing effective prevention programs and examine the arguments espoused by those who are opposed to prevention theory and its implementation. Opposition is strongest from those who accept a disease model of mental disorders and from individuals and groups who oppose social change aimed at the empowerment of exploited groups. Finally, examples of a number of successful prevention programs are examined in some detail to counter the argument that there is little or no evidence to document successful prevention outcomes.

Primary prevention is a concept that should be clearly understood by everyone. In simple terms it means doing something now to prevent or forestall something unpleasant or undesirable from happening in the future or, alternatively, doing something now that will permit or increase desirable future outcomes. As children, everyone was admonished by a parent to do things, or to avoid doing other things, because of their future consequences: Don't get your feet wet, get out of those cold wet clothes, take your vitamin pills, do your homework, don't eat so much candy, eat your vegetables. We all understood that we were being admonished for our own future good. As we grew we were encouraged to save money for a rainy day. We learned to abide by the reality principle: to give up immediate pleasurable gratification to achieve greater long-term gain. We learned to avoid bad company, to work hard, and, more recently, to eat wisely, to avoid saturated fats, to get plenty of exercise, and to carry condoms and to use them when there is any danger of contracting AIDS (Acquired Immune Deficiency Syndrome) from risky sexual encounters. We are told to have only planned pregnancies, to rear our children with love and affection, to "Just Say No" to drugs. The list is endless. The underlying message is always the same. Do something now, or avoid doing something now, so that your future life will be healthier and happier.

In an early paper, Kessler and Albee (1975), reviewing the literature on primary prevention, observed the following:

The platforms of political parties, the writings of political theorists from Lenin and Mao, to Lincoln and Gandhi, to DeGaulle and Buckley, all claim as their major goal the improvement of the human condition, the creation of environments that will reduce or eliminate human misery and emotional distress for large groups of people and for future generations. The writings of the utopians from Plato to Skinner promise a more rational, orderly, and satisfying life for all, or nearly all. Philosophers, theologians, economists, and humanists have in common with

politicians, environmentalists, and liberationists the goal of a better and more satisfying tomorrow. Few have any published data! During the past year we found ourselves constantly writing references and ideas on scraps of paper and emptying our pockets each day of notes on the primary prevention relevance of children's group homes, titanium paint, parent-effectiveness-training, consciousness raising, Zoom, Sesame Street, the guaranteed annual wage, legalized abortion, school integration, limits on international cartels, unpolished rice, free prenatal clinics, antipollution laws, a yoghurt and vegetable diet, free VD clinics, and a host of other topics. Nearly everything, it appears, has implications for primary prevention, for reducing emotional disturbance, for strengthening and fostering mental health. And anyway, as Bleuler said, "they are good things in themselves." (p. 560)

### PUBLIC HEALTH APPROACHES TO PRIMARY PREVENTION

The field of public health has long been concerned with the prevention of disease. Indeed, it is safe to say that public health measures are consistently more successful in keeping the population healthy than are the efforts of conventional medical intervention that use "repair" strategies. In its long history, public health has used primary prevention to reduce or eliminate many of the great plagues that have beset humankind over the centuries. The clearest example is smallpox. It once afflicted a very large percentage of people and killed nearly 1 in 12 of those contracting the disease. Immunization has eradicated smallpox from the face of the earth and diseases such as polio are also well on the way to disappearing as a result of effective preventive vaccination. At a more basic level, safe water supplies (in the more affluent parts of the world) have ensured that water-borne diseases like cholera and typhoid have largely been controlled. Knowledge and technology for protecting people throughout the world from these latter diseases are available, but are not yet being applied because of unwillingness or inability of affluent nations to help bear the cost of providing safe drinking water for millions in Asia, Africa, and South America.

Public health strategies are relatively simple. The first step is to identify a noxious agent and attempt to remove it, or neutralize it. The second strategy is to strengthen the resistance of the host to the noxious agent. The third strategy is to prevent transmission of the noxious agent to the host. Treating drinking water kills noxious agents. Vaccinating all children against polio, and the common childhood diseases like

measles, mumps, pertussis, and so forth has been so successful, at least in the industrial nations, that the high death toll of children characteristic of past centuries, and of poverty-stricken nations today, does not occur. Finally, preventing the noxious agent from reaching the host is clearly effective, whether it involves killing disease-bearing mosquitoes and thereby reducing the incidence of malaria in tropical lands, or recommending the use of condoms to prevent transmission of the AIDS virus.

### THE RISE OF THE MENTAL HYGIENE MOVEMENT

In the early years of the 20th century, public health experts began to turn their attention to the problems of preventing mental disorders. If public health approaches were so successful at preventing organic diseases, could they not also be applied to the prevention of neuroses and psychoses? A leading figure in psychiatry at the time was Adolf Meyer at Johns Hopkins University. He espoused the view that mental and emotional disorders were the result of life-long social experiences. Prevention was a matter of ensuring more adequate child-rearing under conditions that placed less stress on parents. Many public health and psychiatry faculty at Johns Hopkins University and its School of Public Hygiene joined with Clifford Beers, author of *A Mind That Found Itself* (1905), in forming The National Committee for Mental Hygiene. Psychiatrists, however, had relatively little sophistication in statistics, and epidemiologists had relatively little understanding of psychiatry. Despite an uneasy alliance, it was this group of individuals that first attempted to enumerate the people with mental and emotional disorders in the population district studied by the university faculty. It was startling to discover that there was a very high rate of mental and emotional problems, particularly among poor people, those in mixed racial neighborhoods, and those who lived in sections where saloons and prostitution were common. The beginnings of efforts at the prevention of mental and emotional disorders were laid down with attempts at teaching poor mothers to be better parents in the hope that their children could avoid the temptations and dangers of their crime-ridden and poverty-stricken environments. It was also observed that there was a correlation between slovenly housekeeping and mental conditions. Gradually, children's mental health clinics were established in various parts of the country and efforts were made to instill better parenting skills. In this way the child guidance movement spread (Fee, 1987).

### THE RISE OF PSYCHOTHERAPY

Beginning with the work of Freud in Vienna and with the importation to this country of psychoanalytic approaches, psychodynamic psychotherapy took root. The field of social work, beginning with Flexner's (1915) admonition that social work had to have a theory to be a profession, adopted ideas from psychoanalysis, and social case-work became a form of treatment that spread rapidly. During and following World War II, psychoanalysis became a major form of intervention, and professional sophistication regarding the relationship between early childhood experiences and later adult personality, including personality disorders, became widely accepted. Popular writers like Erich Fromm and Karl Menninger helped the educated populace to understand the relationship between early social experience and later adult personality disorders (Hall, 1954). In psychiatry the psychoanalysts had the highest level of prestige, and a majority of psychiatric residents wanted to learn to be psychotherapists. Therapy also became popular in the emerging fields of clinical and counseling psychology following World War II. Today, psychotherapy and counseling are well established as major career choices in both psychology and social work. There are many different schools and approaches to therapy, but the underlying common

assumption is that people learn to be mentally disordered and that they can unlearn pathological and painful behavior. Psychotherapy's most significant contribution to the field of primary prevention is the conviction that most mental disorders are learned and can be unlearned. If this is true, then it follows that it would be possible to prevent the pathological learning in the first place, thereby preventing future mental disorders.

The disadvantage of the current emphasis on individual psychotherapy is the fact that no major physical or mental condition had ever been eliminated through one-to-one therapy. It is difficult to have this message understood by therapists and also by the general public because of the heavy efforts of the mass media to sell a one-to-one treatment philosophy. High-technology medicine, in particular, has had incredibly convincing publicity about heart transplants, cardiac surgery, and drug treatment of chronic diseases like cancer, high blood pressure, and diabetes. Our medical system, as well as our psychotherapeutic delivery system, gains extensive personal and monetary rewards for engaging in and espousing individual treatment. Because of the high cost incurred during such treatment, however, there is little money available for prevention and little acceptance of a prevention philosophy by mainstream medicine and psychology.

### PREVENTING MENTAL AND EMOTIONAL DISORDERS

In the 1960s and early 1970s, there was strong emergence of a prevention philosophy in the field of mental and emotional disorders. Major cultural changes followed the publication of the final report of the Joint Commission on Mental Illness and Health. The final volume, *Action for Mental Health* (1960), led President Kennedy to propose, for the first time in American history, the use of federal funds for the development of an effective system of intervention in the field of mental disorders. Included in his message to Congress was the urgent request for funding for efforts at prevention and community interventions. Major changes proposed included the construction of 2,000 community mental health centers and the gradual reduction and elimination of the overcrowded state mental hospitals. Throughout the 1960s, despite resistance from established medicine, efforts were proposed to level the playing field for poor people. President Johnson's War on Poverty encouraged a social psychiatry that had as its goal the reduction of the miserable living conditions that apparently spawned high rates of mental disorders, alcoholism, and drug use. The Commission on Mental Health appointed by President Carter included in its final report a proposal for major increases in prevention efforts. With the election of Ronald Reagan in 1980, all these efforts came to an abrupt halt. Political conservatives have always opposed social change efforts as prevention strategies. The emphasis shifted to explanations of mental illnesses that stressed physical and organic causes. The National Institute of Mental Health (NIMH), whose first three directors (Felix, Yolles, and Brown) were public health physicians, has recently been headed by a succession of organic, biologically oriented psychiatrists who redirected the institute's research support efforts toward organic research. Gone were investigations on the effects of poverty and unemployment. Since the end of the 1970s, ideas about mental and emotional disorders have taken a 180° turn and a recent director of NIMH, Lewis Judd, has labeled the 1990s as the "Decade of the Brain" in several recent speeches.

### The Problem of Diagnostic Classification

From the days of Kraepelin in the latter years of the 19th century, down to the present, the classification of mental disorders borrowed heavily from the system used in medicine. Each medical disease was believed

to have a separate cause and called for a separate kind of treatment. The nomenclature developed by the American Psychiatric Association took the form of a *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*, 1952, 1968, 1980), revised periodically to include separate mental diseases. With the gradual development of third-party payments for medical care, an increasing number of mental conditions were included in the diagnostic classification. If mental health professionals could be paid only for treating conditions included in the manual, then it was important to broaden the manual to include as many complaints as possible. Since its inception in the 1950s, the *DSM* has added at least 100 new "mental illnesses." (See American Psychiatric Association, 1952, 1968, 1980.) Therefore, it is not surprising to find that the diagnostic categories turn out to be fairly unreliable. The major reason for the unreliability is the absence of an objective biological marker to identify each separate condition. Unlike physical illnesses, where objective laboratory findings or other identifiable defects or malfunctions lead to diagnosis, the presence of a mental disorder is largely determined through subjective observations. Often the judgments of various experts differ substantially. Individuals considered schizophrenic in the United States are often diagnosed with depression in England and vice versa. It has been a matter of urgent priority for NIMH to continue to seek the underlying physiological and genetic causes of mental and emotional disorders. Since 1980, research funds have been made readily available to support this effort. Unfortunately, research support for the examination of possible social and environmental causes of distress has fallen by the wayside.

#### Diseases or Social Disorders?

The power to determine diagnostic categories clearly now belongs to the organic psychiatrist. During the 1980s a whole series of "preliminary findings" suggested the "imminent" discovery of physical causes of most mental disorders. In the absence of compelling evidence, it was the power of organic psychiatry that decided that not only the major mental disorders but also conditions like depression, addiction to alcohol and other drugs, obsessive and compulsive disorders, and phobias were all caused by genetic defects, brain diseases, or both. The steady flow of publicity in the mass media, generated by the organicists and by groups like Jack Hinckley's American Mental Health Fund, was aimed at convincing the public that "all mental illnesses are medical illnesses." The psychoanalysts, who had long been significant in psychiatric education, were frozen out of medical school faculties. The childhood origins of mental disorders are out of favor, and psychiatric residents now receive little training in psychotherapy, but major training in the use of mind-altering drugs. Not surprisingly, the organic model is strongly supported by the major drug companies that produce highly profitable drugs for the treatment of these mental illnesses. Psychiatric conferences, especially seminars for psychiatric residents, are held in idyllic resorts with all expenses paid and the obligation only to attend a daily seminar on the use of specific drugs in psychiatric treatment. The higher incidence of mental and emotional problems among very poor people is no longer reported except with the clear implication that both poverty and mental illness are probably caused by the same inherent constitutional defects that cause these individuals to drift down in economic and sociodemographic status. Extensive propaganda by the medical community and by various parent groups has been highly effective in convincing the lay public that all mental and emotional disorders are organic.

#### A Little Epidemiology

Sometimes clear-cut facts are more powerful than is propaganda. Sound public health doctrine has always insisted that the first essential step in

understanding a disease or disorder is to look at its distribution in the population. Who is most at risk? Scores of examples in the history of public health illustrate the importance of knowing that, for example, poor children living in overcrowded slums are at significantly lower risk for polio than are middle and upper class children living in the suburbs. This fact led to major research funds being spent on polio research. John Snow's (Smillie, 1955) observation that people in London living near the Broad Street pump suffered from cholera with a surprisingly high frequency led him to remove the handle from this pump. In doing so he stopped the spread of cholera in that section and identified an epidemiological fact: Drinking polluted water was dangerous. Unfortunately, such epidemiological evidence can sometimes be used to discriminate against certain high-risk groups. The early discovery that AIDS was more likely to affect gay men and intravenous drug users slowed the funding for research on this disease.

#### Social Class

Repeatedly, epidemiological studies have shown that very poor people are at highest risk for many pathological conditions, including mental disorders. One of the first dramatic illustrations of this was a survey done by Edward Jarvis (1855) who was commissioned by the Massachusetts legislature to study the distribution of "idiocy" and "lunacy" in the state of Massachusetts. Jarvis wrote to every town clerk and asked for the names of all idiots and lunatics in the town. When he compiled the results and studied them, he made a dramatic discovery: A significantly high proportion of persons with idiocy and lunacy had Irish names. His conclusions based on these data were wrong: He said the Irish were constitutionally inferior, but he gave us a baseline that became useful in later years. As the Irish moved up and out of poverty and into the middle class, their rates of idiocy and lunacy declined. Subsequent immigrant groups—Scandinavians, the Russian Jews, the Southern Italians—however, each occupied, in turn, the worst housing and suffered the worst poverty and also had the highest rates of idiocy and lunacy. Although we came to call these conditions by more modern terms like *feeble mindedness* and *dementia praecox*, the pattern was the same. As each group escaped from poverty and moved into the middle class, the rates of these conditions declined. Newcomers into the poverty stratum—Southern Blacks, Puerto Ricans, and Chicanos—are all reported to show higher rates of school learning problems and mental disorders like alcoholism and other drug abuse and schizophrenia. The Carter Commission (1978) reported that the group with the highest rate of both physical illnesses and mental disorders was the landless migrant farm worker. Somehow this compelling evidence that social class, irrespective of racial and ethnic background, is associated with higher and then subsequently average rates of mental disorders has failed to permeate the consciousness of those who control the explanatory models. Poverty and powerlessness are major causative factors. Economic security is beneficial to mental health.

#### APPROACHES TO PRIMARY PREVENTION

The primary prevention of mental and emotional disorders parallels, in many ways, the models that have been used historically by the field of public health. Mental conditions are associated with certain noxious agents like following an inadequate diet, living in toxic environments, suffering high levels of stress as a consequence of unemployment and discrimination, and experiencing heartless exploitation, thus producing feelings of frustration and powerlessness.

Prevention strategies often involve efforts at reducing these noxious agents or at strengthening group resistance to stress. Methods of

strengthening include the development of social skills and competencies, improvements in self-esteem, and the development of strong social support systems.

### A Model of Prevention Efforts

In reviewing the literature on successful efforts at primary prevention, the Task Panel on Prevention of the Carter Commission on Mental Health provided data for the development of a formula that encompassed most prevention efforts. The formula:

$$\text{Incidence} = \frac{\text{Organic Factors} + \text{Stress} + \text{Exploitation}}{\text{Coping Skills} + \text{Self-Esteem} + \text{Support Groups}}$$

To succeed in preventive efforts is to reduce the incidence (the number of new cases) of the various emotional disturbances. The strategies for accomplishing this involve reducing factors in the numerator (noxious agents), increasing factors in the denominator (strengthening the host), or both.

### Yogi and Commissar Approaches

Koestler (1942) discussed techniques for influencing change in large numbers of people. He dubbed these methods the "Yogi" and "Commissar" approaches. In most Yogi approaches attempts are made to convince individuals to change their behavior for their own good. Such approaches often involve preaching, educating, or exhorting. Urging people to eat healthful diets, to reduce their feelings of stress through meditation, and to learn to be better parents are all Yogi approaches. On the other hand, Commissar approaches involve commanding or requiring people to change their behaviors. Examples of these latter may involve requiring that sex education be taught in the schools, passing laws controlling the sale and taxing of alcohol, banning smoking on airplanes, banning child pornography, and so forth.

### Changing Toxic Environments: Community Change

Affluent individuals use up the lion's share of mental health services including psychotherapy. As was noted earlier, people in the lowest social class escape their high rates of "idiocy and lunacy" only when their economic status improves. This suggests that effective primary prevention programs should be aimed at eliminating or reducing poverty, powerlessness, and exploitation.

Preventionists, who are also usually environmentalists, have noted that toxic environments are far more prevalent in areas where poor people live. Toxic dump sites, inner-city pollution with lead, as well as iron deficiency and inadequate diets, are all associated with being poor. Taking into account that these kinds of pollutants and nutritional deficiencies have repeatedly been implicated in the development of mental retardation, various health problems, and increased levels of stress, it is clear that individuals born into and raised in low-income families are being affected, not by genetic, but by environmental and social conditions. Prevention programs aimed at changing these factors are strongly opposed by groups, particularly political conservatives, who increase their own profits by dumping waste and who resist efforts at getting them to clean up the environments they pollute. Proposals for guaranteed employment are opposed by those who see an unemployment pool as essential to recruiting low-cost labor. Therefore, prevention programs that threaten profits or that demand tax-supported interventions are major threats to the power structure.

Another primary prevention strategy involves changes in life-style. It is now widely recognized that persons who smoke cigarettes, eat a diet heavy in saturated fats, get little or no exercise, and suffer from chronic stress are at high risk for a wide range of physical and mental disorders. Obviously, primary prevention strategies are aimed at stress reduction, healthy diets, more physical exercise, and reduction in smoking. It is interesting to note that these prevention strategies are highly publicized and accepted by the mainstream. By and large, this is because these are concerns of the upper and middle classes. Corporations realize that it is in their best interest to cater to the major consumers. Food manufacturers, restaurants, and health clubs have been motivated to implement prevention technologies because it means greater profit. Unfortunately, many prevention programs do not offer short-term gains. Added to these life-style changes is the recent exhortation to practice safe sex, use condoms, or both, as a way to prevent the transmission of AIDS. All of these kinds of prevention efforts require the voluntary cooperation of persons who are at high risk. The government can print warnings on cigarette packages and alcohol containers, but it cannot prohibit the consumption of these substances. Requiring food producers to list on packages the caloric and fat content of foods can be required, but people are still free to buy what they like. Thus, many primary prevention programs must involve efforts at public education about behavior change. These programs may range from sex education in the schools to admonitions about the use of dangerous substances. Success, however, is measured only by a decrease in the rate of consumption, which is a function of the success of public education and moral modeling.

## OPPOSITION TO AND SUPPORT FOR PRIMARY PREVENTION EFFORTS

### Political Values: Resistance and Support

It has been demonstrated (e.g., see Kelly, 1984) that there is an association between political values and attitudes toward primary prevention. Political conservatives favor organic explanations of mental disorders that find causative factors inside the skin of the person suffering the condition. This view challenges prevention theory that requires social change and redistribution of power. On the other hand, political liberals and radicals see toxic environments, both physical and social, as major causes of mental and emotional disorders. Inasmuch as these causes are environmental, prevention programs aimed at changing social or physical environment are supported.

### Organic-Medical Orientation

Persons holding the organic-medical view hold little hope for prevention efforts. Whenever they are asked for examples of effective primary prevention, they talk about genetic counseling. The view that most mental disorders are genetic in origin, arising from biochemical imbalances, makes genetic counseling the only viable option for reducing mental pathology. The medical-organic orientation, however, is largely focused on treatment. It sees drug therapy, using psychotropic substances, as the major hope for controlling mental conditions. Many advocates of this position argue that persons with mental disorders are incapable of deciding whether or not to have treatment; thus, they sometimes advocate involuntary treatment and even involuntary hospitalization. This view is frequently supported by parent groups like the National Alliance for the Mentally Ill. "Psychiatric survivors," on the other hand, often band together to oppose such drug treatment and involuntary hospitalization.

### Social-Learning Orientation

As noted earlier, most preventionists are environmentalists. They argue that pathological experiences in early childhood, such as child abuse, neglect, sexual abuse, and bad parenting in general, often are reflected in later adult maladjustment. They regard most mental disorders as difficulties in interpersonal (and intrapersonal) relationships. If these conditions can be reversed through individual therapy, the argument goes, then they can be prevented from occurring in the first place. Thus, primary prevention programs tend to focus on creating special caring environments for high-risk children, reducing the damaging consequences of poverty, providing for employment for those parents who want to work, teaching social coping skills, enhancing self-esteem (through the mass media particularly), and formulating and encouraging the development of social support groups.

### The Power of Parent Groups

Over the last decade or so, two major new citizens groups have coalesced around the view that "parenting is not to blame." They argue that the professionals in the field have too long blamed parents for the problems of children and that the "schizophrenogenic mother," for example, not only suffered the pain of having a disturbed child but also was blamed for the child's disturbed behavior. Both of these groups (The National Alliance for the Mentally Ill and The American Mental Health Fund) have quickly attracted an articulate and effective group of families who have pressured for the view that "all mental illness is a medical illness" and who have argued that more research is needed to establish the physical causes of mental disorders, particularly in the area of brain research. They have lobbied successfully for increasing funds for the treatment of chronically mentally ill young adults. They have gone on public record as opposing the spending of funds for primary prevention, arguing that prevention is too often focused on social causes and social change. Recently, the American Mental Health fund has announced that it is going to merge with the National Mental Health Association to take advantage of the latter's mass membership and sophisticated organization. We can look forward to more opposition to prevention programs as a result of this merger.

### EXAMPLES OF SUCCESSFUL PREVENTION PROGRAMS

Critics of primary prevention often argue that there have been no reliable or valid studies carried out to support the preventionists' claims. They cite a lack of evidence showing any real or sustained impact following prevention programs and erroneously contend that few studies have included a systematic evaluational component (Albee, 1986). In fact, the literature abounds with evidence supporting the effectiveness of prevention efforts in many areas. If preventionists are succeeding despite their adversaries and a perennial lack of funding, imagine the future possibilities if just some of the monetary and political support given to biologic-psychiatric and medical research were shifted to the field of primary prevention. This is not to say that a single barrier lies between innovative prevention theory and predicted outcome. Indeed, perhaps the greatest deficiency in the field stems from the lack of communication and cooperation among those working in the various areas of prevention, both within and outside of the field of psychology. Effective primary prevention programs must combine findings in the fields of epidemiology, sociology, public health, economics, and political science with the knowledge base from the psychological sciences and mental health field. The following compilation is a modest step in that

direction. It outlines some of the more complete research studies that have been conducted in the area of primary prevention over the years. We advise the interested reader, as well as the skeptic, to peruse the original works because space permits only a brief overview here.

### Cowen's Survey

In 1982 the *American Journal of Community Psychology* published a special issue devoted to evaluating primary prevention programs. Under the editorial eye of Emory Cowen, all preventive work to be summarized was required to meet strict and restrictive criteria. One major criticism of primary prevention has often been that it lacks definitional clarity. The work presented in this special issue was thus required to meet a "taut" definition of primary prevention that included the building of competencies in unaffected individuals to avert maladjustment and the inclusion of a specific methodology and formal evaluation design.

Because prevention research is conducted within natural settings, critics often claim that it is impossible to establish a one to one cause-and-effect relationship, as is the case with many physical diseases. We do know, however, that certain situations or experiences can increase the risk that an individual will suffer from emotional and psychological problems. For example, feelings of powerlessness and helplessness often lead to maladaptive behavior patterns and reduce an individual's ability to respond effectively to environmental stressors (Seligman, 1975). One of the studies reported in this special issue examined the efficacy of stress management for women on public assistance (Tableman, Marciniak, Johnson, & Rodgers, 1982). The program sought to prevent predictable outcomes such as depression and anxiety. Over 2 years, 65 low-income women received specific skills training in problem solving and stress management. The women were also helped to reconceptualize their existing attitudes and capabilities. When compared to a control group, the experimental group showed increased self-confidence and ego strength concurrent with decreased levels of anxiety and depression. From self-report measures taken at the conclusion of the program, it was also apparent that some of the improvements were the result of peripheral factors such as increased social contact, communication between participants, and knowledge gains. Therefore, although a single causative factor cannot always be identified in the development of psychopathology, programs that empower and support at-risk individuals have been shown to be reliable in preventing deleterious outcomes.

Other prevention programs in this special issue covered a wide range of problems and drew targeted groups from a variety of ethnic and sociodemographic populations. Among the problems addressed were the following: marital disruption (Bloom, Hodges, & Caldwell, 1982); disruptive behavior in adolescents (Bry, 1982); the stress involved with school transition in low-income adolescents (Felner, Ginter, & Primavera, 1982); diminished feelings of competence in retired adults (Gatz et al., 1982); behavior problems in young Mexican American children (Johnson & Breckenridge, 1982); depression (Muñoz, Glish, Soo-Hoo, & Robertson, 1982); stressors associated with life changes (Roskin, 1982); and interpersonal problem-solving with Black inner-city youth (Shure & Spicack, 1982). Each of these program descriptions delineated interventions used and outcomes achieved in clear and understandable presentations.

### 14 Ounces of Prevention

*14 Ounces of Prevention* (Price, Cowen, Lorion, & Ramos-McKay, 1988) is a well-organized casebook conceived and published by the American Psychological Association's Task Force on Prevention, Pro-

motion, and Intervention Alternatives in Psychology. The task force was formed to locate and compile descriptions of effective model prevention programs. Its aim was to provide psychologists and other service providers, as well as the lay public, with information about these programs. When the casebook was published in 1988, it was already clear that the need for mental health services far exceeded the available resources. The limitations we face today are the result of our growing dependence on high-technology crisis intervention and repair strategies to minimize pathology. Such costly services are often inaccessible to those in minority and low-income groups.

For example, in the United States alone it is estimated that 19% of the adult population suffer from some form of psychological distress (Regier et al., 1984). Our only hope for reducing the incidence of psychopathology and halting the concurrent cycles of violence, powerlessness, and despair, lies in the implementation of large-scale preventive efforts. Unfortunately, many innovative prevention programs have failed to evaluate their efforts in any systematic fashion or often lack clear program manuals. By providing practitioners with descriptions of well-designed and demonstrably effective programs, the task force hoped that the long-term benefits of prevention that are often overlooked or criticized because of the lag time between implementation and effect would be recognized by those in the health and mental health fields. In addition, authors of programs selected for inclusion were asked to include information about how the program worked, its goals, and its problems and were asked how to start new programs.

The casebook was divided into three sections, covering prevention programs in early childhood, in children and youth, and in adults and in elderly persons. There are several notable early childhood programs including the Prenatal/Early Infancy Project that sought to prevent maternal and child health problems associated with poverty (Olds, 1988) and the Carolina Intervention Program that provided an enriched environment to poor children from undereducated families in an effort to facilitate intellectual development (Ramey, Bryant, Campbell, Sparling, & Wasik, 1988). The second section focused on prevention with the school-age child. The programs described include a range of prevention methods from assertiveness training with children (Rotheram-Borus, 1988) to the prevention of adolescent substance abuse (Botvin & Tortu, 1988). The final section is devoted to the health and mental health of the adult population. One of the many interesting chapters examined the Stanford Heart Disease Prevention Program that sought to reduce cardiovascular risk through mass media education and interpersonal behavior change (Maccoby & Altman, 1988).

Although the prevention programs included in this casebook covered diverse issues and problems, one aspect was common to each. Through rigorous implementation and design, the authors succeeded in amassing a wealth of irrefutable evidence for the efficacy of these programs in the prevention of mental and emotional disorders. One such notable program, The High Scope/Perry Preschool Program (Schweinhart & Weikart, 1988), offered information and support to low-income parents with children between 3 and 4 years of age. The children were exposed to a developmentally appropriate prekindergarten curriculum, and parents were encouraged to work and interact with their children in their learning activities. While typical of many prevention programs with this age group, this program was unique in that it continued to follow the participants over 19 years. Although these children came from backgrounds that put them at high risk for school failure, teen pregnancy, and antisocial behavior, it was found that most of the 123 participants showed high levels of literacy and intellectual development, academic success, avoidance of antisocial behavior, and positive employment histories. In comparison to the control group that did not

receive preschool instruction, the participants in this study were more likely to attend college (38% to 21%), less likely to be on welfare (18% to 32%), and reported lower pregnancy and birth rates at age 19. This program also affords us with an example of the time frame that should be involved in evaluating preventive programs. Clearly, the benefits often increase over time and should not be judged only in the short term. In addition to the benefits gained by those individuals in the study, there are educational, economic, and social benefits. Indeed, a cost-benefit analysis revealed that pre-school experience and the subsequent reduction in intervention services would save taxpayers \$28,000 per child over 19 years, at an original cost of \$5,000 per child.

### National Mental Health Association Prevention Awards

Since 1980, the National Mental Health Association (NMHA) has presented the Lela Rowland Prevention Award each year to a prevention program that is considered by a jury of experts to be among the most innovative and successful of those nominated. In all, there have been 11 recipients, and although some programs such as the High/Scope Perry Preschool intervention have been mentioned earlier, many of the more recent preventive programs have not been compiled elsewhere and deserve attention.

For example, some of the programs to be recognized include an ongoing study at the University of Rochester that seeks to prevent behavioral and emotional problems in children faced with parental divorce (Pedro-Carroll, 1991); a preventive intervention that fostered job-finding skills and coping skills in recently unemployed persons (Vinokur, 1990); and Yale University's School Development Program (Comer, 1989), which sought to improve the school climate in low-income and minority communities by developing an enhanced curriculum and by engaging both parents and children in decision making and school activities. The emphasis of this latter program on promoting psychological development and self-determination has led to higher scores on the California Achievement Tests and to fewer behavioral problems as compared with other district schools.

In addition, NMHA was active in establishing the Commission on the Prevention of Mental/Emotional Disabilities (1987) to assess current knowledge about the prevention of psychological and emotional disorders, to examine critically how this knowledge was being applied, and to make recommendations for future prevention research and implementation. The NMHA Commission's (1987) final report was reprinted in the *Journal of Primary Prevention*. It offers further evidence for the rationale and efficacy of preventive methods. In addition, the report includes a resource list for those interested in the current literature, both in book and periodical form, on primary prevention.

Based on the success that public health strategies have shown in reducing the rates of physical disease, the preventionists have long argued that similar methods could be developed to reduce the incidence of many psychological and emotional problems and that such a focus would offer personal, social, and economic advantages. The findings from this NMHA report supported that assertion. Although not unknown to those familiar with the work being done in this field, it also became clear that a substantial knowledge base exists and that contrary to the carping from critics, it effectively documents successful prevention efforts and establishes national guidelines for future prevention research and implementation.

The remainder of the NMHA report examines the rationale for the use of prevention strategies and presents a framework for looking at how biological, psychosocial, and social factors interact in the development of, or conversely the prevention of, psychological distress. The body of

the report is divided into six sections—Before Birth, Infancy, Childhood, Adolescence, Adulthood, and Aging. This developmental approach allows for the identification of basic needs throughout the life span. In this way, age-appropriate preventive interventions can be developed to reduce the incidence of mental and emotional disabilities in high-risk groups.

One such high-risk group is elderly persons. As life expectancy for both men and women continues to increase, and the post World War II surge in births ages, so too will the proportion of elderly people in the population. The section on aging is especially relevant if, as a society, we are to cope effectively with various age-related health problems. Of particular concern are diseases such as Alzheimer's that cripple an individual both physically and mentally. More subtle problems such as depression, loss of familial and social contacts, loss of independence and decision-making power, and diminished feelings of control, however, occur frequently in elderly populations and can have a significant impact on an individual's health and quality of life. This section emphasizes the importance of support systems, coping skills, information about physical illnesses and medications, and education regarding the aging process. Although physical illness can undoubtedly lead to mental-emotional disabilities, the effects of harmful stereotypes and ageism are far and away more detrimental to an individual's sense of self-esteem and self-worth than is any other factor.

#### **Vermont Conference on the Primary Prevention of Psychopathology Publications**

Since its inception in 1975, the Vermont Conference on the Primary Prevention of Psychopathology (VCPPP) has held an annual conference dealing with the prevention of mental and emotional disorders. Each conference has included discussion of prevention theory, research, and practice in a given area of psychopathology, health, or competence building. Through these conferences, individuals from various fields have been able to interact and exchange information about primary prevention. In addition, each conference has led to the publication of a prevention volume that includes edited versions of conference presentations. These published volumes are excellent resources for professionals and other citizens who are interested in promoting both mental and physical health.

Over the years, these publications have covered a wide range of topical areas, among them the following: the environmental influences on health (Forgays, 1978); social competence and coping in children and adults (Bond & Rosen, 1981; Kent & Rolf, 1979); infant and early childhood development (Bond & Joffe, 1982); health psychology (Rosen & Solomon, 1985); family systems (Bond & Wagner, 1987); delinquency (Burchard & Burchard, 1987); the role of the school in primary prevention (Bond & Compas, 1989); and most recently, global strategies for improving children's lives (Albee, Bond, & Monsey, 1992).

In 1983 the conference focused on human sexuality and the prevention of sexual problems. The presentations from that conference have been included in *Promoting Sexual Responsibility and Preventing Sexual Problems* (Albee, Gordon, & Leitenberg, 1983) and are particularly relevant to many of today's most pressing social issues, particularly the increasing incidence of AIDS and the epidemic rates of teen pregnancy and child sexual abuse. Sexuality is also a key component in developing satisfying and lasting relationships. Both men and women have reported entering into extramarital affairs as a means of fulfilling unmet sexual needs. In fact, it is estimated that approximately 50% of all married men and 25% of all married women will engage in sexual relations outside of their marriage at least once (Gullotta, Adams, & Alexander, 1986).

Cultural stereotypes may also communicate erroneous information about sexuality. For example, it is not uncommon for men to believe that their masculinity hinges on sexual performance and that "real men" should not turn down sexual opportunities (McCarthy, 1988). Clearly, the need for accurate information is acute if we are to prevent the occurrence of pathology, be it social, physiological, or psychological. The work presented in this book addresses many of these issues and presents ways of defining and fostering mature sexuality, understanding sexism and its consequences, preventing victimization, and implementing effective sexuality education in the family, school, and society. A work on psychological approaches to the prevention of AIDS describes the only promising approach to this problem (Mays, Albee, & Schneider, 1989).

Although many of the volumes are devoted to specific topics, the Vermont conference has also published several books that examine primary prevention from a broader perspective. *Readings in Primary Prevention: Basic Concepts* (Joffe, Albee, & Kelly, 1984), *A Decade of Progress in Primary Prevention* (Kessler & Goldston, 1986), and *The Primary Prevention of Psychopathology: The Issues* (Albee & Joffe, 1977) each offer an excellent overview of the field. In addition, several of the publications including *Prevention Through Political Action and Social Change* (Joffe & Albee, 1981) and *Prevention, Powerlessness and Politics: Readings in Social Change and Political Action as Prevention* (Albee, Joffe, & Dusenbury, 1988) stress the importance of social change in reducing the incidence of the so-called "mental diseases."

#### **Conditions for a Successful Prevention Revolution**

A major condition for a successful prevention revolution involves an overt challenge to authority. At this time the medical-industrial, drug company, political-conservative coalition holds the microphone and constantly blares out the message "All mental illness is a medical disease." Those of us who disagree with this message must take every opportunity to counteract, ridicule, and punch holes into the pompous statements made by these people.

The Quakers regularly urged people to "Speak Truth to Power." This is the most important step in establishing effective primary prevention programs. The research evidence needs to be laid out for all to see, evidence that supports the fact that mental and emotional disorders result from stress and are far more common among very poor people and among those who are under greater social stress than among affluent persons. We need to report the compelling evidence from longitudinal studies of social and demographic factors that identify social stresses, like sexism, racism, and involuntary unemployment, for example, as major elements in producing emotional disorders (Brenner, 1977; Mirovsky & Ross, 1989). Lack of adequate social coping skills, low self-esteem, and social isolation are also major causes of psychopathology. John Cassel (1976), a physician who spent many years at the School of Public Health at the University of North Carolina, said in his final major lecture:

A remarkably similar set of social circumstances characterizes people who develop tuberculosis and schizophrenia, become alcoholic, are victims of multiple accidents, or commit suicide. Common to all these people is a marginal status in society. They are individuals who for a variety of reasons (e.g., ethnic minorities rejected by the dominant majority in their neighborhood; high sustained rates of residential and occupational mobility, broken homes or isolated living circumstances) have been deprived of meaningful social contact. (p. 110)

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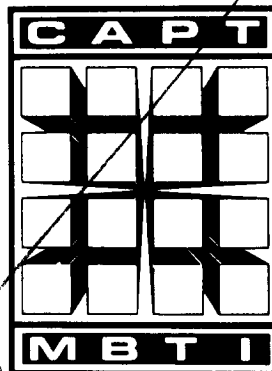
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