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The Argument For Primary Prevention

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I hope I'm not violating any debate rules by standing to speak. My daughter Sarah, the mathematician, once calculated that I have spent twenty-two thousand hours standing and talking in front of classes and groups. I can't really talk sitting down. So, with your indulgence, I will stand.

There's an old Vermont test of intelligence where you hand the subject a dipper and ask him or her to empty out a tub of water into which a tap is flowing. If the subject starts baling, without shutting off the tap, you consider him or her stupid. Those of you with a MAT score above a certain threshold will follow the argument. It was begun for me by John Gordon, a professor of epidemiology at Harvard, who in the late fifties sat me down and said: "No mass disorder afflicting humankind has ever been brought under control or eliminated by attempts at treating the afflicted individual nor by training large numbers of therapists." I never forgot his words, and I make my classes memorize them because this is the essence, the whole spirit of public health. One does not get rid of mass plagues afflicting humankind, including the plague of mental and emotional disorders, by attempts at treating the individual.

One of the arguments that we hear often from people on the political right is that there is no evidence to support primary prevention efforts. I have put out on the table, outside this room, brochures describing our series of seven books resulting from the seven annual conferences on primary prevention at the University of Vermont.

These books contain about a hundred and fifty chapters detailing effective prevention efforts. There also have been extensive reviews of primary prevention successes by Gerald Caplan (in a recent issue of a new journal, *The Journal of Primary Prevention*) by Mark Kessler and me, in *The Annual Review of Psychology*, 1975, and in a book by Steve Goldston and Donald Klein, *Primary Prevention: An Idea Whose Time has Come.* We have a lot of evidence of the effectiveness of primary prevention, and I'm not going to use my precious time tonight

specifying and detailing all of this evidence, because it is available in the literature for all to read.

I am amused and intrigued by the proposition I am supposed to defend: that "Primary prevention is a valid and proven form of intervention." I am willing to defend that statement, but the curious thing is that psychiatry, for many, many years, has used interventions for which the research evidence is *far* from valid and *far* from proven. What is the valid and proven evidence, for example, that supported the use of megavitamin therapy, or lobotomy, or electric shock, or metrazol, or insulin coma, or all of the other periodic enthusiasms that have been seized, embraced, and used by psychiatry as intervention. Why should primary prevention by expected to have a much *higher* standard of validity for its research than the other research in the field. I am willing to defend the argument that we have it, but it's a kind of interesting commentary that the statement to be debated is framed in the way that it is.

A common objection to primary prevention says that we shouldn't be spending our money (this is really *the* key objection) on trying to prevent things when there are so many people lined up who need our treatment. The problem with this position is that we are only seeing a very, very small percentage of all the people who need treatment, and *not* those in greatest need. Dr. Klerman, who was head of the Alcohol, Drug Abuse and Mental Health Administration, has estimated that we have about 34-36 million "hard-core mentally ill" people (his phrase) in our society. And, he adds, in addition to that, there is a very large additional number of people (perhaps 50 million) with serious emotional distresses that are a result of the crises of daily life. But last year, in this country, we saw a total of only seven million people in *all* our mental health intervention programs put together! I want you to be sure to understand we are seeing a very, very small percentage of those needing help, and there is no prospect, no hope, that we will ever have the professional personnel required to do much more than we are doing at the present time. So to stress the importance of treatment, to say we can't spend any more money on prevention because we ought to be spending it on treatment, is really nonsense. Further, we are not treating the right people. In a book by the American Psychiatric Association, called *America's Psychiatrists,* it was shown that the average, the modal, psychiatric patient is a middle class, white, neurotic—sort of a Woody Allen type—who comes for frequent treatment which is psychotherapeutic and which is very expensive. So the disturbed people that we are *not* treating are children and adolescents, members of minority groups, the aged, people with real, genuine

psychotic disturbances, and those with real problems of senility involving brain degeneration. All of these true cases, that most need our help, are *not* being seen because of the dedication of the interventionists to their private office psychotherapy.

In their famous, and widely-quoted article, Dr. Lamb and Dr. Zusman (1979) said, "Mental illness is in large part probably genetically determined and it is therefore not preventable, at most only modifiable. Even that it can be modified is questioned by many and there is little hard evidence one way or the other." Now, if their statement is true, friends, we are in real trouble! If 34 million hard core mentally ill people are the way they are because of genetic factors, we have a real genetic disaster on our hands in this society! We really don't know much of anything about genetic factors although there is a lot of propaganda written about this. Leon Kamin, who did the marvelous expose of Sir Cyril Burt and all of the fakery that went on in the studies in England Burt did on intelligence in twins, is about to come out with an equally devastating paper on the defects in the studies involving the genetics of schizophrenia. I commend it to your reading when it appears. I also recommend the book on schizophrenia by Sarbin and Mancuso as a serious criticism of the genetic research on schizophrenia.

We have all been educated by the great popular medical journals (like *Time, Newsweek,* the *Reader's Digest,* and the *New York Times Sunday Magazine*), that periodically publish the same old article, and I've got a huge collection of these. They go something like this:

> Behavioral and medical scientists today, at the University of Tasmania, have reported that there is a mysterious protein molecule in the spit of schizophrenics. They have been boiling schizophrenics' spit for the past five years and when they inject this substance into spiders, the spiders go and hide in corners. Dr. B. S. Pompous, director of the laboratory, has said, 'Send us more money because we are on the verge of disproving the nonsense that what happens to children affects their later lives.'

One of the serious problems I have had with Dr. Lamb's and Zusman's papers, that I have quoted so frequently, is that they argue that most mental disorders are genetic and therefore not preventable. The problem is that the total number of mental disorders keeps expanding! And each time one of the *Diagnostic and Statistical Manuals* of the American Psychiatric Association is published, we have many new mental disorders! When DSM I was published in 1952, there were 60 mental disorders. In 1968 the number in DSM II had grown to 145. By 1977 the latest DSM III contains 230 different forms of mental

illness! Now either new genetic mental defects are being discovered almost more rapidly than they can be printed. or there are *some* mental illnesses that are not genetic and not organically determined. If we can prevent some of the latter, then we have already won this debate! If we can prevent anything in DSM III, as there are the official diagnostic categories of mental illness of the American Psychiatric Association, we have succeeded!

I want you to know that I am cured of *my* former mental illness. I had a Tobacco Addiction Syndrome, and I quit smoking three years ago, just cold turkey. I have two daughters, however, that I am sorry to say are mentally ill because of the DSM III category of the *excessive use of any substance.* They are both yogurt addicts!

I don't want you to think that because Dr. Goldston and I are over here, and the psychiatrists are over there, that this is a psychology versus psychiatry debate. It is not. There are many distinguished psychiatrists who stand firmly for the truth, *for* primary prevention.

Leon Eisenberg, a distinguished professor of psychiatry at Harvard and past-President of the American Orthopsychiatric Association, some years ago said:

> As citizens we bear a moral responsibility, because of our specialized knowledge for political action to prevent socially induced psychiatric illness. This implies fighting for decent subsistance levels and public assistance programs, good housing, health care, education, and the right to work for all.

Another distinguished American psychiatrist, Harry Stack Sullivan (perhaps the greatest psychiatrist produced in America), says:

> Either you believe mental disorders are acts of God, predestined and inexorably fixed, arising from a constitutional or other irremediable substratum, the victims of which are to be helped through an innocuous life to a more or less euthanaistic exit, or you believe mental disorder is largely preventable and somewhat remedial by control of psychosociological factors.

That was Harry Stack Sullivan, and I'm glad to have him on my side. I could go on with Adolf Meyer, Freida Fromm Reichmann, Eric Lindemann, Gerald Caplan, and many other distinguished psychiatrists who support primary prevention efforts.

Another favorite argument of the anti-preventionists is that: "There is no evidence that poverty *causes* mental illness." Oh, yes, they admit there *is* a correlation between poverty and high rates of psychopathology, but this is a correlation only. Now I have to point

out that medicine accepts correlation in other areas. There is a correlation between smoking and lung cancer. We are now in the process of trying to convince people not to smoke because of this correlational evidence. The "Downward Drift" theory, which is advocated by our distinguished opponents, says that, "It is not necessarily because poor people and people who are powerless have higher rates of disturbance; it is because middle-class people like us have drifted down to poverty levels because we were susceptible." This "Drift Down" hypothesis has been largely rejected in the literature. It really doesn't hold water when you examine the fact that people who *used* to be poor had high rates and now do not after their class level has improved. When the poor moved into the middle class, their rate of mental illness dropped. When the Irish moved up and out of poverty into the middle class, their rates of idiocy and lunacy, high in 1855, subsequently dropped. When the Swedes moved out of Class V and into the middle class, their rates dropped. The same thing was true of the Eastern European Jews, and the same thing was true of the Southern Italians. As each successive immigrant group moved up and out of poverty, their rate of psychopathology dropped. I don't know what happened to all those bad Irish and Swedish genes that accounted for their high rates of lunacy and idiocy, but whatever happened they have fallen to an average or middle class rate of distress.

Another kind of evidence against the "Downward Drift" hypothesis is the current high rate of psychopathology among the involuntarily unemployed. Today in many parts of the country, (i.e., Detroit, Michigan, Gary, Indiana, Youngstown, Ohio,) where there are high rates of involuntary unemployment, there are now also exceedingly high rates of admissions to mental institutions, hospitals, clinics, etc. There is also a dramatic increase, in those places, in child abuse and wife abuse, in the consumption of alcohol, and in alcohol-related deaths like cirrhosis of the liver, all as a consequence of unemployment. These people didn't "drift down" into these higher rates, but because of powerlessness and stress they have higher rates of disturbance.

Our clinical experience certainly ought to be enough to convince us that the consequences of childhood rejection, childhood emotional damage, inconsistent treatment of young children, all have devastating consequences for emotional disturbances in adult life. And this is an environmental approach.

Harry Harlow's studies on the effects of Monster Mothers and of social isolation on the development of baby monkeys are too well known to review here but they give us a perfect model of the damaging consequences of early pathological infant experience. A recent study in

Sweden, and another in Czechoslovakia, examined what happened to unwanted babies (where the mother had tried twice for an abortion and was turned down). These children were born, grew up, and were followed through high school. They had much higher rates of psychopathology than babies that were born to a control group of mothers who had *not* sought abortions. That is, unwanted children are at very high risk, and this is clearly not a "downward drift" but an environmental problem.

Another favorite argument of opponents of prevention goes something like this: "How can you prevent something if you don't know the cause?" This is probably the most frequent comment in the literature criticizing primary prevention. The answer to the question is: "Easy!" In the field of public health, when John Snow removed the handle from London's Broad Street pump and stopped a cholera epidemic, he didn't know what caused cholera. There are innumerable examples in the field of public health, involving miasma theory, for example, which resulted in effective reductions in disease without knowledge of cause.

I think the most important point I can make is that there is not a one-to-one correspondence between cause and effect for mental disorder. Virchow, a great medical expert back in the 1870s, contributed to medicine by announcing that every disease has a separate cause. This insight really put medicine into orbit because it led to the identification of specific diseases. It is *not* the case for psychiatric disorders, however, that each condition has a separate cause with a specific effect. For example, following the death or loss of a loved one (a cause) there can be any number of different consequent forms of psychopathology like depression, or alcoholism, or social withdrawal, or accident proneness. So if there isn't a one-to-one correspondence, this simply suggests that we ought to try to *reduce stress,* every kind of avoidable stress, including the stress of exploitation, the stress of powerlessness, the stress of discrimination, the stresses of sexism and racism and age prejudice. And as a consequence of the reduction of stress, we reduce the consequent distress. Another approach, of course, is to *strengthen the host.* (The typical public health model is either to remove the noxious agent, or to strengthen the resistance in the host. In our field this means competency building programs). In four of our published volumes, our concern is with competency building—building competencies in children, building self-esteem into children and adults, programs to help them resist stress.

The last thing I want to emphasize as a primary prevention technique, is the *building of support networks,* development of support groups. We have an abundance of evidence that people who belong to,

or who can be encouraged to become, a part of strong networks and strong support systems, are very resistant not only to emotional and mental disorders, but to physical disorders also. If there is one overarching public health principle in this field, it is that being a part of a strong support network and support system is an effective form of primary prevention.