Twenty Years of *The Journal of Primary Prevention*: A Collage

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The complete set of JPP issues, from its founding in 1980, to date, stands about 2 feet high, with about 6,000 pages of articles, special features, and reviews. JPP Editor Tom Gullotta asked me to convey something about the flow of ideas that occurred during this time regarding this journal that was dedicated “to better understanding of . . . [primary] prevention theory, research and practice.” I readily agreed to the task, and then spent many a day regretting it—not that it wasn’t a wonderful experience to reread these papers, but I became overwhelmed with the problem of how to convey the enormous and kaleidoscopic developments in primary prevention ideas that have occurred. The solution, inadequate as it may be, is to sample a tiny piece of this continent of ideas through selective quotations in order to give some sense of community and home to many of us immigrants to primary prevention.

I’ll keep my part restricted to some general observations in italics at the beginning of each section of the paper—reflections on where we have been, how far we have come, and how very much further we have yet to go. In the end, the excerpts speak eloquently for themselves. Savor them. I thank the many authors whose work I excerpted—arbitrarily—and to those contributors to the JPP whose work I omitted—equally arbitrarily—for space and other limitations. What follows is not the work of a camera; rather it is an impressionistic chronological collage. The essence of any science is, after all, art.

DEFINITIONS OF THE TERMS OF PRIMARY PREVENTION

First, some observations: Primary prevention has gone through several stages of the definition of its key terms, from Leavell & Clark’s public health perspective distinguishing “prevention” from treatment and rehabilitation, to Gerald Caplan’s important analysis regarding primary, secondary, and tertiary prevention. Later thinking moved back to the public health triad, but with emphases on risk and

protective factors. In 1994, the Institute of Medicine proposed yet another way to discuss the prevention of mental disorders: 1) Prevention was to be limited to those interventions designed to prevent the onset of a disease, divided into "universal preventive interventions" and "selective preventive interventions"; 2) Secondary prevention was to be termed "indicated preventive intervention"; and 3) the concept of tertiary prevention was to be discarded entirely. This definition, much like Leavell & Clark's 1953 public health-oriented definition, may fail to recognize social and cultural factors or the entire enterprise of promoting strengths, in favor of limiting disease-oriented approach. As you will read, many other characteristics have been addressed, such as a focus on collective versus individual targets, proactive or reactive responses, active or passive strategies, the strengths perspective versus the medical pathology model. Albee's formula seems to have struck a vital cord in primary prevention thinking by providing general guidelines for research and practice. Each generation seems to re-define new emphases, while beginning to accept a core meaning of the prevention of predictable problems, the protection of existing states of health and healthy functioning, and the promotion of desired states of affairs for a target population. And now, twenty years of definitions of primary prevention and related terms. All references are attached to the quotation, rather than being listed separately:

"To most of us 'primary prevention' and programs of 'primary prevention of emotional disorder' of children appear to be as unambiguously wholesome as apple pie. Unfortunately, that kind of analogy is reminiscent of the 1950s and early 1960s where theories of primary prevention in mental health first began to flourish (Caplan, 1964). Now in the 1970s the beliefs of the past two decades are being challenged. . . . All definitions of primary prevention clearly include the concept of defending against the emergence of mental health problems by building strength and coping capacity." [Helen Reinherz. (1980). Primary prevention of emotional disorders of children: Mirage or reality. 1:1,5,6.]

"Primary prevention means helping 'vulnerable high risk groups within the community who have not been labeled psychiatrically ill and for whom measures can be undertaken to avoid the onset of emotional disturbance and/or enhance their level of positive mental health' (Goldston, 1977b, p.20). . . . Ryan reminds us that throughout the history of public health, ' . . . no major human disorder or disease has ever been controlled by treating diseased individuals' (Van Antwerp, 1970, p. 453). . . . We have a long way to go before we can begin to approach Tarjan's notion of an ideal prevention program ' . . . (one that would) assure every child of being born with a healthy central nervous system, of having a set of early experiences supportive of intellectual, emotional and social growth and of being protected from damaging physical and psychological traumata' (Tarjan, 1977)." [Mona Silver Kornberg & Gerald Caplan. (1980). Risk factors and preventive intervention in child psychotherapy: A review. 1:2:71, 106.]

“... [T]he National Association of Prevention Professionals (1979) defines prevention as ‘a proactive process which promotes health by ... empower(ing) people with resources necessary to constructively confront complex, stressful life conditions and to enable individuals to lead personally satisfying, enriching lives’.” [Sanford Schwartz and Edward A. Bodanske. (1980). Environmental strategies for primary drug abuse prevention programs. 1:3,192.]

“Prevention can be described as a complex set of activities aimed a) at developing the personal and social competencies of people, and b) at modifying social systems to better meet the needs of people (Cowen, 1971). Working on both these levels, prevention encompasses action directed toward individual, social, economic, and cultural influences which are assumed to contribute to the emergence of individual dysfunctional behavior, or conversely, which can be modified to contribute positively to the emergence of wholesome personal and social behavior (Milwaukee Planning Council for Social and Mental Health Services, Note 5).

“It has the following characteristics:

1. Proactive [and] 2. Generic	General characteristics, which distinguish prevention from treatment.
3. Developmental [and] 4. Experiential	Characteristics pertaining to individuals and families who are usually considered to be the ‘target population’ of wellness and prevention activities.
5. Systemic [and] 6. Collaborative	Characteristics pertaining to the environment, or the social institutions which serve as support systems and resources to the target population.”

[Charles T. Adam.(1981). A descriptive definition of primary prevention. 2:2:68.]

“At the minimum, I believe that a program aspiring to the good name ‘primary prevention’ must meet three *structural* requirements: 1) It must be group- or mass-, rather than individually-oriented (even though some of its activities may involve individual contacts). 2) It must have a before-the-fact quality, i.e., be targeted to groups not yet experiencing significant maladjustment (even though they may, because of their life situations or recent experiences, be at risk for such outcomes). 3) It must be intentional, i.e., rest on a solid, knowledge-base suggesting that the

program holds potential either for improving psychological health or preventing maladaptation.” [Emory L. Cowen. (1982). Primary prevention research: Barriers, needs, and opportunities. 2:3, 132.]

“Primary prevention is the term applied to attempts to reduce the future incidence (new cases) of emotional disorders and mental [illness] conditions. It is aimed at populations of persons free of the disorder—those not yet affected. The efforts are *proactive*, before the fact [of an existing problem] . . . [Albee presents a formula] to reduce the incidence of the different conditions or compulsive lifestyles we refer to as mental disorders. . . .

$$\text{incidence} = \frac{\text{organic factors} + \text{stress} [+ \text{exploitation, added in 1987}]}{\text{competence} + \text{self-esteem} + \text{support networks}}$$

[George W. Albee. (1983). Psychopathology, prevention, and the just society. 4:1, 23, 26. Also (1987). A framework for prevention, 7:4, 199]

“To some extent, Caplan (1964) has confused some issues in characterizing psychopathology prevention in public health terms [‘primary prevention,’ ‘secondary prevention,’ and ‘tertiary prevention’]. His interpretation still follows the medical model and is disease oriented. To avoid this unnecessary snare, perhaps we should return to the language antedating Caplan’s classificatory schema. . . . Kessler and Albee (1975) . . . propose the attractively seductive position that prevention refers to the prevention of mental disorders, and rehabilitation to the reparation of systems affected by the disorder. Therefore, primary prevention ‘can be anything which prevents the occurrence of disorder’ (Kessler & Albee, 1975, p. 559). This approach certainly allows for and even encourages the investigation of social factors as related to mental disorder, in contrast to the medical model. . . .” [Donald G. Forgays.(1983). Primary prevention: Up the revolution. 4:1: 45.]

“The process of defining prevention is the process of making societal values explicit. . . . The important part of the definition process . . . is not arriving at a concise statement that some people will inevitably say is too narrow and exclusive, or one that others will complain is so broad and inclusive as to be meaningless. The important issue is how we elect to interpret any existing or future definitions and thus transform these frameworks into action. . . .

“Primary prevention presents us with a dichotomy between two fundamentally different types of approaches to problems. On the one hand, we have individual level strategies (health promotion/disease prevention) that see problems as failures of individuals to adequately protect themselves. On the other hand, we have environmental strategies (health protection) that view problems as failures of the larger system to provide adequate safeguards for individuals. The former strategies are focused on strengthening individuals against disease through the provision of

adequate information and remedial services. . . . This is contrasted with environmental strategies that seek to reduce the risk for the individual by regulating the system in which the individual exists. . . .

"[T]he way we define the problem determines the types of strategies that we can bring to bear on the problem. . . . Currently, our societal values . . . reinforce a 'blaming the victim' approach (Ryan, 1976) that has little chance of significantly reducing the serious public health problems we seek to address." [Lawrence Wallack. (1984). Practical issues, ethical concerns and future directions in the prevention of alcohol-related problems. 4:4, 199, 204, 205, 215.]

"The concept of the information 'clearinghouse' is a fairly recent one, born out of the realization that knowledge in the health and social sciences is rarely translated into appropriate programs in a systematic or expeditious manner. . . . The clearinghouse concept is an innovation that was designed to bridge the gap between knowledge development and utilization. A clearinghouse is a centre for the accumulation and distribution of information on a specific topic (e.g., family violence, alcoholism and drug abuse) or an approach to a problem (e.g., self-help, education). In contrast to libraries, clearinghouses tend to provide a wider range of information (e.g., information on programs, government documents, funding sources, service providers, and so-called "fugitive literature" which is not published or not widely circulated). Clearinghouses also offer a more individualized approach than libraries by assessing the needs of the information user and by tailor-making information to meet those needs. Clearinghouses are characterized by an active approach to knowledge dissemination, using such methods as referral to other information sources, networking, consultation and education." [S. Mark Pancer, Geoffrey Nelson, and Bryan Hayday. (1990). The Ontario Prevention Clearinghouse: Part I—History and program description. 10:3, 241–242.]

"Primary prevention can be defined as planned efforts to reduce (prevent) the incidence of new cases of dysfunctional behavior in a population not yet demonstrating signs of dysfunctional behavior and to encourage (promote) behaviors that are known to contribute to functional behavior."

"Primary prevention focuses on healthy populations. . . .

"Primary prevention makes sense. That is, dollar 'cents' and wellness sense. . . .

"Opportunities for prevention are everywhere. . . .

"Prevention happens before the onset of dysfunctional behavior and continues across the lifespan. . . .

"Acting as consultants and collaborators, health care professionals use primary prevention's technology of education, competency promotion, community organization/systems intervention, and natural caregiving to encourage the growth of functional behaviors in society." [Thomas P. Gullotta. (1994). Introduction to

the First Issue of the 15th anniversary volume of *The Journal of Primary Prevention*. 15:1, 6,7,8,9,10. Italics removed.]

“Resilience is not a fixed constitutional attribute, but a process, and the choices one makes at key turning points in life can greatly influence this process. . . . Self-esteem and self-efficacy may be the most important traits in resilient people. . . . [O]ther essential characteristics of resiliency are: 1. Possessing intellectual capabilities—especial good verbal and communication skills. . . . 2. Having an easy temperament (generally a generic or biological trait) which helps to attract the positive regard of adults. . . . 3. Acquiring good social- and problem-solving skills . . . 4. Having a sense of humor that enables a person to laugh when things do not go exactly as planned or in times of frustration or upset. . . . 5. Being able to separate from ‘toxic’ situations and environments—especially a ‘toxic’ family. . . . 6. Being able to be empathic, and experience true compassion and understanding of others. . . . [The authors go on to examine gender specific stressors and risk factors, and protective factors.]” [Sandra Turner, Elaine Norman, and Sharyn Zunz. (1995). Enhancing resiliency in girls and boys: A case for gender-specific adolescent prevention programing. 16:1, 27, 26.]

THEORY AND RESEARCH METHODOLOGY IN PRIMARY PREVENTION

Some observations: As some distinguished theorists and researchers have reminded us, we have a long way to go before we can claim sophisticated theory in primary prevention, and that we had better proceed cautiously in the claims (taking baby steps), while moving energetically and meticulously in our work. And yet, it is clear that writers in primary prevention theory and research are informed and concerned about the basic structural elements and logical flows of our theory, and a few writers have offered some remarkably useful strategies—even if these are not the logically precise entities that classical philosophers of science require. As an applied social science, our first requirement is to guide research and practice along fruitful lines, as we simultaneously struggle to understand the fundamental structures and forces involved in primary prevention. As you read these excerpts, you may get a sense of the energy involved in seeking these goals, as well as the breadth and depth of their work. Among the major themes in this set of excerpts are those urging consideration of systemic or ecological models with their multi-systems and multi-levels approach, that is to say, the world as we know it.

“Basic to the [ecological] model is the concept that the physical, cultural, political, and social-psychological environment form a context that influences the behavior of the individual. Any change in one aspect of the system has ramifications for all other aspects of the system. When designing an intervention from an

ecological point of view, the individual person, the social group or organization, the community, the culture, and the interaction of these factors are all considered.” [Patricia Clement McCulloch. (1980). The ecological model: A framework for operationalizing prevention. 1:1:35–36.]

“Just as the question ‘What specific therapeutic interventions produce specific changes in specific patients, under specific conditions (Strupp & Bergin, 1969, p. 20) has guided recent studies of psychotherapy effectiveness, so too must preventive programs address this issue.” [Robert D. Felner, Melanie A. Ginter, Mary F. Boike, and Emory L. Cowen. (1981). Parental death or divorce in childhood: Problems, interventions, and outcomes in a school based mental health project. 1:4, 240.]

“The key to financing preventive interventions to reduce the total number of new individuals manifesting new dysfunctional patterns is to determine *who in the private sector other than mental health professionals are profiting from this critical life junction and how we can improve their profitability?* . . . Everything costs (and costs, here, refers not only to financial but emotional costs as well), but prevention costs less in money and in human suffering than does treatment.” [Thomas P. Gullotta. (1981). An unorthodox proposal for funding primary prevention. 2:1:18.]

“The simultaneous involvement of multiple influence processes at different levels of social organization suggest that a prevention approach aimed at one kind of influence (e.g., peer pressure) or one level of analysis (e.g., psychological adjustment) will be diluted or vitiated by virtue of the inherent complexity of the phenomenon. . . . [W]hat appears to be needed is greater attention to conceptual integration.” [Thomas F. Barbor and Steven Berglas. (1981). Toward a systems-ecological approach to the prevention of adolescent alcohol abuse. 2:1,34–35.]

“Few would contest the assertion that the experiences children have growing up within family units powerfully affect their adjustment, coping styles, and the ways in which they go about resolving interpersonal problems. . . . Such linkages, if found, would provide important cues for future primary prevention programming, especially within the framework of the three step (stressful life-event) paradigm advanced by [B.L.]Bloom (1979): 1) identify stressful life-events that adversely affect many people; 2) through epidemiological and laboratory approaches, study the correlates and consequences of such events and formulate plans for reducing or eliminating negative outcomes; 3) conduct and evaluate preventive interventions based on such knowledge.” [Viviane Perex, Ellis L. Gesten, Emory L. Cowen, Roger P. Weissberg, Bruce Rapkin, and Mary Boike. (1981). Relationships between family background problems and social problem solving skills of young normal children. 2:2, 80–81.]

"Traditionally, events have been viewed as discrete occurrences, as markers for development, or transition points which give shape and direction to the individual's life (Neugarten & Hagestad, 1976). . . . However, if events [can be] viewed as processes, which include a period of anticipation, then preventive interventions which foster planning ahead can be developed. [The authors' project] assumes that many of the difficulties which older adults encounter can be thought of as processes which include period of anticipation. [They offer a] community-based general education [preventive intervention] focused on anticipatory socialization (Atchley, 1977) for the elderly." [Michael A. Smyer, Barbara W. Davis, and Margaret Cohn. (1982). A prevention approach to critical life events of the elderly. 2:4, 198–199.]

"People develop as they do through their experiences in a very few high-impact social environments. For young children, the home and school exercise powerful shaping influences that can facilitate or impede healthy psychological development. That realization poses a challenge for primary prevention in mental health: 'How can high-impact social environments be shaped to optimize the adjustment of their inhabitants?' (Cowen, 1977)." [Stephanie Wright, Emory L. Cowen, and Elizabeth Kaplan. (1982). Perceptions of classroom environment and their relationship to children's mood, achievement, popularity and adjustment. 3:1, 18.]

[This excerpt used italics in the original, offering some principles of prevention and intervention in health centers:] *Identify the issues. . . . Develop strategies to understand community attitudes and feelings prior to planning any intervention. . . . Simultaneously, explore staff attitudes and feelings about the issues. . . . Agencies need to reflect the concerns of the community through an official agency position (rather than contribute to crises, conflict, or potential polarity). . . . During the planning stage, allow adequate time for relationships and consensus to develop and identify leaders who represent various points of view and facilitate communication among them. . . . Never act independently, either individually or as an agency. . . . Recognize the potential role of the media and attempt to educate and work closely with them in an effort to have their impact be in the best interests of the community. . . . Agency personnel are in a position to model effective coping behaviors by continuing to provide their usual range of services. . . . Rumor control mechanisms should be developed throughout the community, including within the Center itself. . . . Provide safe places for people to 'cool off' and plan effective coping strategies. . . . [W]e think that the principles outlined here can be applied to health and mental health intervention in communities experiencing various types of natural and man-made crises and disasters. . . . [Ward J. Cromer and Barbara J. Burns. (1982). A health center response to community crisis: Some principles of prevention and intervention. 3:1, 35–44.]*

"Increasing the supportiveness of individuals' social environments is becoming a central focus in the prevention of pathology and the promotion of personal

well-being. Interest in social support has stemmed, in part, from recent efforts to reformulate models of prevention. The traditional, public-health model of primary prevention focused on controlling very specific disorders attributed to rather specific causes. However, among those concerned with psychosocial well-being, there is increasing acceptance of a general environmental stress model wherein psychological impairment is linked to a heterogeneous array of immediate and distal stressors ([B.L.] Bloom, 1979; Dohrenwend, 1978). The ubiquitous, varied, and often inevitable nature of these stressors (including negative life-change events such as bereavement, and ongoing life strains such as marital conflict or work dissatisfaction) suggests the need to increase stress-involvement as well as to control exposure to stressors." [Roger E. Mitchell, Andrew G. Billings, and Rudolf H. Moos. (1982). Social support and well-being: Implications for prevention programs. 3:2, 77-78.]

"... Social scientists have postulated that various mental health benefits arise from peer support: (1) mutual help groups aimed at the mastering of developmental tasks can be a primary prevention strategy to reduce maladjustment and promote positive growth (Goldston, 1977); (2) social support can buffer the stress of transitions, including the transitions to parenthood [which is the topic of this paper], and can facilitate coping through help, resources, and caring (Cobb, 1976); (3) reference groups of similar others can provide role models and standards for self-evaluation (Festinger, 1954); (4) accurate information and support can lead to more appropriate parenting behaviors (White, 1975) and coping skills (White, 1974)." [Lois Pall Wandersman. (1982). An analysis of the effectiveness of parent-infant support groups. 3:2, 102.]

"Study of informal assistance suggests the power of the natural social and familial networks in supporting health, providing referrals, and in generating direct assistance (Coward, 1978; Gottlieb, 1979; Pilisuk & Froland, 1978; Stoller, 1979). . . . The five major components of the helping network model are: (1) selection of the *external intervention and coordination team* or project staff; (2) developing a *community umbrella group* to provide guidance and sanction for the overall project; (3) identification of and contact with *natural community helpers*; (4) the development of *natural helping teams* for problem solving on behalf of a family or individual in crisis or pre-crisis situations; and (5) the use of *constituency-based problem solving* as a means for increased community and human service agency interaction in addressing community level issues." [Marc Pilisuk, Susan Hillier Parks, Jacqueline Kelly, and Elizabeth Turner. (1982). The helping network approach: Community promotion of mental health. 3:2, 116-117.]

"The Perceived Personal Control Model is a theoretical model of crisis. It explains the locus and intensity of crisis as a function of the perceived personal control (PPC) of the individual. . . . The PPC model has significant implications

for crisis intervention. It calls for manipulation of situational variables, such as natural and organized support systems, information, and the person's share in the decision making process, as well as task-oriented activity, geared to enhance emotional, cognitive, and behavioral control. . . ." [Ciporah S. Tadmor and Joseph M. Brandes, 1984). The perceived personal control crisis intervention model in the prevention of emotional dysfunction for a high risk population of Caesarean birth. 4:4, 240,241.]

"The main point . . . is that the full and open expression of emotion, or emotional discharge . . . is a natural healing process, which enables individuals (adults and children alike) to recover from a distressing event or condition. . . ." [Phyllis Bronstein.(1984). Promoting healthy emotional development in children. 5:2, 98.]

"Moral training of young children in contemporary American culture focuses more on proscriptive rules and regulations, what *not* to do, rather than on positive altruistic values of what *to* do. . . . In summary, this [literature] review suggests that if a parent wants to encourage altruistic behavior in children, the adult must establish a warm, nurturant relationship with the child and be a model of altruistic behavior. If this exists, then praise, instruction, and reinforcement will enhance the effects. Additionally, an inductive style of discipline is preferred because it encourages the child to empathize with the victim. Encouraging cooperative behavior and assigning responsibilities can also help develop altruistic behaviors." [Linda F. Patrick and Patricia A. Minish.(1985). Child-rearing strategies for the development of altruistic behavior in young children. 5:3, 154, 160.]

"Etiological work has been crucial in shaping current prevention efforts [regarding adolescent drug abuse]. The [nine] models reviewed here have contributed to the specification of the most proximal variables of concern as well as suggested methods for achieving change in drug use patterns. The change in focus of prevention efforts from knowledge dissemination programs to social skills and environmental concerns has come directly from this literature. . . ." [Cheryl L. Perry and David M. Murray. (1985). The prevention of adolescent drug abuse: Implications from etiological, developmental, behavioral, and environmental models. 6:1,48.]

"The social development model provides an empirically grounded theoretical base for designing, implementing, and assessing delinquency prevention programs. . . . [This model is] derived from integrating control and social learning theories. . . . [It is] a process in which the most important units of socialization—families, schools, and peers—influence behavior sequentially, both directly and indirectly.

"In each unit of socialization, three types of process variables (opportunities for involvement, skills, and reinforcements) determine whether a youth's participation in that unit will contribute to the development of a bond of attachment

and commitment to and belief in conventional society.” [J. David Hawkins and Joseph G. Weis. (1985). The social development model: An integrated approach to delinquency prevention. 6:2,81,79.]

“Mental health prevention research is making progress in the task of generating and scientifically testing hypotheses about the efficacy and cost-effectiveness of its techniques and programs (Forquer, 1980). . . . [T]he Center for Prevention Research at the National Institute of Mental Health (NIMH) emphasizes, as a program priority, testing the efficacy and cost-effectiveness of mental health prevention techniques and programs. Additional steps, however, must be taken toward constructive interactions between those who have been immersed in the early development of prevention programs and those who are embarking on planning and designing research. . . . Thus, the goal of prevention research would be to detect null effects, i.e., to show that some set of events did not occur because of the preventive intervention. . . .” [Joseph A. Walsh, Frederick L. Newman, and Stephen E. Goldston. (1986). Blending research, service and cost-effectiveness in prevention: What helps and what hinders? 7:2, 74–74.]

“Culture change principles: 1) Involve all the people affected. . . . 2) Adopt non-blame-placing approaches. . . . 3) Establish mutually beneficial solutions. . . . 4) Work towards task and goal clarity. . . . 5) Emphasize sustained change. . . . 6) Integrate concern for people with concern for achievement [. . . individual enhancement through greater organizational success]. . . . 7) Work from an organization and subculture-specific information base. Change programs need to be custom tailored to the needs of the setting at hand. . . . 8) Adopt multi-level change strategies [e.g., workers, organization, community, society]. . . . 9) Develop a positive outlook . . . [see needs as challenges, not as problems]. . . . 10) Create a sense of community. . . . [Using these principles within an action research strategy, the author and his colleagues succeeded in changing a migrant worker’s camp situation from one of low pay, poor housing, unhealthy conditions and chronic health problems, no unemployment compensation, violations of child labor laws, etc. to one where all regular employees were provided with medical and life insurance, retirement and savings plans, paid vacations; year around employment, sanitation in the fields, child-care centers, better connections with the schools, and opportunities for workers to build homes (with federal and company funding), etc.] [Judd Allen. (1986). Achieving primary prevention program objectives through culture change systems. 7: 2, 94–95, 100–104.]

“Prevention does not want for a constituency. The public readily subscribes to the belief that actions taken by them or by the larger community for them can promote health and prevent disease. . . . but mental health practitioners are more cautious. . . . Part of the problem this problem rests with the failure of preventionists to clearly articulate what constitutes prevention’s technology. [This paper

introduces five basic technologies:] [1] Education... the most frequently used of all prevention methods. . . . [2] Community Organization/Systems Intervention [—problems affecting groups at an institutional, community, or societal level, and addressed by solutions articulated at these same levels. . . . [3] Competency promotion. . . . [4] Natural caregiving. . . . 5] Consultation/collaboration.” [Thomas P. Gullotta (1987). *Prevention’s technology*. 8:1 & 2, 4,6, 9,13, 18.]

“...[S]ocial support can contribute to primary prevention in two ways: by *protecting health* at times when people are exposed to adversity accompanying stressful life events and role transitions, and by *enhancing health and morale* in everyday life. Its former contribution is reflected in studies documenting a stress-buffering role of support, while its contribution to health promotion is reflected in studies which find a direct or main effect of support on health. . . .” [Benjamin H. Gottlieb. (1987). *Using social support to protect and promote health*. 8:1 & 2, 54–54.]

“Empowerment . . . refers to activities directed to increasing people’s control over their lives. . . . The term empowerment has appeared with increasing frequency in psychology and mental health literature over the past decade. . . . Mental health professionals have been slow to adopt the empowerment construct, in part because psychology’s traditional practice orientation is individual-rather than systems-oriented. . . .

“Most empowering activities take place outside of the mental health profession—in consumer action groups, trade unions, social movements, housing and food cooperatives, etc. Preventionists need to identify and ally with those who are already implementing empowerment activities. . . .” [Carolyn Swift and Gloria Levin. (1987). *Empowerment: An emerging mental health technology*. 8: 1 & 2, 71, 83–84.]

“[First,] . . . almost everything that is known about the prevention of mental disorders applies equally well to the prevention of physical disorders. . . . [Second,] whether we consider physical or mental disorders, the research of the past two decades has made a compelling case that there is a biology of health, a psychology of health, and a sociology of health (Bubos, 1959; Engel, 1977, 1980, 1982) and that whether we are thinking about treatment or prevention, these three domains must be studied in their natural interactions. . . . [A] third aspect of the growing convergence in the thinking about physical and mental health is the increasing evidence that there is a very strong generic component to illness (Dumont, 1984; Stein & Jessop, 1982). An example of this generic phenomenon can be found in the research regarding stressful life events and social support networks. . . .

[Fourth,] “the evidence suggests that there are nonspecific mental health components that should be introduced into any preventive intervention program. Included in this list would be reduction of social isolation by the building of a psychological sense of community (Sarason, 1974); reduction of the sense of

powerlessness by increasing of self-efficacy (Bandura, 1977; Rappaport, 1981); and enhancement of interpersonal problem-solving skills by the use of such methods as social competency building, mental health education and community organization (Spivack & Shure, 1973; Shure & Spivack, 1982). . . .

"A fifth component of the convergence of thinking about physical and mental disorder has been the attention that has been drawn to the role of lifestyle in the predisposition, precipitation, and perpetuation of illness (Lalonde, 1974). Of the ten leading causes of death in the United States, seven are in large part behaviorally determined (Albee, 1985). . . . [Bernard L. Bloom. (1988). Primary prevention and the partnership of clinical, community and health psychology. 8:3, 150, 152, 153, 154, 155.]

"Investigations into child rearing practices tend to consider at least two orthogonal dimensions along which parenting behaviors may fall (Baumrind, 1967; Becker, 1964; Rickel, Dudley, & Berman, 1980). These may be labeled nurturance, which includes parental warmth, affection, or involvement, and restrictiveness, involving control, rules and expectations. . . . Several studies have suggested that the combination of a high degree of warmth with firm control and demanding parental behaviors, which has been labeled 'authoritative' (Baumrind, 1967p 1972; Peterson, Southworth & Peters, 1983), fosters the largest degrees of social responsiveness, intellectual striving and independence in children. Alternatively, permissive parents fostered dependence and less social responsibility in their children. Children of parents who were authoritarian, in that they were both cold and strict, tended to be discontent and withdrawn (Baumrind, 1967)." [Jana G. Atlas and Annette U. Rickel. (1988). Maternal coping styles and adjustment in children. 8:4, 169.]

"The concept of risk plays a critical role in the development of successful primary prevention programs (Kellan & Werthamer-Larsson, 1984; Kornberg & Caplan, 19880; Rolf & Hasazi, 1977; Vance, 1977; Watt, 1984). . . . [G]roups of individuals are considered to be at risk if they currently do not exhibit a disorder, but are statistically more likely to do so at a later time than are those from a general population (Bell & Pearl, 1982). Application of the risk model in primary prevention serves to restrict those targeted for intervention to groups defined as at risk, rather than intervening with the general population. This procedure conserves and focuses resources on those populations most in need of preventive services. . . ." [Mark A. Fine and Carolyn F. Swift. (1988). The prevalence of young children 'at risk' for later handicapping conditions. 8:4, 186.]

"It is clear that the nonorthogonal nature of risk factors presents significant challenges for researchers who are concerned with exploring the origins of human maladaptation. The preceding discussion leads to several suggestions for high-risk researchers.

"First, when possible, sampling should be dictated by the goal of securing a representative group that reflects the central tendencies and variability of the target population with respect to demographic variables. . . . Second, the notion of statistical control should be supplanted with the idea of incorporating multiple risk factors as they co-occur in the target population. . . . Third, as a general rule, in order to test the validity of a purported marker of constitutional risk for a specific disorder, the predictive power of parental psychopathology should be pitted against the predictive power of other risk factors and interaction terms." [Elaine Walker, Geraldine Downey, and Narina Nightingale. (1989). The nonorthogonal nature of risk factors: Implications for research on the causes of maladjustment. 9:3, 159–160.]

"There are several important advantages to including the input of youths in preventive programs. Whereas teachers are more credible sources of factual information, peer leaders have been found to have a greater credibility regarding social information (Klepp, Halper, & Perry, 1986). Similarly, peers can serve as potent role models. Youths that are involved in interventions can directly demonstrate prosocial behaviors, create and reinforce norms that certain behaviors are deviant rather than acceptable, and promote alternatives to these activities. Through the modeling of appropriate behaviors in a variety of social contexts, these skills and norms are more likely to generalize beyond the training settings (Bandura, 1977). . . . [T]here is a universe of influences on children, and to the extent that they are adequately conceptualized when planning preventive programs, there is a greater possibility of developing comprehensive interventions that produce both immediate and more long-term gains." [Leonard A. Jason and Jean E. Rhodes. (1989). Children helping children: Implications for prevention. 9:4, 203, 210.]

". . . [T]here is little evidence that a comprehensive understanding of complex behavioral phenomena such as delinquency will come from a continuing accumulation of fragmentary pieces of evidence. This does not imply that such evidence is useless or, worse, that we ought to abandon all experimental research, but rather that, beyond a process of isolation and reduction, one of integration and expansion is also necessary. It is obviously important to know which factors are reliably associated with the development of delinquency and interfere with prevention efforts, but it is equally important to understand the conditions under which such factors come to influence behavior and the processes through which they come to exercise their influence. In other words, we must study the discrete elements which make up a behavioral phenomenon *and* the organization which is characteristic of these elements and reliably predicts that phenomenon." [Jean E. Dumas. (1989). Primary prevention: Toward an experimental paradigm sensitive to contextual variables. 10:1, 35–36.]

". . . [There are] primary institutions, such as family, peer play and school [which can be described as] Key Integrative Social Systems, or KISS. These serve

children epigenetically, i.e., family to peer play to school. Those who are unable to function in the KISS need to use AID (Ailing in difficulty) institutions such as hospitals, courts, special schools, welfare agencies, probation offices, etc. . . . If one doesn't make it in the AID institutions and return to KISS, one can wind up in the ICE (Illness Correctional Environments). These institutions have the least degrees of freedom and are composed of mental hospitals, state and federal prisons." [Eli M. Bower. (1990). Going up river with Sue Scholar and John D. Dollarsense. 11:2, 114–115.]

"Medically trained prevention professionals have now accumulated over 20 years experience in conducting and evaluating 'community-based' medical experiments focused on the reduction of cardiovascular disease, strokes, and related risk factors. These studies represent a rich source of both technical expertise and practical know-how that other prevention professionals should consider before they design similar projects. . . . This paper is a review of past medical community interventions from the perspective of the development of alcohol problem prevention programs." [Michael Hennessy (1991). Designing and evaluating alcohol problem community interventions: Quasi-lessons from the experience of medical trials. 11:3, 169–170.]

"The Humiliation Dynamic is a powerful factor in human affairs that has, for a variety of reasons, been overlooked by students of individual and collective behavior. It is a pervasive and all too often destructive influence in the behavior of individuals, groups, organizations, and nations.

"The Humiliation Dynamic is used to socialize children and engineer conformity among adults. It poisons relationships between individuals and groups . . . [and] is a major weapon in the oppression of women, people of color, and other stigmatized groups. The experience of humiliation and the fear of humiliation are implicated in a variety of mental illnesses and engender rage which is manifested in anti-social behavior, murder, and suicide. Moreover, the dynamics of humiliation. . . . play an important part in perpetuating international tensions and violence.

"As it is defined for this paper, humiliation involves the experience of some form of ridicule, scorn, contempt, or other degrading treatment at the hands of others." [Donald C. Klein. (1991). The humiliation dynamic: An overview. 12:2, 93–94.]

"... [I have identified] certain approaches that promise to help us manage others' attempts to humiliate us and to diminish, if not eliminate, our need to humiliate others.

"They include: psychological immunization [—anticipatory instillation of pride in self and one's collective identity], refusing the role of victim by re-defining one's identity [—"consciousness-raising in which a previously introjected self-image of inferiority is almost literally 'vomited out' to be replaced

in successive stages by creating a separate, self-sustaining culture of one's own kind, and finally, being prepared to enter into an interdependent relationship of equal power with one's former oppressors."], participating in self-help and mutual support groups, using healing laughter, achieving a state of transcendent humility ["Humility means dying to self in the sense that one is no longer driven by pride and self-importance."], and responding with one's capacity for appreciation to the potential humiliations that come one's way ["I think of them as 'inverse paranoids.' That is, they project onto events *positive* expectations of hope and promise rather than negative ones of suspicion and mistrust".] [Donald C. Klein. (1992). Managing humiliation. 12:3, 255, 256, 257,262, 263.]

"What we have argued for in this paper is an appreciation of the useful role that behavioral time series data might play in better documenting some of the rich theoretical perspectives of transactional and ecological investigators. Similarly, the reciprocal system's orientation can provide behavioral investigators new perspectives for understanding the behavior influences that contribute to the long-term success of their interventions." [Leonard A. Jason. (1992). Eco-transactional behavior research. 13:1, 65.]

"In a symbolic interactionist approach, 'culture' can be defined neither as individual traits nor as the contexts which shape the lives of those individuals, but rather as the individual's active participation in an array of socially meaningful contexts. These contexts shape those who participate in them, just as the participants themselves shape the context. . . . Symbolic interactionism is uniquely well-suited to serving as a conceptual framework for prevention programs which target both the individual and the multiple contexts in which the individual is embedded, distinguish between the contexts of poverty and ethnic heritage, and focus on understanding, accommodating to, and explicit teaching the interactional norms, strategies, and styles appropriate to different sociocultural contexts." [Robin L. Harwood and Roger P. Weissberg. (1992). A conceptual framework for context-sensitive prevention programming: A symbolic interactionist perspective. 13:2, 109.]

"This paper describes an innovative technique, referred to as *previewing*, that may be used to predict and deter instances of child abuse. In general terms, previewing replicates specific patterns of interaction that have been observed among adaptive caregivers and their infants. These patterns allow the caregiver to predict imminent developmental change in the infant and to engage in behavior designed to foster the emergence of those new skills. . . . Parents who preview are likely to experience an enhanced sense of competence in their caregiving skills and to be more sensitive to the child's needs for autonomy, as well as security. This parental perspective tends to result in an enhanced rapport between parent and

infant, diminishing the likelihood of abusive behavior.” [Paul V. Trad. (1993). The therapeutic use of previewing to deter parental abuse. 13:4, 265.]

“Understanding the [Piagetian] cognitive level of children may be a critical initial step in efforts to design appropriate intervention strategies that promote health and prevent diseases in children. . . . The findings from this investigation suggest that greater attention needs to be given to children’s cognitive capabilities when considering disease prevention, in general, and health decision-making, in particular. Specifically, it was observed that the preoperational children in this study not only made fewer health enhancing decisions but also tended to ‘skip’ more steps in the decision-making process that did children at higher levels of cognitive functioning. . . .” [Jebese O. Okwumabua, Theresa M. Okwumabua, Apasra Hayes, and Keith Stovall. (1994). Cognitive level and health decision-making in children: A preliminary study. 14:4, 286, 284.]

“[This is a] community-based alcohol problem prevention program grounded in public health theory and focusing on changing environmental factors to reduce alcohol-related risks [in a non-alcoholic Afghan community exposed to an alcohol-drenched American society, using a social marketing approach, so as to help] Afghan children . . . successfully adapt to bi-cultural lives. . . .” [Linda Cherry and Sonjia Parker Redmond. (1994). A social marketing approach to involving Afghans in community-level alcohol problem prevention. 14:4, 289, 307.]

“In our earlier publications . . . we have discussed problems raised by the widespread dissemination among human services care givers of the idea that they should engage in preventive intervention in the lives of people who have *not felt need* for assistance. . . . We focused on distortion of the meaning of our message of primary prevention among care givers of unpredictable levels of skill, knowledge, and ability that may lead to those professionals unduly infringing on privacy, attacking defenses, promoting dependency, etc. . . . In the present article, we will deal with situations in which people in the community are involved in predicaments that they do recognize as being a reason to invoke outside professional help. . . . [but we must] be concerned that the interventions we have energized should help and not hinder. . . . by making [clients’] predicaments more complex, protracted, and more hazardous to mental health.” [Gerald Caplan and Ruth B. Caplan. (1994). The need for quality control in primary prevention. 15:1, 19, 20.]

“In this paper we have attempted to bring together the divergent fields of teen pregnancy and child abuse research. . . . [The authors review research and present a model which] predicts that: 1) Child abuse leads to dissociation in some individuals, reflected in elevated Schizophrenia scores, mediating the outcome of teen pregnancy; 2) child abuse leads to a rejection of conventional norms by some adolescents, reflected in an elevated Psychopathic scale, which then also mediates their

risk of early pregnancy; 3) child abuse results in lowered self-esteem, which independently mediates depression and teen pregnancy; 4) child abuse increases vigilance, which manifests as elevated Paranoia scores, for some related to pregnancy risk, but for others, related to depressive symptomatology." [Evvie Becker-Lausen and Annette U. Rickel. (1995). Integration of teen pregnancy and child abuse research: Identifying mediator variables for pregnancy outcome. 16:1, 49, 50.]

"This article is designed to help planners and community groups (a) anticipate the dynamics and barriers involved in implementing prevention programs in a multicultural urban environment and (b) minimize the disruption those factors can exert." [Maryann Amodeo, Susan Wilson, and Deborah Cox. (1995). Mounting a community-based alcohol and drug abuse prevention effort in a multicultural urban setting: Challenges and lessons learned. 16:2, 165.]

"Recent reviews of the literature on the etiology of adolescent substance abuse have emphasized the importance of investigating the role of protective factors as well as that of risk factors. . . . In the model tested in this paper, both child attachment with parents and peers' prosocial norms were hypothesized to be predictive of the alcohol refusal outcome. Additionally, child attachment with parents was expected to be significantly correlated with peers' prosocial norms. . . . Overall, the tested model is consistent with the concept of multiple protective mechanisms involving cumulative effects related to family and peer socialization processes." [Richard Spoth, Seongmo Yoo, Jeffrey H. Kahn, and Cleve Redmond. (1996). A model of the effects of protective parent and peer factors on young adolescent alcohol refusal skills. 16:4, 373, 374, 389.]

"The challenge of promoting social competence and preventing problem behaviors in [special education (SE)] populations has broad implications. As our world inevitably becomes more multicultural and technology and communications revolutions bring individuals into increasing contact with one another, any conceptualization of prevention and social competence must increasingly take into account issues of multicultural competence." [Peter J. Gager, Jeffrey S. Kress, and Maurice J. Elias. (1996). Prevention programs and special education: Considerations related to risk, social competence, and multiculturalism. 16:4, 408.]

[The authors constructed a topology of prevention activities with regard to the primary prevention of tobacco, alcohol, and other drug abuse, including the following:] "1) Increasing Knowledge/Raising Awareness; 2) Building Skills/Competencies; 3) Increasing Involvement in Drug-Free/Healthy Alternative Activities; 4) Changing Institutional or Organizational Policies; 5) Increasing Attention to Law Enforcement and Regulatory Practices; 6) Building Coalition/Partnership Capacity; 7) Building General Institutional/Community Capacity, and

8) Treatment/Early Identification and Referral.” [Roger E. Mitchell, John F. Stevenson, and Paul Florin. (1996). A typology of prevention activities: Applications to community coalitions. 16:4, 420.]

“The bedrock fact in [John Gordon’s (Professor of Epidemiology at the Harvard School of Public Health)] discussion [on the history of public health] emphasized that no mass disease (disorder) in human history has ever been eliminated or significantly controlled by attempts at treating the affected individual, nor by training large numbers of individual treatment personnel. . . . [George W. Albee. (1996). Introduction to the special issue on social Darwinism. 17:1, 4–5.]

“Since the broad demographic variables seem to encompass something closer to ‘ultimate’ causes, and since we seem to be better able to design prevention programs when we deal with these causes of causes, why do we choose the middle ground? Why do we ask: What is it about poverty that produces increases in birth defects, prematurity, perinatal deaths, instead of designing programs to prevent poverty? Why do we ask, what is it about powerlessness that produces breakdown, misery, and violence, instead of trying to redistribute power? . . .

“None of this is to argue that social change will solve all the problems but rather that without such changes much of whatever else we do may be futile. We will have to do it over and over again. Social change may not be sufficient, but it is necessary. . . . The perspective of primary prevention might be defined as never concluding that the minimum has been reached.” [Justin M. Joffe. (1996). Looking for the causes of the causes. 17:1, 204, 207.]

“Throughout its early development, the field of substance abuse prevention has lacked clear, quantifiable procedures for determining goals and prioritizing targets for intervention (Murray and Perry, 1987). The Funding Priority Matrix [presented in this article] addresses this need by offering a means for quantitative synthesis of risk factors, protective factors, and local community resources. [Specific lists of risk and protective factors are provided, along with the sources where these public data may be found.] This not only enhances the objectivity of the funding process but, more importantly, helps ensure that prevention dollars are given to those communities where the ‘net’ needs are highest.” [Jane Carlisle Maxwell, Lynn S. Wallisch, David Farabee, Richard T. Spence, and Liang Y. Liu. (1997). A model for assessing primary prevention needs and resources. 17:3, 332.]

“An alternative approach to drug policy which forces a distinction between drug use and harmful drug use is that of harm reduction. ‘Harm reduction is a policy of preventing the potential harms related to drug use, rather than trying to prevent the drug use itself’ (Duncan et al., 1995). . . . In this formulation, the goals

of drug policy should be to:

1. Reduce harm,
2. Increase safety,
3. provide care for those who need it, and
4. achieve a balance between formal and informal drug control by fostering the social atmosphere where informal controls are maximized to the limit of their effectiveness." [David C. Lewis, David F. Duncan, and Patrick R. Clifford. (1997). *Analyzing drug policy*. 17:4, 352.]

"Successful recruitment and retention of participants is an essential component of prevention program effectiveness. . . . Preventive interventions are of little value if they are not used by those for whom they were designed. . . . Recruitment rates for all types of prevention programs are typically low . . . [and with high-risk participants] particularly low. . . . Improvement of recruitment and retention of high-risk families has been hampered by the fact that many of the lessons learned in implementing prevention programs have not been systematically passed along to others in the field. . . . [The authors report and describe some 35 or so recruitment and retention strategies employed in their study.] Our recruitment and retention rates appear to be significantly higher than those typically reported, indicating that with sufficient effort a majority of high-risk low-income mothers can be recruited and retained in preventive parent training interventions." [Larry E. Dumka, Camille A Garza, Mark W. Roosa, and Heather D. Stoerzinger. (1997). *Recruitment and retention of high-risk families into a preventive training intervention*. 18:1, 25, 26, 28, 36.]

"School administrators are faced with the need to make careful choices with regard to selecting prevention programs." [The authors present and discuss eleven major guidelines for selecting substance abuse and related prevention curricula for use in schools.] [Maurice J. Elias, Peter Gager, and Staci Leon. (1997). *Spreading a warm blanket of prevention over all children: Guidelines for selecting substance abuse and related prevention curricula for use in the schools*. 18:1, 41, 44-45.]

"Commitment to our youth and to fiscal responsibility demands that the effectiveness of drug prevention programs be validated. As school administrators attempt to identify efficacious drug prevention programs, they are faced with conflicting recommendations. . . ." [The present article is a meta-analysis of 120 experimental or quasi-experimental school-based adolescent drug prevention programs, examining some 30 major content areas in these programs. In general, interactive programs (like Project STAR and also the Minnesota Heart Health Program) are more effective than non-interactive ones (like Project DARE). [Nancy S. Tobler and Howard H. Stratton. (1997). *Effectiveness of school-based drug prevention programs: A meta-analysis of the research*. 18:1, 71, 74, 117, 118.]

At the start of the AIDS epidemic behavioral prevention strategies were seen as a temporary solution to hold off HIV infections until a preventive vaccine arrived. With a vaccine now a distant hope, behavioral prevention offers the only means for curtailing the AIDS epidemic. . . . Prevention approaches that are grounded in theories of behavior change have offered great promise in meeting demands for long term changes in high-risk sexual practices. . . . HIV risk-reduction interventions have most commonly been based on behavior change principles derived from Social Learning Theory (Bandura, 1986, 1989, 1994). These interventions use skills training to build self-efficacy for behavioral risk-reduction and foster behavioral change and maintenance. . . . While there is an urgent need for continued research and development of HIV risk-reduction technologies, they will do little to prevent HIV infections unless intervention approaches are effectively transferred to communities. Closer collaboration through community-research partnerships is one way that better prevention can be realized.” [Seth C. Kalichman, Lisa Belcher, Charsey Cherry, and Ernestine A. Williams. (1997). Primary prevention of sexually transmitted HIV infections: Transferring behavioral research technology to community programs. 18:2, 168, 150, 168–9.]

“The object of this paper is to propose a different but complementary approach to study children’s health cognitions. We examine children’s perceptions about health-related reciprocal interactions between them and significant others; that is, the health-related actions children do for significant others and the health-related actions significant others do for them in the course of daily life. We label these health-related reciprocal interactions by the concept of *mutual help in relation to health*. . . .

“Our findings on the nature of child-received and child-initiated actions and the patterns of symmetry and balance in exchanges of actions, provide information about bidirectional health-related actions, an aspect for which we have very limited knowledge. . . . From the perspective of primary prevention interventions, our findings emphasize the importance that health promotion reinforce links with parents. Health education programs directed at children or their parents could reinforce children’s active contributions to others’ health. Such health promotion interventions could precisely emphasize health actions that children of different ages feel competent to initiate.” [Sylvie Jutras, Sylvie Normandeau, and Ilze Kalnins. (1997). Mutual help in relation to health: The experience of children. 18:2, 174, 189.]

“. . . [T]his study has demonstrated that a cohort study of treatment and comparison group students can be an appropriate study design to estimate the impact of adolescent drug prevention studies, but follow-up continues to be challenging. . . . Dose-response modeling can also be a fruitful method of estimating program impact when follow-up rates for the cohort design are problematic. This study also points to the need to adjust for variations in baseline risk status of subjects. . . .” [Jennette Valentine, Barbara Gottlieb, Stefano Keel, John Griffith, and Robin

Ruthazer. (1998). Measuring the effectiveness of the Urban Youth Connection: The case for dose-response modeling to demonstrate the impact of an adolescent substance abuse prevention program. 18:3, 386.]

[Four primary models of empowerment theory—Rappaport, Zimmerman, Dunst, and Kieffer—are applied to adolescents by the authors.] These four empowerment models share several features. First, all suggest that active participation is involved in empowerment development. Second, they share the view that help-givers should build on strengths and collaborate with the help-seeker rather than take the one-up position. Third, all acknowledge that empowerment builds on the strengths of others, and may develop differently for different people . . . [These same components] are also developmentally important during adolescence. Many theories of adolescent development and problem behavior (e.g., identity development, rolelessness, bonding, and social control) appear to include these concepts and thus imply that an empowerment process is essential to positive, socially appropriate development during adolescence.” [Matthew J. Chinman and Jean Ann Linney. (1998). Toward a model of adolescent empowerment: Theoretical and empirical evidence. 18:4, 395.]

RESEARCH IN PRIMARY PREVENTION

Some observations: Some critics rightly point out that there are relatively few basic research studies in JPP, but primary prevention is an applied social science, and thus, is involved with strategic transfers of knowledge and skills to individual, group, and community concerns, leaving to the basic sciences to continue their work at foundation research. But what a picture of applied social research we have, particularly its growth from the early years to the present day. Not yet enough, of course, but moving in the right direction. Some writers, such as Botwin & Tortu (1988) have introduced the idea of generations of research, beginning naturally, with basic comparisons of major factors, and then proceeding through improved theory and/or research methodology, to consider multiple factors operating at multiple levels over time. These second and third generation studies begin to approximate the complexity of the social reality that primary prevention actually addresses.

“[A]s [B.]Bloom (1968) and Munoz (1976) indicate, there is only the beginning of hard evidence that primary prevention programs have positive results. Evaluations of prevention programs still are in their infancy.” [Helen Reinherz. (1980). Primary prevention of emotional disorders of children. 1:1:5.]

“In America today, the elementary schools have tremendous unmet mental health needs. . . . Over the past four years, a team of investigators at DePaul University has been implementing a series of community mental health . . . and

community psychology . . . school-based interventions. . . . The interventions illustrate a circumscribed range of primary prevention projects in three conceptual areas: (a) establishing or strengthening abilities and skills to enhance mental health functioning or prevent onset of later problems ([through] peer tutoring and social skills [training]); (b) preventing onset of specific target disorders (smoking); and (c) facilitating mastery of developmental transitions (first job, school transfer, public speaking in high school). [Successful outcomes are reported in all of these areas.]” [Leonard A. Jason and Louise Fernoe. (1980). From early secondary to primary prevention interventions in schools. 1:3,156, 158, 163.]

“[The outcome-oriented evaluation instrument (Student Attitudinal Inventory)—regarding adolescent drug use] has several properties that are essential to a practical and economical measurement device: (1) it is an instrument which is anonymous but which can be used for both pre and post tests and, at the same time, allows the user to match individuals between tests so that the evaluation design itself provides a greater sensitivity in detecting student attitudinal changes between the tests than a design which does not permit such a matching mechanism; (2) . . . which has attitudinal syndromes that are theoretically based and are empirically related to adolescent drug involvement; (3) . . . which can be understood easily by students in the lower grade levels, including those with poor reading skills; (4) . . . which is relatively short so that it may be completed within, say, 25 minutes; (5) . . . which has been tested extensively both in terms of its reliability and its validity; and finally, (6) . . . which can be scored very easily by a layperson.” [Schwan Kim. (1981). Student Attitudinal Inventory for outcome evaluation of adolescent drug abuse prevention programs. 2:2, 91–92.]

“[This study has produced] a list of stressful events associated with [the onset of] parenting and the ordering of events is comparable for different groups of parents. The list could have implications for the development of parent education programs . . . could advance research on parenting . . . could help practitioners to design primary prevention programs by indicating particular stressors, and pointing to the need for parent discussion of optimal ways of coping with these stressors and ways of modifying, diminishing, or avoiding some of them.” [Judith L. Alpert, Mary Sue Richardson, and Linda Fodaski. (1983). Onset of parenting and stressful events. 3:3, p. 158.]

“In an effort to address some of the needs of young children in recovering alcoholic families, a prevention/intervention strategy was employed which emphasized competence building in both children and parents . . . applying RET [Rational Emotive Therapy] principles. These sessions concentrated on applying the principles in potentially upsetting everyday situations not limited to residual effects of having been in a family in which one or both parents abused chemicals. Goals of increasing self-esteem and applying specific coping skills in a peer group were

realized.” [Eric E. Anderson and Wentworth Quast. (1983). Young children in alcoholic families: A mental health needs-assessment and an intervention/prevention strategy. 3:3: 185.]

“Our findings identify several screening variables that combine to accurately predict [preschool] children’s later receipt of guidance services. What emerges . . . is a problem topology of a child who comes from a family with low socioeconomic status, who exhibits low cognitive capacity for information processing, and who is judged by parent and/or teacher to have attention problems. These findings are congruent with those of other studies of children receiving mental health services in community and school settings. . . . These behaviors represent the types of problems, classified as ‘conduct disorders,’ that most frequently lead to referral for mental health services (Quay & Werry, 1979). They are particularly important in that, as our [longitudinal] results have shown, they persist over time, manifesting at third grade as problems of hostility and lack of productivity.” [Helen Reinherz, Alan L. Gordon, Kathleen M. Morris, and Jeane W. Anastas. (1983). Who shall be served? Issues in screening for emotional and behavioral problems in school. 4:2, 89–90.]

“The [Ombudsman Program (OP)] is [a semester-long] affective education program designed for students in grades 5–9. [‘This article presents the results of a short-term evaluation of a national drug abuse prevention model. . . .’ The findings are] (1) the OP is more effective when the regular classroom teachers have close interactions with the Ombudsman instructors and when the regular classroom teachers have either taken the ‘Ombudsman Training for Teachers’ training prior to the intervention of the OP or when the regular classroom teachers themselves have implemented the OP; (2) the OP program is more effective when implemented during fall semesters. . . . ; (3) the greater the time spent in ‘processing’ Ombudsman exercises. . . . ; (4) among elementary students than among junior high school students . . . ; (5) [among programs] that have implemented the . . . project outreach [component]. . . .” [Sehwan Kim. (1983). The short-term effect of a national prevention model on student drug abuse. 4:2:122, 127.]

“In contemporary society, several youth organizations [for example, 4-H, Boy Scouts, Campfire Girls, etc.] have identified one of prevention’s tools, competency promotion, to be a major reason for their existence. . . . The present investigation suggests that 4-H programs promote positive psychosocial development. . . .” [Robert L. Young and Gerald Adams. (1984). The 4-H youth organization: Primary prevention through competency promotion. 4:4, 226, 238.]

“The present study addressed . . . prevention research needs respective to cigarette smoking of youth. The study employed a repeated measures, control group research design. Pretest, posttest, and follow-up measures quantified precursors

and outcomes of nonsmoking. Biochemical data collection increased the accuracy of youths' reported smoking. A skills-building prevention approach that helped youths manage multiple influences toward cigarette use was compared with a traditional attitude modification approach. . . . Study results support improved methods to prevent cigarette smoking." [Steven Paul Schinke and Lewayne D. Gilchrist. (1984). Preventing cigarette smoking with youth. 5:1, 49, 51.]

"Caplan (1964) provided a definition of, and conceptual model for, primary prevention. The foundation of his model was the concept of supplies, with the assumption that to avoid mental disorder people need access to . . . physical [supplies], which are necessary for bodily growth and development; psychosocial [supplies], which include cognitive and emotional stimulation through social interaction; and sociocultural [supplies], which refer to expectations arising from the customs and values of a culture and the social system. . . .

"This study was undertaken to construct a comprehensive and reliable measure of all those aspects of the three supply categories . . . [and to test the hypothesis] that those individuals who report high access to supplies would evidence significantly less mental disorder. . . .

"Our results revealed that in each of the Supply categories low access was associated with significant less satisfaction with life and significantly more psychological distress than high access. . . ." [Paul J. Handal and Carolyn Moore. (1986). The influence of physical, psychosocial, and sociocultural supplies on mental health and life satisfaction: A test of Caplan's Supply Model. 7:3, 132. 133. 141.]

"A logical and increasingly popular form of child abuse prevention programs involves providing services during prenatal care and continuing through the first year of life. . . . These perinatal prevention projects typically include prenatal education and support, early and extended postpartum contact, parent education, and home visitation by professionals, paraprofessionals, or volunteers (Gray, 1982; Payne, 1983). To date, available research on perinatal child abuse prevention programs provides minimal assurance of their effectiveness. . . .

"Despite the [Child Parent Enrichment Project's] intent to increase client's use of formal and informal support as a means to improved parenting, multiple indicators did not show significant changes in support as a result of participation in the project. . . . On the most important question asked by the project—that is, did the project prevent child abuse—the evidence is equivocal. . . . Even though current results cannot show that the services reduced the rate of child abuse, preliminary indications do suggest that providing task-centered, paraprofessional-delivered, perinatal services promotes nonabusive parenting in high-risk mothers. . . ." [Richard P. Barth, Susan Hacking, and Jordana R. Ash. (1988). Preventing child abuse: An experimental evaluation of the Child Parent Enrichment Program. 8:4, 201–2, 213–4, 211,215.]

"Maternal mortality, like infant mortality, is universally considered a reliable indicator of the quality of life of a country or population because both maternal and infant death rates are highly sensitive to socio-economic conditions and to the presence or absence of adequate health services. In the United States, pregnancy and childbirth related deaths have declines so markedly over the past 50 years—falling from 636 deaths per 100,000 live births in 1933 to 8.0 deaths per 100,000 live births in 1983—that maternal mortality is no longer considered a serious problem. . . . Unfortunately, however, not all women in the United States have shared in these impressive gains, as maternal mortality rates show striking demographic variations. In 1983, the U.S. maternal mortality rate was 5.9 per 100,000 live births for white women, but 18.3 for black women (National Center for Health Statistics, 1985)." [Kristine Siefert and Louise Doss Martin. (1988). Preventing black maternal mortality: A challenge for the 90's. 9: 1 & 2, 57, 58.]

"The purpose of this paper is to demonstrate how secondary analysis of an all-black data set, The National Survey of Black Americans, can contribute to what is known about the social epidemiology of psychopathology in blacks. The intent is to show how information gained from such analyses contributes to the development of an epidemiologic knowledge base which can be used for public mental health interventions. This paper focuses on how the problem-solving strategies of seeking help and obtaining financial aid impact upon the relationship between socioeconomic status and mental health." [Harold W. Neighbors and Thomas A. LaVeist. (1989). Socioeconomic status and psychological distress: The impact of financial aid on economic problem severity. 10:2, 149–150.]

". . . [D]ata from these analyses seem to be unambiguous regarding the timing of prevention and intervention. Assuming prevention is best initiated before risk is high, preventive efforts should be initiated during childhood and early adolescence regarding all three forms of violent deaths [homicide, suicide, and accidents]. In contrast, preventions and social interventions should be introduced for high school age students with even greater efforts directed at late adolescent college-age and working youths. Gender differences indicate greater preventive efforts directed at males are warranted, given risk rates for being substantially higher than for females. Further, racial differences suggest prevention efforts for Blacks should focus most strongly on problems of homicide, while suicide and motor vehicle accidents are focal in the lives of White and Other minority groups. This is not to imply efforts should be limited to a given racial group, only that focus and attention are clearly needed more in some contexts than others." [Gerald R. Adams, Layne Dee Bennion, D. Kim Openshaw, and C. Raymond Bingham. (1990). Windows of vulnerability: Identifying critical age, gender, and racial differences predictive of risk for violent deaths in childhood and adolescence. 10:3, 239.]

"Understanding how children develop strengths and resources in the face of profound life adversity is an understudied area with significant implications for primary prevention (Cowen & Work, 1988). This emerging focus stems from a growing awareness of the limitations of mental health's dominant emphases on diagnosing and treating already dysfunctional behavior, and its neglect of forces that promote adaptation and wellness (Cowen, 1990; Masterpasqua, 1989).

"Within a public health framework, considered by many to offer a fruitful matrix for primary prevention, Gruenberg (1981) identified three questions around which to orient inquiry: Under given circumstances who gets sick? Under similar circumstances who does not get sick? Why?... Garmezy and Tellegen (1984) point out that these three questions highlight different foci. Whereas 'Who gets sick?' emphasizes conditions that predispose pathology, 'Who does not?' directs attention to protective or ameliorative factors, and 'Why?' orients us to the processes that favor different outcomes under given conditions....

"Cowen & Work (1988) [argue that] the availability of adaptive models who provide care, warmth, support and understanding helps the young child to acquire resources and strategies needed to cope effectively with major life stress. Whereas, initially, the model's support is largely protective, later, as the child's awareness grows, model(s) provide concrete examples of effective coping strategies in difficult circumstances, that the child comes to adopt in dealing with future stressors." [William C. Work, Emory L. Cowen, Gayle R. Parker, and Peter A. Wyman. (1990). Stress resilient children in an urban setting. 11:1, 4, 5.]

"The study's main thrust was to identify child variables associated with SR [stress resilient] outcomes.... Of some importance and hope, is the knowledge that several attributes found to be associated with SR outcomes have been shown to be teachable, e.g., social problem-solving skills (Shure & Spivack, 1982), coping skills (Pedro-Carroll & Cowen, 1985), and empathy (Feshback, 1978). [Gayle R. Parker, Emory L. Cowen, William C. Work, and Peter A. Wyman. (1990). Test correlates of stress resilience among urban school children. 11:1, 32.]

"Recent years have seen big changes in the literature on the evaluation of programs for the prevention of alcohol problems. The changes reflect developments in two directions: in the scope of prevention programs in the field, and in the technology and conceptualization of evaluation studies.... The new prevention evaluation literature has taken several directions. One direction has been the development of a literature of experimental studies operating on a much broader level than a classroom [such as the Stanford Heart Disease Study].... A second new direction has been the development of traditions of 'natural experiment' studies.... A third direction... has been a growing literature of time-series analyses of the correlation of changes over time." [Robin Room. (1990). Recent research on the effects of alcohol policy changes. 11:1, 83,86, 87, 88.]

"It is estimated that approximately 7 million U.S. children, about 10% of the population under 18, live with an alcoholic parent. . . . A large number of studies have clearly demonstrated that these children are at increased risk for a wide variety of mental health problems including emotional disturbances . . . aggressive or acting out behavior . . . depression . . . anxiety . . . and alcohol abuse. . . .

This article described the steps followed in the development of a preventive intervention aimed at elementary-aged COAs (children of alcoholics), including the hard to reach children of untreated alcoholics. Unlike many preventive efforts, this program was based on a well articulated theory and supported by empirical findings from the literature and from our own series of studies. The final product was an eight week school-based prevention program designed to minimize or prevent mental health problems that are common among COAs. The objectives of the program . . . [were to enhance] individual competencies to promote psychological wellness, in this case the enhancement of self-esteem and coping skills to help children better deal with the stress of living with a problem drinking parent. . . . The preliminary findings were encouraging." [Mark W. Roosa, Leah K. Gensheimer, Tim S. Ayers, and Jerome L. Short. (1990). Development of a school-based prevention program for children in alcoholic families. 11:2, 119, 136–137.]

"From a community health perspective, because [family support] programs are capable of reaching a large number of parents at a relatively modest cost, evaluation of their feasibility and impact should be of great interest. However, such evaluations are still rare.

"This article reports on the evaluation of a parental support intervention, *Parents Magazine* [a bilingual, French-English publication not to be confused with the monthly commercial American magazine of the same name], a age-paced newsletter distributed to parents starting with the birth of their children. . . . Findings showed that *Parents Magazine* was read, appreciated, and used by a very large number of parents and that its circulation through the natural family network increased its penetration." [Marie-Claire Laurendeau, Gilbert Gagnon, Nicole Desjardins, Robert Perreault, and Natalie Kishchuk. (1991). Evaluation of an early, mass media parental support intervention. 11:3, 208, 218.]

"In both the original study and the replication a year later, [adolescent] smokers and nonsmokers agreed that there is a strong relationship between cigarette smoking and the development of lung cancer. Realistically, nonsmokers rated their chances of developing lung cancer as being below average. In comparison, although smokers rated their chances of developing lung cancer as higher than nonsmokers, they still viewed their own chances of developing the disease as average, a clearly unrealistic expectation." [Jonathan D. Reppucci, Tracey A. Revenson, Mark Aber, and N. Dickon Reppucci. (1991). Unrealistic optimism among adolescent smokers and nonsmokers. 11:3, 235.]

"The strategy [of TOGETHER! Communities for Drug Free Youth] posits that when the social units [including the family, school, and peer groups] provide a young person with opportunities for active involvement, the skills to participate successfully, and a consistent system of rewards for successful involvement and moderate, consistent punishment for misbehavior, then bonds of attachment, commitment, and belief will be forged between the young person and the social unit. . . .

"This project's experience in stimulating communities to form TOGETHER! Teams for drug abuse prevention planning and action suggests that large numbers of communities can be successfully mobilized for the prevention of youthful substance abuse, specifically focusing on reducing risk factors identified through research. The project has demonstrated that community leaders, including elected officials, can be trained in a risk focused approach to preventing drug abuse and involved in a way that supports community ownership and participation." [Tracy Harachi Manger, J. David Hawkins, Kevin P. Haggerty, and Richard F. Catalano. (1992). *Mobilizing communities to reduce risks for drug abuse: Lessons on using research to guide prevention practice*. 13:1, 5, 19.]

"The Children of Divorce Intervention Program (CODIP) is a preventive, group intervention that addresses the emotional and behavioral reactions that many children have to marital disruption. The approach rests on the provision of on-going support and competence enhancement. . . .

"The study's most central finding was that CODIP benefited children's adjustment. Program children improved significantly more than the other two groups on all child and parent adjustment measures, in their understanding of divorce related events, and in the ability to handle changing family situations. They also evidenced diminished anxiety, and fewer negative attributions about themselves and their families. . . ." [JoAnne L. Pedro-Carroll, Linda J. Alpert-Gillis, and Emory L. Cowen. (1992). *An evaluation of the efficacy of a preventive intervention for 4th-6th grade urban children of divorce*. 13:2, 120, 126.]

"In a major departure from the categorical, or disease-by-disease approach to research and service delivery for children with chronic diseases, researchers have recently begun to recognize that issues such as social and psychological adjustment and impact on family are common to a variety of diseases (Pless and Perrin, 1985). . . . This exploratory study addresses the following question: are there any disease-specific differences in the social and psychological adjustment of the child or impact on the family among children with two very different disease entities: children with asthma, and children with cancer. . . . [Although the sample in this study is small, . . .] Nevertheless, the findings do lend support for the argument that there are no disease-specific differences in the social and psychological adjustment of children with chronic illness." [Kristine Siefert, Daniela Willman,

Susan Farquar, and Frances Talsma. (1992). Similarities and differences between children with asthma and children with cancer: Implications for preventive intervention. 13:2, 151, 155.]

“‘I can’t do that,’ . . . ‘No one likes me.’ . . . Meichenbaum (1977) hypothesized that irrational beliefs lead to inappropriate self-verbalizations which, in turn, cause maladaptive behaviors. . . . Cognitive self-instruction is based on the theoretical position that individuals can learn to recognize their irrational thoughts, coping thoughts can be learned and used to replace maladaptive irrational thoughts, and rational and irrational thoughts cannot occur at the same time. . . . As a primary prevention strategy, cognitive self-instruction is analogous to an inoculation. . . . In the present study, the effects of a counselor-led preventive group program were compared with a self-instructional placebo attention control condition. . . . The results . . . provide evidence that Meichenbaum’s . . . idea can be adapted to a group primary prevention formate in order to prepare adolescent females to identify irrational self-defeating thoughts and replace them with more rational self-enhancing thoughts.” [(Debra E. Haldeman and Stanley B. Baker. (1992). Helping female adolescents prepare to cope with irrational thinking via preventive cognitive self-instruction training. 13:2, 161, 162,166.)]

“The research of the 80’s [on adolescent substance abuse prevention] has left many questions unanswered. . . . Prevention planners generally agree, however, that the most effective prevention approach is a multiple strategies approach . . . [including]:

1. Strategies that are targeted at changing adolescents’ norms and expectations about substance use.
2. Strategies that build and enhance social and resistance skills.
3. Strategies that change community norms and values regarding substance use.

Most recently, strategies that foster and enhance resiliency and protective factors, especially in high risk youth, are beginning to be used and evaluated.” [Elaine Norman and Sandra Turner. (1993). Adolescent substance abuse prevention programs: Theories, models, and research in the encouraging 80’s. 14:1, 16.]

“Although pathological gambling is an addiction similar to alcoholism, it was not officially recognized until 1980. Gamblers were defined as individuals who suffer from ‘a chronic and progressive failure to resist impulses to gamble, and gambling behavior that compromise, disrupts or damages personal, family or vocational pursuits’ (APA, 1987, p. 324). . . . There is a consensus among clinicians that practically all pathological gamblers began gambling during adolescence. . . . The prevention program [in this study] improved knowledge about gambling and coping skills. Unfortunately, skills in coping with gambling were not maintained at

follow-up. . . . Furthermore, the program did not significantly affect gambling behavior or attitudes. Increased knowledge, therefore, is not sufficient to modify behavior and attitudes, at least not in the short term." [Anne Gaboury and Robert Ladouceur. (1993). Evaluation of a prevention program for pathological gambling among adolescents. 14:1, 22, 26.]

"The surprising result of this study [of military downsizing] is that blacks appear to be more similar to whites than to Hispanics in their attitudes toward military service and its benefits for their families. . . . Hispanics reported a more favorable organizational attitude than either blacks or whites. . . . [These differences might be explained by the following factors:] [A] larger number of Hispanics are Catholic . . . and the military's hierarchial structure coincides with that of the Catholic church. In addition, Hispanic families tend to be more traditional in gender role orientation and male-centered than either black or white families . . . and these features are very compatible with the 'masculine-oriented' and 'male-dominated' culture of the U.S. military. . . . Despite available statistics that suggest that Hispanics fare better in the civilian labor market than blacks. . . . Hispanics may perceive less available options in the civilian economy than blacks since a large percentage of Hispanics are involved in migrant and farm labor and lower-paying jobs without health insurance. . . . [Thus, downsizing may affect Hispanics more harshly than others, and raises important primary prevention issues.]" [Kara B. Richards and Gary L. Bowen. (1993). Military downsizing and its potential implications for Hispanic, black, and white soldiers. 14:1, 87, 88.]

". . . [T]he primary purposes of the present study were: a) to examine the relationship between detailed attitudes toward specific drinking patterns and self-reported levels of drinking; and b) to develop a stable prediction equation that included attitudes as a predictor of drinking behavior. . . . [A] theoretically based, psychometrically sound instrument [was developed] . . . [The] results demonstrated that the seven-predictor-variable model was very stable for predicting the alcohol consumption index. [Elizabeth W. Edmundson, Patrick Clifford, Debra S. Serrins, and David Wiley. (1994). The development of a model to predict drinking behavior from attitudes in university students. 14:4, 246, 247, 260.]

"As women's participation in the workplace has increased to substantial levels, with women now comprising approximately 45 percent of the labor force, concerns about the level of stress experienced by employed women and its effects on their health also have increased. . . . The [present study's] intervention was designed to teach participants a wide range of adaptive coping strategies that they were encouraged to practice throughout the program. In addition, they were taught to substitute the new strategies for maladaptive strategies such as alcohol use and avoidance coping . . . [with regard to] their roles as employee and parent. . . . [T]he intervention was primarily effective in producing changes in stressors within the

work domain and in the perceived demands resulting from the interplay between work and family roles. . . . The intervention failed to have any impact . . . on reported levels of mother role stress [that is, in changes in family-related risk and protective factors]." [Marsha L. Kline and David L. Snow. (1994). Effects of a worksite coping skills intervention on the stress, social support, and health outcomes of working mothers. 15:2, 105, 109, 115.]

"The current paper describes . . . a corporate partnership that sought to remove barriers to participation in parent training by providing parent training to parents, at the worksite during the lunch hour. . . . [The program reached] difficult to serve [parents, such as] fathers, single parents, less educated workers, and more high-risk/distressed families for substantial numbers of sessions and for prolonged periods. . . . Thus, when higher levels of sessions and exposure were provided, parental appraisals and affective reactions to child behavior may have changed in ways that decrease children's exposure to developmentally hazardous transactions with the parents (Sameroff & Fiese, 1990). [Robert D. Felner, Stephen Brand, Kay Erwin Muhall, Brian Counter, Joyce B. Millman, and Judy Fried. (1994). The parenting partnership: The evaluation of a human service/corporate workplace collaboration for the prevention of substance abuse and mental health problems, and the promotion of family and work adjustment. 15:2, 124-125, 140.]

"This evaluation project suggests that a multi-faceted worksite prevention program can reduce alcohol consumption, improve employee and supervisor prevention skills, motivate employees to share prevention responsibility, and reduce the incidence of the negative impact of substance use on work. The latter finding, combined with some preliminary evidence on increased morale, could conceivably translate into increased productivity with positive financial implications." [J.A. Stolfus and Peter L. Benson. (1994). The 3M alcohol and other drug prevention program: Description and evaluation. 15:2, 158.]

"The present study compared 31 resilient adults who were middle-aged, upper-middle class and well educated with 19 controls from comparable life circumstances who had not been exposed to severe early adversity. . . . Several salient features of the resilient subjects . . . emerge from the empirical comparisons and the clinical anecdotes:

- * their relentless, almost indomitable drive toward autonomy;
- * their assertions of self-worth, bordering on arrogance;
- * their missionary zeal to promote disclosure about the flip side of pathology as an outcome of stress. . . .
- * the intensity of their suffering as children and adolescents, and the residual wounds that persist today;

- * the impressive degree of normalcy and accomplishment in their adult lives . . .
- * the depth and intensity of their conviction that transcending life's slings and arrows depends *primarily* on persistent, willful determination." [Norman F. Watt, James P. David, Kevin L. Ladd, and Susan Shamos. (1995). The life course of psychological resilience: A phenomenological perspective on deflecting life's slings and arrows. 15:3, 209, 243.]

"This report describes the development and evaluation of a preventive intervention designed to enhance resilience in urban children exposed to major life stress. Although growing up under highly stressful conditions, as many children do, sharply increases risk for adjustment problems, some fraction of stress-exposed children not only 'overcome the odds' (Werner and Smith, 1992) but adapt outstandingly well in the face of such adversity. . . .

"Although the findings include several encouraging signposts, they should be interpreted conservatively. Illustratively, inferences cannot be made beyond the immediate, short-term benefits found to follow this child-only, preventive intervention. . . . [A more promising conceptual pathway to facilitate resilience] would be a yoked parent-child intervention . . . when the children are young and their basic coping styles are still being formed." [Emory L. Cowen, Peter A. Wyman, William C. Work, and Miriam R. Iker. (1995). A preventive intervention for enhancing resilience among highly stressed urban children. 15:3, 247–248, 258.]

"This paper presents results from a pilot study to investigate multiple problem behaviors in a sample of young, urban adolescents. The results indicate that about 64% of the sample is experiencing problems in the areas of delinquency, high-risk sexual behavior, school failure, or substance abuse: 34% report involvement in one or two areas, and an additional 30% report multiple involvements (3–4 areas). . . . [in these sixth- and seventh-grade students]. . . .

"The results argue strongly for the need to implement comprehensive preventive interventions before the adolescent years. Efforts occurring later are likely to be less useful with this population given that a significant proportion of youth already will be engaged in high-risk behaviors." [Charles Barone, Roger P. Weissberg, Wesley J. Kaspro, Charlene K. Voyce, Michael W. Arthur, and Timothy P. Shriver. (1995). Involvement in multiple problem behaviors of young urban adolescents. 15:3, 276, 277.]

"Consultation, which is defined as a joint, systematic, problem-solving process between two or more professionals conducted for the benefit of clients (Zins, Kratochwill, & Elliott, 1993), is widely accepted as an effective means for delivering mental health services. . . . [This review] concludes that consultation's preventive benefits should not be oversold, and caution must be exercised when citing

its preventive bases. It would be most appropriate to state that there is *emerging* empirical evidence of consultation's primary prevention benefits and outcomes." [Joseph E. Zins. (1995). Has consultation achieved its primary prevention potential? 15:3, 285, 295.]

"Intrigued by the problem of cross-cultural prevention program 'transfer,' we developed an exploratory project that might later be useful for research and application. [The authors chose five exemplary American programs from *14 Ounces of Prevention* (Price, Cowen, Lorion & Ramos-McKay, 1988) and interviewed 27 informants from 12 countries on their transferability.] . . . Needs, goals and ideals about positive mental health vary across countries. . . . In conclusion, we can list some general guidelines for applying prevention programs in another cultural context (especially in developing countries in Asia and Latin America): 1. *Basic principles*: The six Albee factors—organic problems, stress, group exploitation, competence, self-esteem, and social supports—will provide useful guidelines for program design. . . . 2. *Cost/benefit analyses* . . . [need to be included]. . . . 3. *Cultural resources*: [should be employed] . . . 4. *Appropriate technology*: [should be employed]. . . . 5. *Community sensitivity*: [needs to be recognized and incorporated into the plans]. [Norman D. Sundberg, Johana P. Hadiyono, Carl A. Latkin, and Jesus Padilla. (1995). Cross-cultural prevention program transfer: Questions regarding developing countries. 15:4, 363, 373, 374–375.]

"The findings presented in this paper illustrate the importance of process/formative evaluation of community-based intervention programs. . . . The results from this evaluation study demonstrated the process whereby alternative and more relevant roles for providers working in community-based prevention programs emerged. The ability of the RAP [Real Alternatives Project] case counselors to develop a flexible and evolving role for themselves in the context of a developing program proved to be an important asset. . . . 'Ultimately the goal is to work with the kids and to make things better for them. Whatever you do has to come from that perspective'." [Patrice A. Vaeth, Patricia Morgan, and Lee A. Kaskutas. (1995). Examining the link between provider roles and program development: Findings from a process evaluation of a community-based drug prevention program. 16:1, 71, 72.]

"The application of diffusion theory (Rogers, 1983) in the planning and evaluation of substance abuse prevention programs is a useful, theoretical approach to ascertaining the process and extent of program adoption. . . . This paper described the development and implementation of a seminar designed to train education professionals concerning common problems and experiences of children living with an addicted parent, and in strategies designed to mitigate the effects of living in such an environment. . . . [E]valuation indices indicated that the trainings were highly successful. . . ." [Molly Laffin, Elizabeth W. Edmundson, and Sarah

Moore-Hirschl. (1995). Enhancing adoption of an alcohol abuse prevention program: An application of diffusion theory. 16:1, 75, 91, 93.]

"The research on effects of community service on the [adolescent] volunteer, although somewhat limited, seem quite promising. . . . There is good evidence that volunteering, along with school-based support, relates to a reduction in teen pregnancy, course failure, suspension from school, and school dropout, and an improvement in reading grades and self-concept (Allen, Philiber, & Hoggson, 1990; Cardenas et al., 1991). In addition, community service also seems to relate to less alienation, increases in positive attitudes toward adults, self-acceptance, moral development, and likelihood of taking responsible action (Calabrese et al., 1986; Conrad et al., 1981b; Newmann et al., 1983)." [Cynthia W. Moore and Joseph P. Allen. (1996). The effects of volunteering on the young volunteer. 17:2, 242.]

"The factor analysis of the [Perceived Sense of Community Scale] appears to support the notion that sense of community is a multi-dimensional construct. Consistent with the literature, the present study suggests that component elements are both distinct and conceptually coherent. The present discussion identifies three factors as salient within the sense of community experience.

The first factor may be understood conceptually as a sense that oneself and one's surrounding others are actively engaged in the pursuit of a common purpose. . . . The second factor is centered on the ideas of reciprocal responsibility and connection, and may be interpreted in a sense that one receives aid from the group, offers help in return, and thereby establishes connections to other members. . . . The third factor is determined by negative attributions to one's experience of a community group." [Peter D. Bishop, Fern Chertok, and Leonard A. Jason. (1997). Measuring sense of community: Beyond local boundaries. 18:2, 205.]

"The high rates of [high school] dating violence reported in a number of studies . . . underscore the need for primary prevention and early intervention programs. . . . In the present study, we found that past experience with dating violence was associated with current violence, suggesting that programs be presented to children before they begin to date. Perhaps preventing the onset of dating violence may decrease the likelihood that this behavior would occur during adolescence and young adulthood.

Our findings that a history of dating violence and verbal and physical aggression by the partner as well as self-reported verbal aggression are all highly associated with one's own use of dating violence suggest that attempts should be made to educate students of the long-term consequences of violence." [Annmarie Cano, Sarah Avery-Leaf, Michele Cascardi, and K. Daniel O'Leary. (1998). Dating violence in two high school samples: Discriminating variables. 18:4, 442-443.]

PROGRAM AREAS: SOME EXAMPLES OF PRIMARY PREVENTION PRACTICE

Some observations: The following excerpts are literally everywhere; there are few topics that primary preventionists have not ventured to consider. This may be the basis for the irrepressible optimism that characterizes many people in primary prevention, that it is possible to consider ways to prevent a wide range of predictable problems, protect existing states of health, and promote desired goals and some "impossible dreams." These ideals may not always be translated with fidelity into practice conditions in the less-than-ideal world; nor are the many-fold numbers of existing primary prevention projects ever reported in this literature. So we must encourage colleagues to share their experiences, good or bad, so that we can all benefit for expanded ideas and successful and unsuccessful ventures. What primary prevention practitioners need is an accumulated practice wisdom, and the skills to convey this to colleagues.

"The inseparable nature of the cognitive, affective, and motor domains is often ignored or neglected by educators, who have historically emphasized cognitive and motor development to the implied exclusion of the affective from the curriculum. Schools have nonetheless had profound impact on the overall psychological development of children (Minuchin, Biber, Shapiro & Zimules, 1969). The problem is that the schools' influence has been haphazard and without perspective—the result of 'hidden curricula' (Jersild, 1952; Mosher & Sprinthall, 1973). . . . The general goal [of affective education] is for children and youth to understand themselves and others better and to be able to apply this understanding to everyday situations. . . ." [Saul Cooper, Richard Munger, and Mark M. Ravlin. (1980). Mental health prevention through affective education in schools. 1:1:24–25]

"The Community Helpers Project addresses the mental health needs of rural America through the development of a training strategy whose goal is the enhancement of helping rural residents. In its primary prevention emphasis, the project gives the average person skills to use in dealing better with common problems brought to them by friends, acquaintances, and family. The project is designed to be self-sustaining and as a complement to any existing professional service. In designing similar interventions, it is essential that community support and involvement be sought through all phases of the project and that explicit provisions be made to turn the project over to local leadership." [Anthony R. D'Augelli, Theodore R. Vallance, Steven J. Danish, Carl E. Young, and John L. Gerdes. (1981). The community helpers project: A description of a prevention strategy for rural communities. 1:4, 222.]

"The current era has witnessed serious challenges to mental health's past practices, stemming from the conviction that such practices have not resolved

society's most pressing mental health problems (Cowen, 1973; 1977). Accordingly efforts have grown to: 1) identify sensitive, effective new therapeutic variants; 2) expand the reach of helping services; 3) identify qualitatively different strategies for approaching entrenched, refractory mental health problems . . . that need led us . . . to explore the interpersonal helping behaviors of hairdressers as informal caregivers. . . . [T]he beauty parlor is a setting that may dispose discussion of personal problems, i.e., a setting in which informal help giving interactions may take place with high frequency." [Emory L. Cowen, Ellis L. Gesten, Edward Davidson, and Alice B. Wilson. (1981). Hairdressers as caregivers II: Relationships between helper characteristics and helping behaviors and feelings. 1:4, 225, 227.]

"An exciting phenomenon is occurring now all over the country: the development of perinatal support programs in child welfare agencies, mental health centers, obstetricians' offices, preparation for childbirth series, hospitals, public health clinics, volunteer agencies, and combinations of these settings. The trend is exciting for a number of reasons, not the least of which is the truly multidisciplinary participation in this movement to provide an optimally close and comforting environment for the parents and child to get to know and fall in love with each other." [Ellen B. Gray. (1982). Perinatal support programs: A strategy for the primary prevention of child abuse. 2:3, 138.]

" . . . The constraints to effective parenting among adolescent parents include lack of concrete knowledge and skills, compounded by the frequent lack of familial and institutional support, the lack of awareness of the implications of parenthood, and the competing demands of their own developmental needs. The tasks of adolescence and the tasks of parenthood are difficult enough to accomplish in their own right; combined in the same person at the same time, they can become overwhelming, unless the adolescent parent has sources of significant support." [Robert Halpern and Laird Covey. (1983). Community support for adolescent parents and children: The parent-to-parent program in Vermont. 3:3, 162.]

"In the Early Intervention Project [that seeks 'to curb socially unacceptable behavior or, in the case of children with intellectual or physical handicaps, to prevent the emergence of maladaptive behavior patterns'], parents (usually mothers) of enrolled youngsters 'pay' for units of service to their child with units of service they themselves provide after a designated period of structured parent training. . . . Professional staff originally provide training and are then phased out as the trained parents take over not only work with their own children but also activities designed to help new parents. With trained parents available to carry out service functions, a small core of professional staff can use their time for supervision as well as for program planning, program evaluation, and other administrative duties." [Victoria V. Lavigne, James John Reisinger, Iris Bernard, and

Carla Stewart. (1983). Prevention and early intervention: An operational model. 4:2: 107, 108.]

"Media, particularly television, have long been thought of as a means of providing information, influencing beliefs and attitudes, and changing behavior. . . . [I]n the past several years psychologists and mental health workers have begun to explore the use of television as a tool for large-scale, preventive health care. Television enables fewer professionals to reach a greater number of clients/consumers, thereby potentially reducing delivery costs. Additionally, television reaches individuals in their own environment, thereby enhancing the likelihood that information on positive health patterns and lifestyle changes will be conveyed before major problems arise. Television can also reach those individuals who might not otherwise seek professional assistance." [Laura J. Solomon, Lee Frederiksen, Susan E. Arnold, and Kathleen A. Brehony. (1984). Stress management delivered over public television: Steps toward promoting community mental health. 4:3, 140.]

"In child welfare, the family is the single most important primary prevention institution. . . . When the family is viewed as the primary service unit, all other institutions should enter into partnership with it to meet needs or solve problems within the family context. . . . Respite care is one option in a balanced family welfare system designed to promote the quality of family life through supportive services, by providing parents with temporary, time-limited, short-term relief from child care responsibilities. . . . [with different programs for families of disabled children, for internally stressed families at risk, and for externally stressed families]." [Deborah P. Valentine and Theresa Andreas. (1984). An extended view of respite care: Supporting families. 5:1, 27,28, 30.]

"Primary prevention programs need to address the total context in which teenage sexual decision-making takes place. This larger context consists of the family of the adolescent and attending family values; the adolescent peer group and values; the thinking processes and reasoning skills of the parents and adolescents; and the values and behavior of the adolescent couple involved in sexual activity . . . [because] teenage sexual decision making has implications for teens, for their families, and for society. These consequences are not just physical and economic, but also social and emotional, immediate as well as long-term." [Terrance D. Olson, Christopher M. Wallace, and Brent C. Miller. (1984). Primary prevention of adolescent pregnancy: Promoting family involvement through a school curriculum. 5:2, 81.]

"One way social service organizations and communities have attempted to mitigate [the] possibility of maladjustment among single-parent children has been by establishing programs that provide adult models for children. . . . [such as]

'surrogate parental role models' Probably the largest organization involved in primary prevention by providing surrogate role models to single-parent children is Big Brothers-Big Sisters of America. . . ." [Jean E. Edmondson, Thomas B. Holman, and W. Reed Morrell. (1984). The need for and effectiveness of surrogate role models among single-parent children. 5:2, 111-112.]

"One of the major tasks of those concerned with primary prevention has been the specification of groups of individuals at risk for development of disorders later in life. . . . The most researched of these developmental risk factors is prematurity. . . . [which] has been associated with a significantly elevated incidence of disorders including Sudden Infant Death Syndrome, Failure to Thrive Syndrome, Child Abuse, Minimal Brain Dysfunction, Learning Disabilities, Speech and Language Disorders, Hearing Deficits, Cerebral Palsy, and Epilepsy. A direct linear relationship between prematurity and these disorders has not been established and it is doubtful that a causal sequence can ever be satisfactorily delineated. However, the fact that individuals with histories of prematurity are statistically over-represented among those diagnosed with these disorders suggests that premature birth is an early indicator of certain types of later dysfunction." [H. Russell Searight and Paul J. Handal. (1986). Premature birth and its later effects: Towards preventive intervention. 7:1, 3.]

"While research has shown the detrimental consequences of ethnic prejudice among children, few intervention programs have attempted to reduce or prevent this serious and widespread problems. . . . (Katz (1976) reviewed existing research and identified three characteristics of social settings that have been shown to reduce prejudice: (a) inter-ethnic contact is encouraged by authorities, (b) the participants do not manifest prevailing ethnic stereotypes, and (c) some degree of intimacy is present in the contact. A fourth situational characteristic that can encourage reductions in ethnic prejudice, perhaps by promoting intimacy, is when the participants share common objectives in their interactions (Aronson, Blaney, Sikes, Stephen & Snapp, 1975)." [Patricia Rooney-Rebeck and Leonard Jason. (1986). Prevention of prejudice in elementary school students. 7:2, 63.]

"Approximately 1.8 million women yearly are victims of battering in their own homes (Straus, 1977). . . . Although myths about the extent and causes of wife abuse have been exposed and disproved, beatings continue to occur and to be socially accepted (Hilberman, 1980). . . . In this study the effects of viewing a film dispelling myths about wife abuse were examined. . . . These results indicate that the film *Battered Women: Violence Behind Closed Doors* did not significantly affect the attitudes of high school students toward wife abuse. . . ." [Debra J. Walther. (1986). Wife abuse prevention: Effects of information on attitudes of high school boys. 7:2, 84,85, 88.]

“‘He’s autistic.’ A mother was telling us that her child was severely emotionally disturbed. [However, after much testing, the author did not agree with the mother’s ‘diagnosis.’] Why did the mother [and other nonclinical parents as well] attach such a severe label to this [pre-schooler’s] behavior? . . . [T]he mothers who attached such serious labels to their children were . . . relatively isolated, without significant social supports, subject to high levels of stress from various intrafamilial and extrafamilial sources, and only minimally aware of normal stages of child development. . . . [A four session workshop was designed. . . . A peer support group in which these mothers could share control with each other and with the leaders and experience themselves as socially competent and accepted was planned. . . . Reframing techniques and instruction in normal developmental stages in a peer group setting seemed effective in reducing social isolation and increasing maternal self and child evaluation as normal. . . . This preventive method is relatively short and inexpensive compared to therapeutic models, and seemed to produce changes in maternal attitudes and behaviors. . . .]” [Victoria D. Lutzer. (1986). An educational and peer support group for mothers of preschoolers at-risk for behavior disorders. 7:3, 153, 155, 160.]

“Students making the transition to junior high school present an opportunity and a challenge for primary prevention programming. The data obtained in the surveys reported here suggest the desirability of relatively broad-based preventive interventions to prepare early adolescents for this major life transition. Such interventions may be more effective when they move beyond strengthening independent study skills and employ a broad range of cognitive and behavioral skills methods to promote students’ social and emotional—as well as academic—adaptation to their new school environment and new social role requirements.” [Lewayne D. Gilchrist, Steven P. Schinke, William H. Snow, Robert F. Schilling II, and Virginia Senechal. (1988). The transition of junior high school: Opportunities for primary prevention. 8:3, 106.]

“The feminization of poverty is now an all too familiar societal process that currently concentrates three-fourths of all poverty in the United States among women and children. . . . This impoverishment of women and their children has proceeded at an alarming rate, especially among those who are not married—single parents, widowed or never married women over age 65, and displaced homemakers. . . .

“To decelerate the feminization of poverty and then to supplant it with economic equality and opportunity, we must first identify and then change the structural foundation of this major social problem. This foundation has five sides: 1) the vitality of the cultural preconception that women are dependent on men; 2) the sexual division of labor that continues to make women either primarily or solely responsible for children, household management, and the care of aged family members; 3) the pervasive racism encountered daily by minority men and women

as they seek schooling, training, and jobs; 4) the dual labor market and its poor cousin, the dual welfare system; and 5) the systematic discrimination that women and girls face in the work force, housing market, and educational system. . . .

"[P]reventive strategies . . . include: 1) public policies that assure women of wages and income supports that will place them above, rather than below, the poverty level; 2) grassroots organizing that will put pressure on judges, administrators, and legislators to remove those obstacles that keep women out of many sorts of jobs, obstacles such as sexual harassment and the discrimination of employers and unions in assigning jobs, apprenticeships, training opportunities, and promotions; 3) the redistribution of responsibility for caring for young, sick, or old family members; and 4) the reconstruction of gender roles to make economic independence a gender-neutral attribute and to eliminate forever the stereotypes of woman as dependent and man as provider." [Barbara, Levy Simon. (1988). *The feminization of poverty: A call for primary prevention*. 9: 1 & 2, 6, 7, 12.]

"A commonly held myth is that Acquired Immunodeficiency Syndrome (AIDS) is a disease of gay men and drug addicts. In reality, AIDS is the leading cause of death among women aged 25-34 years in New York City (Kristal, New York City Department of Health, 1986). AIDS may ultimately become the primary cause of death among all women of childbearing age. . . . Women have different absolute and relative risks than men for many diseases and disabilities and AIDS is not exception. . . . Heterosexual women are four times more likely to contract AIDS through heterosexual transmission than heterosexual men (Guinan & Hardy, 1987). . . . The risks of HIV infection, ARC, and AIDS are not distributed equally among all groups of women (CDC, 1985). The greatest proportion of AIDS cases occur among black and Hispanic women (Bakeman, et al. 1986). Among all women with AIDS, blacks account for 51% and Hispanics account for 21%. . . .

Lifestyle practices are the strongest predictors of risk exposure for HIV infection. Clinicians and researchers interested in AIDS prevention can profitably apply the concept of risk levels to guide lifestyle intervention efforts to help people reduce high-risk AIDS practices. . . . [Joanne E. Mantell, Steven P. Schinke, and Sheila H. Akabas. (1988). *Women and AIDS prevention*. 9: 1 & 2, 18, 19, 20, 27.]

"Women have been socialized to move discontent out of their awareness, maintaining an illusion of 'everything is really all right.' Reconnection of the women to her reality and to the reality of her common situation with all women is crucial, not only to validate her experience for herself, but also to begin to lift her eyes from herself to others and the environment. . . . Empowerment is that stage of development when one begins to confront the environmental sources of stress with the goal of social change. It can only be accomplished through joining together with others with common concerns and needs. . . . [Karen Strauch Brown and Marjorie Ziefert. (1988). *Crisis resolution, competence, and empowerment: A service model for women*. 9:1 & 2, 101, 102.]

"The . . . MADRE parent education program [is] a prevention program targeting Hispanic women designated at high risk for abusive and neglectful behavior toward their children . . . and provides [them] with the necessary knowledge and skills for more effective parenting. . . . The findings clearly establish the need for an ethnically sensitive parenting education program in the Hispanic community as a preventive measure against child abuse and neglect." [Catalina Herrerias. (1988). Prevention of child abuse and neglect in the Hispanic community: The MADRE parent education program. 9: 1 & 2, 105, 107, 114.]

" . . . [W]e have documented that for many women, their unfulfilling placement in the occupational structure combined with their stressful familial demands, result in stress associated with the *quality* of their multiple roles. Ultimately, . . . this stressful combination will have an adverse affect on the mental health status of female workers found in these circumstances. Prevention of negative mental health impact requires action by women, and by society as well. . . . Women, like all workers, need better jobs, and better control over the jobs they do have. One possibility is for women to join trade unions. . . . [C]ollective bargaining needs to occur around such issues of concern to women as job sharing, flex-time, leave to care for sick family members, and child care provisions as well as efforts to improve wages, hours and working conditions which constitute the traditional fare of trade union negotiations. . . . Policies that increase autonomy of women workers, encourage promotion of women, and are supportive of their familiar roles, will prevent illness (thereby reducing the employer's health care cost) and increase productivity (compounding the return on their investment in women workers)." [Sheila H. Akabas. (1988). Women, work and mental health: Room for improvement. 9: 1 & 2, 137, 138.]

"Because of the developmental characteristics and special circumstances of children require particular treatment approaches and strategies, . . . disaster workers have designed special programs to meet the needs of children following disasters. . . . On the day following the flood, [the author] contacted the local county school system [and offered] school officials consultation and education regarding two goals: first, to meet the students' immediate emotional needs in their return to school; and, second, to prevent the high absenteeism that typically occurs following a disaster. . . . A manual, 'After the flood: What educators can do,' was presented. . . . Thousands of copies of a brochure for parents, 'After the flood: Emotional first-aid for children,' also were distributed by the school. . . . Teachers, parents, and students reacted positively to the information and activities presented in the program." [Lennis G. Echterling. (1989). An ark of prevention: Preventing school absenteeism after a flood. 9:3, 177, 178, 179.]

"The [mass] media represent an excellent forum for alerting thousands of community residents to health promotion initiatives. Once alerted to these

programs, participants can pick up materials and resources to reinforce the concepts broadcasted, and encourage opportunities for practice. Perhaps the most exciting possibilities lie in the more interactive interventions. Groups can be assembled to watch the programs together, or participants can be provided additional support by actually being put in contact with helpers, self-help groups, or other community agencies. Many, if not most of, psychologists' efforts to alter addictive behaviors have been unsuccessful in producing long-term changes. Perhaps by lowering barriers to participation in programs, and devising imaginative ways to enable participants to continue receiving support and encouragement following the end of the media programs, sustained improvement will be engendered." [Leonard A. Jason, Isiaah Crawford, and Charles L. Gruder. (1989). Using a community model in media-based health promotion. 9:4, 245.]

"Hazardous wastes are being manufactured at rates which far exceed our present capacity to properly dispose of them. . . . Furthermore, there is recognition of past illegal dumping and storing of toxic materials, and the need to clean up these dump sites. In an effort to meet this public health challenge, new hazardous waste disposal facilities are being planned and built. Yet, certain members of our society will have to bear a greater share of the social costs of hazardous waste disposal: these individuals are the people who live near disposal sites. . . . A primary prevention goal is to identify which individuals are at greatest risk and to minimize the negative psychological impact of these facilities on the local population." [Kenneth M. Bachrach, Alex J. Zautra, and Ana V. Cofresi. (1989). Minimizing the negative impact of a planned hazardous waste facility on the surrounding community. 10:2, 133, 134.]

"Certain consistencies in refugee experience and behavior transcend the superficial diversity of groups from distinct cultures and historical circumstances. . . . and may contribute to increased rates of mental illness. Previous work with refugee groups demonstrates that psychological problems will increase when 1) a prolonged wait occurs between initial exodus and final resettlement; 2) refugees are separated from families and other natural support systems; 3) host and home countries are very dissimilar; 4) refugees plunge from a higher socio-economic status to a lower one; 5) the refugee flight is traumatic, and 6) people are robbed of individuality by residing in massive refugee camps. . . . These findings suggest that preventive efforts should begin at the start of a refugee crisis and that public mental health professionals should be involved throughout the resettlement process." [Carolyn L. Williams. (1989). Prevention programs for refugees: An interface for mental health and public health. 10:2, 168.]

"Teenage pregnancy in America is a problem of growing proportions, with one out of ten sexually active teens becoming pregnant every year [M]ore than half of all pregnant teenagers [keep and attempt] to raise their babies. Surprisingly,

U.S. females ages 15–19 lead all other developed countries in the incidence of adolescent pregnancy (Alan Guttmacher Institute, 1986).

“[These young mothers] . . . are often ill-prepared for the excessive demands of parenting. Additionally, the unavailability of adequate day care frequently necessitates that the new mother remain at home with her baby. At present, it is estimated that only half of those girls bearing children during their school years will graduate from high school.

“Financial pressures for this group are unrelenting, thus teenage mothers and their offspring are far more likely to live in poverty than their older, married counterparts. When these young parents do become employed, wages are typically half that earned by their non-parenting peers. Sadly, most teenage mothers are forced to rely on public assistance, and all too often their daughters will grow up to be teenage parents themselves. Moreover, teenage pregnancy results in a complicated pattern of increased health risks for the mothers. . . . [and for] infants of adolescent mothers, there is a higher incidence of illness and mortality, as well as educational and emotional difficulties throughout the child’s development . . . [including becoming] targets for abuse by frustrated parents who lack understanding of their child’s development.” [Elizabeth Thomas, Annette U. Rickel, Christine Butler, and Edith Montgomery. (1990). *Adolescent pregnancy and parenting*. 10:3, 195–196.]

“One spring day in 1981, 40 Hampton students went out into the parking lot of their high school to smoke marijuana. This was not an unusual occurrence at the time. Use of alcohol and other drugs among youth was widespread in the city. The difference which marked this occasion was that, as a result of a prior cooperative agreement between the school division and the city’s police department, the entire event was captured on film. Thus the city ‘discovered’ its school-age substance abuse problem.

“This ‘bust’ marked the beginning of cooperative community involvement in the school-age substance abuse problem. From its beginning in 1981, a program has developed which is comprehensive both in nature and scope, serving a school division of 20,000 students in an urban, coastal community. It involves a wide variety of community agencies and groups, and provides a continuum of prevention and intervention services from kindergarten through high school. . . . [This program] appears to be a promising strategy in the fight against school-age substance abuse.” [Cynthia E. Carlson. (1990). *HIPP: A comprehensive school-based substance abuse program with cooperative community involvement*. 10:4, 289, 299.]

“Research in the field of primary prevention has continued to demonstrate the high vulnerability that elementary school students experience in their transition to intermediate school. . . . [The author describes a “Sixth Grade Transition

Groups” program to help students cope with the transition . . .] through a social competency/stress reduction program that consists of a 3-day (one hour each day) curriculum. . . . Day One: . . . The primary goal of Day One is to help students begin to identify and confront their fears, concerns, distortions, and fantasies about junior high school and, in the process, gain a more realistic perspective of what awaits them. . . . Day Two: . . . Students are taught six components of effective communication by means of the ‘S.O.F.T.E.N’ formula, viz, Smiling, Open responses, Find out something interesting and unique, Territory and personal space, Eye contact, and Names. . . . Students are taught six components of problem-solving by means of the ‘S.O.L.V.E.D.’ formula, viz, State the problem, Observe and clarify feelings, List alternative solutions, Visualize implementing each solution, Examine the probable results of each solution, then Determine the best solution and try it! . . . Day Three: . . . The primary goal is to teach students strategies for dealing with changing peer relationships.” [David W. Hellem. (1990). Sixth grade transition groups: An approach. 10:4, 303, 307, 308, 309.]

“Program evaluation of three preventive parent training efforts suggest that parents can effectively be taught new ways to manage behavioral struggles, that such training leads to observable improvements in child behavior, and that the training is rated highly useful and leads to improvements in parent confidence. The interventions are research-based, enduring (two of the programs have been in continuous operation for over 10 years), effective, and efficient (over 2,000 citizens have participated). The preventive potential of the interventions lies in their contribution to parent coping skills and competencies, increases in self confidence and sense of influence or control, reductions in the frequency and intensity of behavioral struggles, consequent reductions in perceived stress, and general changes in parent-child interaction characterized by more frequent positive and less frequent negative encounters. The ability to influence both child and adult behaviors simultaneously is particularly noteworthy in light of the reciprocal, mutually deterministic nature of parent-child interaction. By altering such mediating factors, we have hopefully reduced the likelihood that the behavioral struggles will worsen or persist, lowering the risk of future adjustment problems.” [John R. Morgan, Jeannett Nu’Man-Sheppard, and Diana W. Allin. (1990). Prevention through parent training: Three preventive parent education programs. 10:4, 331.]

“Overall, the surveys [of California high schools], discussions, and observations indicate that high school level child abuse prevention programs typically target one or more of four goals: (1) prevention of adolescent abuse by adults, (2) prevention of adolescent abuse by peers, (3) prevention of adolescents from becoming child abusers, and (4) identification and reporting of suspected child abuse. Programs also tend to focus on changing student awareness rather than ensuring increases in student skills for meeting these four challenges.” [Richard P.

Barth, David S. Derezotes, and Holly E. Danforth. (1991). Preventing adolescent abuse. 11:3,196.]

"In general support of the help-seeking literature, [the present] findings suggest that not only are [military] husbands and wives somewhat reluctant to seek marital and family counseling services given a marital or family problem, but also some are more reluctant than others to pursue these services as a resource in times of relational distress." [Gary L. Bowen and Jack M. Richman. (1991). The willingness of spouses to seek marriage and family counseling services. 11:4, 287.]

"In 1982, the number of labor accidents in Europe was estimated at 10.6 million, of which 21,000 resulted in fatalities. In the U.S., 11,500 persons were killed at work year 1984 at a total cost of \$33 billion (National Safety Council, 1988). . . . Control over workplace hazards could be achieved in two ways: increased attention to worker behavior and by expanding engineering requirements for environmental control. . . . [This article is presented in] the form of a process description and is based on ten years' experience (1977-1986), with emphasis on factors that have contributed to the possibilities of carrying out long-term preventive work in a whole country [Sweden]." [Bjarne Jansson and Bo Haglund. (1991). Intervention strategies directed at exposure to organic solvents at worksites: A case study. 11:4, 295,296, 297, 298.]

"There is increasing evidence that mass communication programs for the general public can be effective in disease prevention programs, and that the contributions are both direct and indirect (DeJong & Winsten, 1989). . . . [C]autious optimism is in order. . . . Flay's review (1987) of 40 mass media efforts to influence cigarette smoking concluded that mass media can be used successfully in reducing this addictive behavior. . . . [O]ther health behavior initiatives related to cardiovascular disease, e.g., fat and salt intake and physical activity, have produced positive outcomes with mass media techniques. . . ." [Fred Kroger. (1991). Preventing HIV infection: Educating the general public. 12:1, 12, 13.]

"Behavior change is key to stopping the AIDS epidemic. . . . The importance of basing preventive educational messages [regarding HIV prevention] on accurate, updated, epidemiological information and ensuring that the messages are clear, practical, and culturally sensitive cannot be overstated." [Peggy L. Peterson, David G. Ostrow, and David J. McKirnan. (1991). Behavioral interventions for the primary prevention of HIV infection among homosexual and bisexual men. 12:1, 19, 25.]

"[Intravenous drug users (IVDUs)] represent an ominous 'second wave' of the human immunodeficiency virus type 1 (HIV-1) epidemic in the United

States. . . . [P]rimary prevention strategies [for IVDUs] include: 1) substance abuse treatment, specifically methadone modalities for opiate addiction, 2) medical treatment of sexually transmitted diseases which may increase the risk of acquiring and transmitting HIV-1, 3) provision of family planning services to HIV-1 infected IVDUs and sexual partners, 4) HIV-1 antibody counseling and testing, 5) needle exchange programs, and 6) outreach education programs like the 'Chicago Model' [which target entire social networks of IVDUs to initiate and sustain behavioral changes] undertaken at the community level. . . ." [W.Wayne Wiebel and Thomas M. Lampinen. (1991). Primary prevention of HIV-1 infection among intravenous drug users. 12:1, 35, 39, 41.]

"As women's role in the AIDS epidemic continues to increase, the need for effective AIDS prevention programs for women has become critical. . . . It seems clear that women's response to preventive interventions is greatly affected by their cultural and risk-taking orientations, socioeconomic status, and role and sense of power . . . in decision making around sexual and drug use behavior. . . . In developing specific intervention strategies, projects report that the best—indeed, usually the only workable—strategy is to listen to the women being targeted. Intervention strategies should address the issues, problems, concerns that these women identify as the most pressing in their lives rather than areas funders, researchers, program designers, and service providers may identify as most pressing." [Gloria Weissman and the National AIDS Research Consortium (NARC). (1991). AIDS prevention for women at risk: Experience from a national demonstration research program. 12:1, 50, 51, 60.]

"In the creative drama approach to social skills training the students develop through experiential learning the basic skills of taking turns, listening to others, understanding their feelings, and negotiating conflicts, because they can not create a successful skill without these interpersonal resources (Walsh et al., 1991a). Furthermore, improvisational drama provides an intrinsically motivating medium, given that each actor can express her or his private world of imagination, will, and planning in her or his character (cf. Singer, 1973; Vygotsky, 1967). Pivotal to drama is the function of social perspective-taking which developmentalists have noted to be crucial in the growth of peer relation skills. . . ." [Richard T. Walsh-Bowers. (1992). A creative drama prevention program for easing early adolescents' adjustment to school transitions. 13:2, 143.]

"Rite of Passage Experience (ROPE) offers communities a process for facilitating a modern day ritual of initiation [..that have been largely forgotten by contemporary society]. . . . ROPES provides activities in a ceremonial process which when linked together attempt to promote good physical health and nutrition, develop decision-making and problem-solving skills, build competencies, increase self-esteem, and most importantly enhance support systems that help strengthen

the linkages among and between schools, family, community and peers (Bates, 1987)." [David G. Blumenkrantz and Stephen M. Gavazzi. (1993). Guiding transitional events for children and adolescents through a modern day rite of passage. 13:3, 203, 201, 204.]

"The experience of transferring into a new school has been frequently documented in the literature as a particularly difficult adjustment for children. . . . An estimated six million children between the ages of 5 and 13 transfer to new schools each year. . . . Interventions that revolve around parental support, school orientation, or peer role models might be used in helping transfer children adjust to their new schools. . . . This pilot study . . . combined an orientation program and school-tutoring for the transfer students, with training to help parents become more effective tutors for their children. . . . The present study suggest that when parents become actively involved in a preventive tutoring program, their children do better in coping with the academic requirements of the new school." [Leonard A. Jason, Karen S. Kurasaki, Lisa Neuson, and Corina Garcia. (1993). Training parents in a preventive intervention for transfer children. 13:3, 213, 214, 224.]

"The life challenges faced by teenagers and young adults who are lesbian or gay have only recently become the focus of the concerted attention of researchers and helping professionals. . . . Much of this concern centers on mental health problems of youth . . . up to as many as 30% of all youth suicides may be related to issues of sexual orientation. . . .

"Changes in the following areas will have a significant preventive impact on the lives of lesbian and gay young people: 1) changes in mental health services [to be accessible and helpful], 2) the development of safe settings for identify development [. . . most important is campus housing facilities . . . where much harassment and victimization takes place.], 3) integration of lesbian and gay issues into the curricula [This omission helps to perpetuate the stereotypes which provide the foundation for the biases and victimization. . . .], and 4) changes in institutional policies [. . . statements that harassment based on sexual orientation will not be tolerated . . . [and] . . . institutional mechanisms for implementation]." [Anthony R. D'Augelli. (1993). Preventing mental health problems among lesbian and gay college students. 13:4, 245, 255, 256, 257, 258.]

"Death is an integral part of the hospital experience. . . . The trauma of dying and the finality of death create stress for the surviving family members which warrants professional intervention. . . . The goal of such intervention is a healthy bereavement process—the prevention of pathological mourning. To achieve this aim, the interdisciplinary team must enter into the family circle as strangers and rapidly assess the relationships, reactions, and requirements of the bereaved—all at a time when the family is most vulnerable and defensive, protective and sensitive

to any intrusion upon their privacy. The team approach [doctor, nurse, medical social worker] has proven to work very well in achieving this goal: it is meant to humanize the process of death and its aftermath for the living and to help them use the available professional resources." [Batya Rappaport. (1993). Families of the deceased in the hospital: A multi-disciplinary approach to intervention. 13:4, 281, 282.]

"... [T]here seems to be consensus about how to implement positive youth development programs in school settings. Most importantly, these programs should be developed in close collaboration with school systems. This collaboration should combine the expertise of the school staff with the knowledge of the program developers in order to conceptualize, design, implement, evaluate, and maintain such programs. Such a process requires a great amount of energy and dedication over a long period of time." [Aleta Meyer, Suzanne Miller, and Mindy Herman. (1993). Balancing the priorities of evaluation with the priorities of the setting: A focus on positive youth development programs in school settings. 14:2, 112.]

"As we have entered into an age of electronic media, it is fitting our attention is focused on a video that might serve as a catalyst to help bring people to a greater understanding and appreciation of prevention. This video, 'An Ounce of Prevention,' [originally developed as part of a larger telecourse] might serve as a stand-alone piece... in undergraduate and graduate course work related to prevention." [Maurice J. Elias. (1993). Educating students, the public, decision makers, and professionals about prevention: A special review section on the video, 'An ounce of prevention'." 14:2, 129-130.]

"Evidence that parenting factors may play a critical role in determining whether or not people misbehave as children and even later as adults is one of the most replicated findings in the deviance literature... [but] the empirical and causal connections between parenting and delinquency/crime remain ambiguous and equivocal....

"The work summarized and analyzed in this essay carries a critical message: parenting is important. The way we treat our children can have devastating repercussions for them, for us and for society at large. Delinquency and crime are expensive enterprises that erode the very foundation of society.... Part of that expense lies in this fact that children who become delinquent and criminal are prone toward poor health, drug abuse, marital instability and severe employment problems (Dryfoos, 1990, p. 32)." [Ann Goetting. (1993). The parenting-crime connection. 14:3, 169, 183.]

"The appearance of a class of drugs called 'nootropics' currently being reported in the popular press has a number of implications for substance abuse

prevention among students. . . . They are currently being legally purchased for use by healthy individuals as intelligence enhancers/memory booster. They are known in the vernacular as Smart Drugs.

"The goal of this paper is to draw the attention of physicians, prevention specialists, educators and researchers to the possible emergence of nootropics use among students and the younger population who may be at risk for misuse of this class of drugs." [R.J. Canterbury and E. Lloyd. (1994). Smart drugs: Implications of student use. 14:3, 197.]

"More than half of the deaths in the US each year result from health damaging lifestyle behaviors. . . . [This paper discusses implementing primary prevention programs for adolescents in rural environments.] . . . In light of the foregoing discussion related to the lifestyle risks and health status of adolescents, coupled with long-established belief systems of rural residents and the overriding rural health care delivery issues, providers would do well to work closely with a community when planning and implementing a primary prevention program. . . . Despite the lack of resources, historically, most [rural residents] fared rather well with self-care, neighborliness and community support." [Angeline Bushy. (1994). Implementing primary prevention programs for adolescents in rural environments. 14:3, 209, 220, 221.]

"I would like to propose [a new speciality:] a children's community psychology. . . . [which] would explore children as experienced by communities, and communities as experienced by children. It would analyze children's environments, study children's transactions with settings, and help to improve both the environment and children's behaviors within certain environments. It would document the catastrophic effects of many dangerous communities on kids. It would take children seriously as an underprivileged class of people, and propose ways to advocate and organize politically for the sake of youngsters." [Andrew M. Weine. (1994). A modest proposal for a new specialty: Children's community psychology. 14:4, 237, 239.]

". . . [T]he workplace, through the efforts of business, industry and labor groups, in concert with community-based prevention organizations, can be an important partner in primary prevention efforts." [Judith R. Vicary. (1994). Primary prevention and the workplace. 15:2, 103.]

". . . [T]he 'Home and On Your Own' program incorporates current knowledge about self-care and prevention technology [for latchkey children] into a comprehensive, workplace-based, family-oriented prevention program. . . . The program itself focuses on educating parents and children about important self-care and family management skills such as dealing with peer pressure, [personal] safety, communication and decision-making." [Neil B. Colan, Katherine C. Mague, Ronna

S. Cohen, and Robert J. Schneider. (1994). Family education in the workplace: A prevention program for working parents and school-age children. 15:2, 171.]

"In this essay, we suggest that a loss of connectedness or community has contributed to the strain within society. . . . [An historical review of the loss of the psychological sense of community] provides a way to explore and eventually address [current problems, like homelessness, AIDS, gang activity, and domestic violence] at a deeper level." [Leonard A. Jason and Robynn B. Kobayaski. (1995). Community building: Our next frontier. 15:3, 197, 196.]

"Project Northland is currently the only community-wide primary prevention program funded by NIAAA focusing on young adolescents [grades 6 through 8] prior to onset of use. It is an efficacy trial combining school curricula, peer leadership training, parent involvement programs, and community task forces working on access reduction and other related policies. . . . Project Northland's primary goal in the sixth grade [reported here] was to alert parents and the community about the need for constructive communication and efforts to discourage alcohol use among sixth graders." [Carolyn L. Williams, Cheryl L. Perry, Bonnie Dudovitz, Sarea Veblen-Mortenson, Pamela S. Anstine, Kelli A. Komro, and Taci L. Toomey. (1995). A home-based prevention program for sixth-grade alcohol use: Results from Project Northland. 16:2, 144.]

". . . [T]he major contributions of this project are, first, the development, piloting, and institutionalization of a K-6 child sexual abuse prevention curriculum with accompanying teacher training materials and student and teacher evaluation instruments. Second, data analysis demonstrates that the curriculum leads to significant learning between pre-test and post-tests at all grade levels—learning that does not appear to be mediated by gender and/or school socioeconomic status. Third, teachers' feedback indicates an overall satisfaction with the curriculum and training. Fourth, presentation of the curriculum materials and training appears to have increased teachers' awareness of sexual abuse and has led to increased disclosures of abuse by students. . . ." [Sharon K. Araji, Ray Fenton, and Tom Straugh. (1995). Child sexual abuse: Description and evaluation of a K-6 prevention curriculum. 16:2, 161.]

"Churches and other religious organizations represent a potentially productive avenue into American racial and ethnic minority communities." [Mary Sutherland, Charles D. Hale, and Gregory J. Harris. (1995). Community health promotion: The church as partner. 16:2, 214.]

"Communities That Care (CTC) is a comprehensive, community-wide risk-focused prevention strategy based upon research on predictors of health and behavior problems. Theoretically grounded in the social development model (Catalano

& Hawkins, in press; Farrington & Hawkins, 1991; Hawkins & Weis, 1985), its goal is to mobilize and train communities to reduce risk factors that predict adolescent problem behaviors and increase protective factors that inhibit these behaviors. . . . TOGETHER! Communities for Drug-Free Youth [the program under discussion in this article] sought to discover whether communities could be effectively mobilized and trained using the CTC strategy. . . . Forty Oregon communities responded to the initial invitation to send key leaders to an orientation on the project. Of those 40, 35 ultimately completed all three trainings. Four years later, 31 boards are still active, and 28 of them were involved in the implementation of risk reduction programs." [Tracy W. Harachi, Charles D. Ayers, J. David Hawkins, Richard F. Catalano, and Judy Cushing. (1996). Empowering communities to prevent adolescent substance abuse: Process evaluation results from a risk- and protection-focused community mobilization effort. 16:3, 235, 237, 251.]

"The growth of alcohol, tobacco, and other drugs (ATOD) addictions and related social problems among the rapidly increasing Hispanic population has seriously challenged service providers. . . . [The *La Familia Community Drug and Alcohol Prevention Program* is a] family-centered prevention strategy [targeting] the families of high-risk youth from 6 to 11 years, and attempts to reduce identified risk factors while simultaneously increasing culturally relevant protective factors." [Lawrence P. Hernandez and Ed Lucero. (1996). DAYS La Familia Community Drug and Alcohol Prevention Program: Family-centered model for working with inner-city Hispanic families. 16:3, 255, 256.)]

"... [E]vidence strongly suggests that many [public housing] communities experience a serious concentration of illegal drug markets and high levels of addiction and drug-related crimes. . . . Moreover, the high incidence of co-factors for substance abuse, such as unemployment and health problems, among lower income populations also suggest that substance abuse is likely to be higher among public housing residents. . . . The Prevention in Housing Communities Training project . . . [was designed] to train and enhance the skills of individuals (Public Housing Authority staff, residents, and representatives of other key social institutions in selected public housing communities) to join together as ever-expanding teams to start creating their own solutions to substance abuse. . . .

"... Underlying most community organizing or mobilization initiatives are these premises: (a) that, in joining together, individuals can affect the conditions that affect them, and (b) that the more these individuals represent all segments of the community, the more likely they are to succeed. . . . [F]indings indicate that training as a community prevention strategy is a very promising one, *if* it incorporates effective transfer of training principles. This means (a) that potential barriers and opportunities for application of the training must be considered prior to (and during) the training, and (b) that follow-up support, such as technical assistance or further on-site training, must be provided to assist the teams to

overcome barriers and maximize use of available resources.” [Thérèse van Houten, Susan Hailman, Claudette Renée Yanssaneh, and Vernon Bowen. (1996). Transferring prevention skills to teams in public housing communities. 16:3, 173–274, 275–297, 300.]

“The Community Health Demonstration Project’s programming is based on a community systems model in which individuals are viewed as members of several different, yet intertwined and interacting, systems . . . [including] families, peer groups, schools, and worksites. These primary systems are contained in larger systems, such as neighborhoods; communities; and local, State, and national governments. All of these systems are interconnected in some manner, either overlapping, comprising or encompassing other systems. . . . In essence, prevention programming is a process of community development, with a goal of building a locality’s capacity to address community problems. This involves a deliberate attempt to develop communicative bonds between different segments of the local society. The end result of such a process is the development of a community among a local population, which . . . is assumed to be an important factor in individual and social well being (Wilkinson, 1979).” [Judith R. Vicary, Melanie K. Doebler, Jeffrey C. Bridger, Elise A. Gurgevich, and Randall C. Deike. (1996). A community systems approach to substance abuse prevention in a rural setting. 16:3, 307.]

“America is a violent society, with a murder rate ten times higher than that of England and twenty-five times higher than Spain. . . . [T]eenagers were two-and-one-half times as likely to be victims of violent crimes than were adults. . . . Traumatic events, such as exposure to violence, may provoke a variety of [acute and extended] responses in exposed children. . . .

“A stable and safe—in the sense that the family is not characterized by either violence nor drug abuse—family appears to be a child’s best defense against the harms resulting from exposure to violence. . . . Studies of children’s coping with disasters have shown that open communication in families allows the parents to sympathize with the children’s fears, to reassure them that their fears are normal, and to help them to understand the problems in their environment. . . .

“There are a variety of reasons why parents may fail to provide the emotional support their children need in order to cope with community violence. . . . Schools are in many ways a natural setting for the provision of interventions to help children to cope with violence in their communities, . . . [but the effectiveness of school programs has not yet been established]. . . . Preparing parents and teachers to provide that help should be one of the major primary prevention tasks for the decades ahead.” [David F. Duncan. (1996). Growing up under the gun: Children and adolescences coping with violent neighborhoods. 16:4, 344, 349, 350, 352, 354.]

“Several studies have shown that group HIV prevention interventions that are grounded in social learning theory result in reductions of HIV-risk behaviors across

diverse at-risk populations. Research has suggested that videotape presentations increase knowledge and alter risk-related attitudes that increase readiness to reduce HIV risk behaviors. Videotapes have the potential for wide-scale dissemination and may be inexpensively implemented by community-based service agencies. . . . The public health impact of videotape interventions will likely be meaningful when the effects are projected over mass distribution to high-risk populations. . . . Most HIV prevention programs using videotapes have not resulted in behavioral changes that would reduce risk for HIV infection. However, most efforts have not included cognitive behavioral skills training and have not been based on theoretical principles of behavior change." [Seth C. Kalichman. (1996). HIV-AIDS prevention videotapes: A review of empirical findings. 17:2, 276.]

"Family disruptions resulting from separation and divorce affect nearly three million parents and children annually. . . . Children of Divorce Intervention Program (CODIP) is a school-based preventive intervention that features group support and coping skills training (Pedro-Carroll & Cowen, 1987). The program was originally developed for 4th–6th grade suburban children. . . . [This project involves kindergarten and first graders.]. . . . Results of program evaluation data suggest that the program can be developmentally tailored for 5 and 6 year olds with positive outcomes in social and emotional adjustment at home and at school. [JoAnne L. Pedro-Carroll and Linda J. Alpert-Gillis. (1997). Preventive interventions for children of divorce. 18:1, 5, 7, 17.]

"Childhood lead poisoning is a unique example of how environmental and public health perspectives have converged in the fight to eliminate a preventable childhood disease. Lead poisoning is one of the most common environmental health problems for children in the United States today. . . . In the effort to eliminate childhood lead poisoning as a public health problem, several strategies are available, including screening and follow-up exams of children with high blood lead levels; identification and control of environmental lead hazards; development of data to guide allocation of resources; and education about childhood lead poisoning and its prevention." [This article emphasizes lead education.] [Tim L. Tinker and Niki Keiser. (1997). Childhood lead poisoning prevention: An overview of federal education programs and resources. 18:1, 130.]

"Increasingly, high-risk youth can look forward to a bleak adolescence and a social environment that contributes to, rather than averts, problems. . . . What is the most effective way to remedy these problems? Programs that strengthen families and enhance young children's resiliency work. . . . ; these programs also illuminate key family processes that foster healthy development. This paper describes evaluation findings from DARE to be You, an early prevention program that promotes youths' resiliency to later problem behaviors, including drug use,

by means of co-training parents and children to enhance self-efficacy, effective child rearing, and problem solving. . . . [drawing heavily on developmental theories of self-efficacy (Bandura, 1986) and social behavior (Hawkins & Weis, 1985) as well as family interaction theory (Brook et al., 1990).] [This DARE to be You is not affiliated with the Drug Abuse Resistance Education program (D.A.R.E.)] [Jan Miller-Heyl, David MacPhee, and Janet J. Fritz. (1998). DARE to be You: A family-support, early prevention program. 18:3, 258.]

"On the basis of our findings we conclude that a culturally appropriate multi-component intervention [involving risk and protective factors at the individual, family, and school levels] can bring about measurable reduction in alcohol use among high-risk Latino youth. Development of culturally appropriate materials and implementation by a culturally sensitive staff (predominantly Latino and from the same origin cultures as the target population) are valuable aspects of intervention for this target group." [John F. Stevenson, Bradley McMillan, Roger E. Mitchell, and Mercedes Blanco. (1998). Project HOPE: Altering risk and protective factors among high risk Hispanic youth and their families. 18:3, 315.]

"The findings from this study suggest that Africentric programs may be effective in increasing protective factors for alcohol, tobacco, and other drug use (ATOD) among African American youth. Since our study showed more program effects on protective factors (as opposed to ATOD attitudes and behaviors), one speculation is that this program and other culturally congruent programs may also promote protective factors for other risk behaviors (e.g., violence, teenage pregnancy, school drop-out)." [Valerie R. Cherry, Faye Z. Belgrave, Willa Jones, Darryl Kofi Kennon, Famebridge S. Gray, and Fred Phillips. (1998). NTU: An Africentric approach to substance abuse prevention among African American youth. 18:3, 336.]

"The goals of the Families in Action (FIA) program were to increase resiliency and protective factors within high risk youths and their parents [in rural areas] in order to reduce the likelihood that youths would use alcohol, tobacco, and other drugs (ATODs). Specifically, the FIA program sought to significantly increase amongst participating students: 1) positive attachment to their family, 2) positive attachment to their school, 3) positive attachment to their peers, 4) willingness to talk with counselors when needed, and 5) appropriate attitudes toward the use of ATODs by minors. For parents, the goals were to increase: 1) positive attachment to their family, 2) time spent in enjoyable family activities, 3) involvement in their child's school, 4) willingness to talk to family or school counselors when needed, and 5) appropriate attitudes toward the use of ATODs by minors." [Colleen Pilgrim, Antonia Abbey, Peggy Hendrickson, and Sue Lorenz. (1998).

Implementation and impact of a family-based substance abuse prevention program in rural communities. 18:3, 343–344.]

“The results of the survey highlighted the important roles Latinas are playing in the community. They not only own and operate their own businesses [in botanical shops offering health-oriented goods and in beauty parlors] but also provide social services to their customers and community. . . . All Latina owners stated that they had an ‘obligation,’ and that it was a ‘gift’ and an ‘honor’ to be of help to their community. . . . The botanical shop owners viewed their obligation as a means of thanking ‘God’ for the power to heal. . . . Latina owners offered a tremendous range and level of assistance as part of their businesses [including] providing consultation on medical ailments, prescribing herbs, offering ‘advice’ on interpersonal problems, and making referrals to folk healers.” [Melvin Delgado. (1998). Latina-owned businesses: Community resource for the prevention field. 18:4, 455, 457, 458.]

THE POLITICS OF PRIMARY PREVENTION

Some observations: Primary prevention faces an array of entrenched interests, theoretical, methodological, and practical, that have put major road blocks in its path to help healthy people help themselves. It is interesting to read the following excerpts to recognize that we have to be forceful and well prepared to communicate the truth, excitement, and success of primary prevention. Yet, it may not matter what the truth of the primary prevention enterprise is; it may be enough to recognize that no matter what we say or do, we will be a threat to the status quo of blaming the individual for his/her problems rather than taking complex social actions against powerful interest groups (including fellow helping professionals). As Joffe notes, society resists above all dealing with the “cause of causes” of all of the many separate miseries and evils in the world. So, it is likely there will always be a role for the activists among the professionals in primary prevention.

“If there is to be a redirection of effort in the mental health field—a shift toward the prevention of emotional disturbance, alcoholism, substance abuse, and toward the development of increased competence and coping skills—then there must be a change in professional goals and values. While both compassion and logic support increased efforts in primary prevention, there are powerful professional forces that support and defend the defect model and the status quo. The outcome of this struggle remains uncertain. . . .

“Now the mental health field appears to be on the threshold of the Fourth Mental Health Revolution [following Pinel, Freud, and the community mental health centers movement]. This revolution will emphasize social changes aimed at

improving the quality of life and reducing avoidable stresses. It will challenge the authority of the mental health establishment and attack the ritualistic devotion to one-to-one intervention. It will expose the fallacies of the illness model." [George W. Albee. (1980). *The fourth mental health revolution*. 1:2, 67, 68.]

"[President John F. Kennedy's message on the dual avenues toward prevention in community mental health reads, in part:]

Prevention will require both selected specific programs directed especially at known causes, and the general strengthening of our fundamental community, social welfare and educational programs which can do much to eliminate or correct the harsh environmental conditions which often are associated with mental retardation and mental illness.

While the former approach is presently embodied in more widespread infant nutrition, maternal health, and environmental safety programs, the latter approach is only now being fully articulated. It is an approach that does not involve reform of our existing health and social welfare institutions or the creation of new ones because it lies outside institutions. It is not based on a new prevention technology because it marshals experiential rather than expert knowledge to accomplish its health purposes. It does not require new forms of training that will produce yet another new breed of prevention specialists because its practitioners are ordinary citizens. Nor does it require large financial outlays in support of a massive public education campaign aimed at swaying public opinion toward a more psychologically and socially hygienic lifestyle. Rather, it is an approach that attempts to strengthen the social fabric in which people are embedded and to mend this fabric which is rent by disruptive environmental events . . . carried out by persons already familiar to one another. . . [T]he process of their work . . . hinges on exchanges of mutual aid and collective negotiation about the best means of promoting the common welfare." [Benjamin H. Gottlieb. (1982). *Social support and risk reduction*. 3:2, 71–72.]

"The appeal of the ecological perspective is that it offers alternative solutions to a wide range of critical sociopolitical and economic issues in the contemporary human services area that are equally attractive to conservative and liberal tastes. . . [F]or instance, . . . its emphasis on the development and support of the natural caring function of the family, the neighborhood, self-help groups, and natural helping networks—an emphasis that offers the prospect of a more efficient and cost-effective use of human resources. . .

"Similarly, its emphasis on informal and nonbureaucratic modes of social organization for the solution of common problems, as in the alternative services, on the utilization of natural social processes, such as free market mechanisms, and on natural life experiences for remediation and prevention of human ills—all offer the prospect of an engaged and less alienated society, and a diminished dependence on excessive government and professionalism." [Robert A. Porter. (1983).

Ecological strategies of prevention in rural community development. 3:4, 235–236.]

“It is the central thesis of this article that mental health promotion activities should not be conducted in mental health agencies that are systems designed to deal with mental illness, but rather that this direct service should be delivered within the context of those institutions in society that are involved with normal processes of living. A second thesis of this article is that such a partnership requires a clear delineation and differentiation of roles performed by mental health professionals vis-a-vis the other human service systems.” [Felice Davidson Perlmutter. (1983). Partnerships for mental health promotion. 4:2, 96.]

“In the postwar era, alcohol consumption has increased almost everywhere in the industrialized world, and in many developing countries for which data [are] available. . . . Associated with [this rise in consumption] has been a rise in the rates of various alcohol-related problems—health problems, casualty problems, and social problems—in many countries. . . . The societal response to this increase has been remarkably uniform in very diverse cultural situations. . . . On the one hand, there has been an increase in mass media-oriented *public education* efforts and in alcohol education for school children. In general, careful evaluation of these efforts leave us dubious about their pragmatic effects, particularly in view of their competition with alcohol advertising campaigns which are several orders of magnitude more costly. But such efforts have allowed governments to give an *appearance* of doing something substantial about alcohol problems, in an era of rising but generally unfocused public concern about the problem.

“On the other hand, there has been a remarkable increase in societal investment in *treatment resources* for alcoholism and alcohol-related problems. In the U.S., the treatment capacity for alcoholism expanded at least 20-fold in the 30 years after World War II (Room, 1980). [However, the end of the postwar economic boom in the late 1970s and 1980s meant a “dramatic retrenchment in the treatment response . . . [including a rise] in the use of compulsion in treatment. . . . We need to broaden the area of policy alternatives to include collective and environmental, as well as individualized approaches to alcohol problems prevention. . . .” [Robin Room. (1984). Alcohol policies in industrial nations: Recent trends and alternative approaches. 4:4, 190, 192, 193.]

“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 [the lowest social class] 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.” [George W. Albee. (1985). *Argument for primary prevention*. 5:4, 217.]

“Mental health professionals are now operating in a world of shrinking resources. There is not enough money to support even basic mental health direct service programs that are fundamental and essential. Funding expensive [primary prevention] programs that are unlikely to prevent mental illness with money allocated to mental health services seems to us a dangerously foolish gamble.” [H. Richard Lamb. (1985). *Argument against primary prevention*. 5:4, 224.]

“Sweden and Cuba have undertaken structural reforms through macro-environmental planning, including the elimination of special interest groups, an equitable distribution of wealth, drastic reduction of unemployment, and economic stabilization at the price of economic growth. The situation in both countries is imperfect, but health conditions continue to improve through primary and secondary prevention that encompasses broad environmental [change] contingencies. . . .

“Many Americans hold the illusion that material possessions somehow ensure comfort, peace, and well-being. They also value individualism, free enterprise, self-sufficiency, competition, and the right to private property—all in contradiction to the basic Judeo-Christian tradition that places the welfare of the community above individual interests. . . . Even though the role of government within a democratic framework is to insure the health and safety of all its citizens, the responsibility for these prevention objectives is generally placed on individuals. . . . Thus far, changes in the environment to enhance mental health have been limited and superficial, and while the quality of medical and psychological services in the U.S. is among the highest in the world, the economic structure fosters an unequal access to health-care (Starr, 1982). . . .” [Arthus G. Nikelly. (1986). *Prevention in Sweden and Cuba: Implications for policy research*. 7:3, 128, 129–130.]

“Shortly after President Reagan assumed office in 1981, the Administration proposed to repeal some 40 categorical health programs, reduce their funding, and replace them with block grants to the states. Among the justifications that were given for these dramatic changes in policy was that states would have ‘enhanced responsiveness to local needs’ (Rosoff, 1981). . . . This analysis did not support the contention. . . . In fact, state administered block grants demonstrated much less responsiveness to women’s family planning needs in the 50 states than did Title X of the Public Health Service Act, the federally administered categorical program. . . . [Deborah R. McFarlane. (1988). *Family planning needs: An empirical study of federal responsiveness before and during the Reagan administration*. 9: 1 & 2, 41, 51.]

“ . . . [I]nteraction between mental health and public health professionals, and the application of public health concepts in the field of mental health, and mental

health concepts in the field of public health, have been minimal. . . . This paper suggests areas where future efforts at fostering a MH/PH working relationship might be directed.” [Michael S. Goldstein. (1989). *Mental health and public health: Strengthening a working relationship*. 10:2, 99, 100.]

“The problem of child abuse . . . requires knowledge on levels extending from the molecular to public policy and service delivery. It requires a systems or ecological approach and there is no better candidate to provide the leadership than public health. But for the year 2000 objectives to be accomplished on reducing child abuse, a deeper and broader commitment must be made not only by public health but workers in all the helping professions.” [Blair Justice. (1990). On accomplishing a national objective to reduce child abuse. 11:2, 103.]

“A long time ago a psychologist named Nicholas Pastore did a study of opinions of world scientists on the nature-nurture question: is nature (heredity) more responsible [for human behavior], or is nurture (the environment) more responsible. There was almost a perfect correlation between the scientists’ political beliefs and their attitudes toward this question [with conservatives taking the heredity point of view, and liberals taking the environmental position]. . . .

“ ‘The cause of causes’ [an essay that Justin Joffe and George Albee wrote] [asserts that it is] the economic system which allows horrible poverty in the midst of an affluent society. The highest rate of almost all . . . kinds of [mental and physical health] disorders exists among the poor and poverty stricken. . . .

“ . . . [A]s each immigrant group arrived in the United States, they occupied the bottom of the socioeconomic ladder. They had the highest rates of every kind of pathology. So in the 1850’s it was the Irish. . . . [F]ollowing them came the Scandinavians. . . . [then came the] European Jews and Poles and Hungarians. . . . Then the Southern Italians. . . . The point of all this is whoever is at the bottom of the socioeconomic ladder has high rates of school learning problems and mental disorders. When they move up into the middle class, their rates drop. Now if this is a genetic phenomenon, what happened to all those bad genes?” [George Albee, interviewed by Jack Pransky. (1991). *Reflections on prevention at the macro-level: An interview with George Albee*. 11:4, 246, 249, 259.]

“America’s drug problems did not appear overnight nor will they disappear overnight. They are rooted in fundamental aspects of individual behavior, societal dynamics, and historical phenomena. . . . It is apparent that current drug laws, policies, and attitudes are maladaptive and ineffective. Significant negative drug-related consequences are felt in the areas of health, social issues, family relations, legal systems, and economic productivity. . . . Tens of millions of Americans are addicted to alcohol and tobacco. The costs of these abuses are staggering. Illicit

drugs are widely available despite over a decade of intense law enforcement efforts to limit their availability. Forty million Americans have tried illicit drugs. Approximately 10–15% of regular users of these drugs are ‘dependent’ on them in some fashion and suffer substantial negative consequences. Cocaine is now the most profitable article of trade in the world and a \$100 billion a year business in the U.S. alone (The Economist, 1989). . . . Current criminal justice approaches to illicit drugs are largely ineffective and often counterproductive. It is becoming increasingly apparent that many of our drug problems are the result of our drug policies rather than drug consumption itself. . . . [The author then presents “an alternative comprehensive model which includes decriminalization and legalization of drugs. . . .” [Thomas Nicholson. (1992). The primary prevention of illicit drug problems: An argument for decriminalization and legalization. 12:4, 284, 281–282, 275.]

“ . . . [T]he stages of initiation into use of various drugs (i.e., the sequencing of onset) is consistent across many different kinds of groups. In the overwhelming majority of cases, cigarettes and alcohol use precede marijuana use which almost invariably precedes use of other drugs such as cocaine. Therefore, temporal order of onset is not an issue for debate. . . . If we are serious about drug abuse prevention and intervention, the most effective predictor of who is using marijuana may be who is using cigarettes. . . . If we are really serious about drug prevention in the United States, legalization is clearly not an answer. In fact, it is 180 degrees opposite. . . . If we are really serious about drug use among adolescents in the United States, the only feasible and logical direction for public policy is . . . toward a tougher stance regarding the so-called ‘legal’ drugs. Through explicit prevention efforts in the schools and stronger efforts to control the environment, perhaps we can narrow the openings provided by the gateway drugs and reduce the probabilities of transition to marijuana, cocaine, and heroin.” [Richard R. Clayton and Carl G. Leukefeld. (1992). The prevention of drug use among youth: Implications of ‘legalization.’ 12:4, 294, 299, 301.]

“In this paper I shall present an outline of the major intervention strategies by which primary prevention was so successfully prevented. . . . To prevent [primary prevention]:

- First, don’t make it a high priority.
- Second, don’t fund it.
- Third, emphasize individual behavior change.
- Fourth, staff it with clinicians.
- Fifth, set unrealistic or impossible goals.
- Sixth, assume that mental illness has a biological inevitability.”

[David F. Duncan. (1994). The prevention of primary prevention, 1960–1994: Notes toward a case study. 15:1, 74.]

“... [I]n spite of popular rhetoric, we do not really like children—not as a nation.... [S]ubstantial numbers are experiencing a formidable array of preventable burdens of ignorance, illness, suffering, failure, humiliation and lost opportunities. Every relevant indicator suggests that our children are... victims of institutional-level neglect....

The United States has:

1. A higher infant mortality rate than 19 other countries....
4. A worse low-birth weight rate than 30 other nations....
9. A ranking of 13 out of 14 among industrialized nations in mathematics achievement among all 13-year olds....
11. An estimated 2.4 million children involved in juvenile prostitution each year.
12. An estimated 100,000 children going to bed homeless every night....
14. The highest rate of teen drug use of any nation in the industrialized world....
- [The following things are true of the United States:]
16. Every 12 seconds of the school day, an American child drops out (380,000 a year)
17. Every 13 seconds, an American child is reported abused or neglected (2.7 million a year)
18. Every 26 seconds, an American child runs away from home (1.2 million a year)
19. About every minute, an American teenager has a baby.
20. Every 9 minutes, an American child is arrested for a drug offense.
21. Every 40 minutes, an American child is arrested for drunken driving.
22. Every 53 minutes in our rich land, an American child dies from poverty.
23. Every 3 hours, a child is murdered....”

[Ann Goetting. (1994). Do Americans really like children? 15:1,81–83.]

“In contemporary America there has been a steady movement toward the medical defect/bad genes explanatory model of mental disorders.... To treat the emotionally distressed victims of discrimination, of exploitation, of impoverishment, as if their problems are a result of biological/genetic defect is clearly a form of blatant Social Darwinism. To drug them into silent passivity rather than to fight for social justice is to join the powerful exploiters.” [George W. Albee. (1996). Introduction to the special issue on social Darwinism. 17:1, 14–15.]

“According to Social Darwinism, as the human species evolves, less intelligent and less mentally competent beings will remain at the bottom of the social hierarchy while the most superior individuals advance. Therefore, because it is the functional nature of this hierarchy that deficient individuals remain in the lowest

social class, it is not the duty of society to better the conditions of the poor; impoverished circumstances are in fact their fate.

“Strikingly similar lines of reasoning are found in the IQ debates that have dominated psychology since the early 1900’s and that remain visible today. Biological determinists argue that we must accept inferior intelligence as part of the natural order of society; as part of the ‘normal distribution’ of individuals (Herrnstein & Murray, 1994) and that there is little we should feel compelled to do to improve IQ standings. . . . [However,] the weight of evidence that suggests that [the groups with the lowest IQs are the most marginalized groups in society, the poor, ethnic minorities, immigrants, migrant workers, etc.] show these lower IQ scores because they have not been afforded adequate education and equal access to economic opportunities. . . . [as well as] the middle class cultural biases inherent in the IQ testing system. . . .” [Melissa J. Perry. (1996). The relationship between social class and mental disorder. 17:1, 27–28.]

“It is time for contemporary social and applied human sciences to recognize that the ‘traditional’ nuclear family is a culturally- and historically-specific ideological construct, a way of structuring and giving meaning to relationships. . . . It is also time for contemporary social and applied human sciences to develop an account of, and a research agenda about, families that take into consideration their variations across time, place, social class, ethnicity, and culture.” [Silvia Sara Canetto. (1996). What is a normal family? Common assumptions and current evidence. 17:1, 43–44.]

“The crypto-eugenics movement [or the reform eugenic movement—one of the manifestations of social Darwinism] both in the United States and other parts of the world has influenced individual perceptions and attitudes about sex, marriage, and motherhood, as well as a number of social, legal, and medical policies. . . . The images of [over breeding] are not of too many white, middle and ruling class children, but of too many children of color. . . .

“We know, however, that children are not living in poverty because the wrong kinds of women are having too many of them, but because of resources, including sex education, health care, housing, jobs, and the political power for reproductive self-determination are denied them. . . .” [Susan H. Franzblau. (1996). Social Darwinism influences on conceptions of marriage, sex, and motherhood. 17:1, 49, 68.]

“. . . [M]uch of what passes for science here is a myth-making process which develops a momentum of its own, powered by a variety of interests, and supported by a lack of real analysis and an inclination to provide results which support a biologically determinist stance. . . . [The author discusses a World Health Organization multi-nation study of schizophrenia.] Over the two years of the study the

course and outcome for 'schizophrenia' was much more favourable in the poorer countries. . . . The two most interesting observations in the study go entirely without remark. First, 90 percent of the richer country subjects spent time in a psychiatric hospital. The corresponding figure for poorer countries was 38 percent. Secondly, almost 60 percent of the studied population from richer countries took 'antipsychotic' medication for most of the two years. The contrasting figure for poorer countries was just 16 percent. . . . [T]here is no speculation about the possible iatrogenic effects of 'antipsychotic' medication and psychiatric hospitalization. Nothing. Instead the report opts for the illusory safety of genetic explanations for which the observations do not provide evidence. . . ." [J. Richard Marshall. (1996). Science, 'schizophrenia,' and genetics: The creation of mythos. 17:1, 100, 102.]

"At the societal level, biologically deterministic explanations of behavior help to 'solve' pressing social problems (e.g., substance abuse, crime, school problems) by identifying individuals, or culturally defined populations, as constitutionally defective. This allows us to redirect energies and money away from well researched social etiologies and fundamental social change. Thus, our society maintains its current status quo, as well as disguising social control of affected individuals with 'benevolent caring' and treatment. . . . [Walker S. Carlos Poston II and Allen A. Winebarger. (1996). The misuse of behavioral genetics in prevention research, or for whom the 'Bell Curve' tools. 17:1, 143.]

HISTORY AND CRITICISM

Some observations: If we neglect our scientific and practical history, we will be doomed to repeat its mistakes, as Santayana noted. Yet, as a young field, we have very little historical perspective, particularly of ancestors of the past centuries. So, I note with interest the fledgling historical observations reported here, along with a sampling of the criticism to which primary prevention has been exposed. The maturity of a field like primary prevention may be indicated by its response to criticism, even the hostile, politically motivated kind. It is interesting that so small an enterprise as primary prevention (in the world of health, education, and welfare) causes such a disproportionately large critical response, leading me to suggest that we have touched a vital point, either the heart of the matter that involves a paradigm shift in thinking and helping practice, or the pocketbook of vested interests. In either case, we must move on, never forgetting the engineering motto from World War II: The difficult we do immediately, the impossible takes a little longer.

"The concept and practice of prevention passed through an era of sanitation and mercantilism and only became a medical concern with the mid-nineteenth-century discoveries of antisepsis (Lister), pathology (Virchow), immunology (Pasteur), and epidemiology (Snow and Koch). With its medicalization, prevention

moved into the private domain of the doctor-patient relationship. . . . With that boundless expectation as our implicit policy, and a huge insurance industry organized to pay providers to use the available technology, public as well as private spending for medical care has clearly shoved prevention into the bottom drawer of the medicine chest. Except for research into vaccines, there has been little technological or fiscal excitement in prevention. . . .

“When Dr. Julius Richmond became Surgeon General in 1976, an emphasis on prevention began to emerge. . . . Out of that effort [directed by Dr. Mike McGinnis] came some of the best work done on prevention to date in the United States—a major conference at the Fogarty International Center. . . . an analysis of all national program efforts that had a substantial prevention emphasis (Office of Disease Prevention and Health Promotion, 1981), . . . and the Surgeon General’s report on prevention, *Healthy People* (Surgeon General, 1979). . . .

“The stage would seem to be set for the development of some long overdue efforts to wrestle with national health policy issues. The problem is that the stage is finally set for Shakespeare and the actors we’ve elected can only do Horatio Alger.” [George Pickett. (1983). *Prevention in a free society*. 3:4, 215, 216–217.]

“The purpose of this paper is to review the history of consultation and education services within community mental health centers (CMHCs) over the past two decades. As first envisioned, these services were to involve some of the most innovative approaches to mental health problems, with a particular emphasis on prevention, and were to be implemented as part of a newly designed system of mental health care (Foley & Sharfstein, 1983). . . . Our analysis will show, however, that [these innovative programs were not] given much support in community mental health centers. . . .” [David L. Snow and Carolyn F. Swift. (1985). *Consultation and education in community mental health: A historical analysis*. 6:1, 3,4, 28.]

“In 1984, the National Mental Health Association established the Commission on the Prevention of Mental-Emotional Disabilities to review the status of prevention within the mental health field. . . . From the extensive and rich information furnished by consultants, its members’ own extensive experiences and review of the literature, the Commission found the following:

- “I. A substantial and rapidly expanding knowledge base exists to direct efforts in the prevention of mental-emotional disabilities.
- “II. The present application of that knowledge to services is creditable but far from sufficient.
- “III. A prudent investment in prevention research and interventions over the next decade would dramatically lower the incidence of mental-emotional disabilities.”

[*Journal of Primary Prevention*, 1987, whole issue, Major findings of the Commission, p. 183.]

"Twenty-five years of experience with the crisis model indicates that it has fostered two significant developments in community mental health practice. First, it has emphasized the importance of a short time framework in dealing with persons exposed to hazardous life circumstances. It has provided a catalyst for changing agency policies and professional practices to ensure that time-limited help would be made available on an immediate and intensive basis during the first few days and weeks following the upsetting life event—and, wherever possible for predictable hazards, even ahead of time in the form of anticipatory guidance.

"Second, the model defines crisis as a period of opportunity as well as danger, and links the chance for improved mental health with the quality of the individual's immediate coping and problem-solving reactions." [Gerald Caplan. (1989). Recent developments in crisis intervention and the promotion of support service. 10:1, 5.]

"Long-standing biases against the efficacy of prevention pervade human services and the social sciences. Critics in these fields have stated repeatedly that: 1) researchers know too little about the causes of mental illness to be able to prevent them; 2) most forms of mental illness are a result of genetic defects and/or biochemical imbalances and are, therefore, not preventable through social manipulations and environmental change; or 3) research to demonstrate the effectiveness of prevention programs has not yet produced much in the way of significant positive findings. The critics continue to argue that it is foolish to expend funds that are in short supply for vague and untested prevention efforts (Albee, 1984)." [Andrea Re, Betty Noble, and Gerald Howard. (1990). Techniques for promoting a healthier society: Thoughts on prevention planning and needs assessment. 10:3, 207.]

"[Alfred] Adler was concerned with prevention, that is medical prevention in the form of public health, before he became formally engaged in psychotherapy, and he retained this concern with prevention throughout his life. . . . [His first publication was in a health series addressed to workers; the motto of the series was 'To know a danger is the first step toward its prevention.' . . . [A later publication is quoted:] 'Not to treat and cure sick children but to protect healthy children from sickness is the logical and noble challenge of the science of medicine.' . . . Mental health is characterized by self-confidence and well-developed social interest which assures identification and empathy with the surroundings, especially the social. Under these conditions a person feels at home in the world and confident to be able to cope with the life tasks." [Heinz L. Ansbacher. (1990). Alfred Adler, pioneer in prevention of mental disorders. 11:1, 38, 39, 41, 47.]

"I believe that we will not make substantial progress [in primary prevention] until we acknowledge that the problems facing our youth are too serious to be subjected to any half-hearted, vaguely conceived, conveniently brief, inadequately

funded, or poorly monitored interventions. Implementation of short-term, band-aid, cosmetic solutions even indirectly under the rubric of primary prevention erodes our credibility and makes the work of those who advocate the necessity of long-term, collaborative, carefully monitored efforts much more difficult. Yet, this is the state of the art today.” [Maurice J. Elias. (1995). Primary prevention as health and social competence promotion. 16:1, 9.]

[Compiler’s note: George Albee’s Introduction to the special issue on social Darwinism (17:1, 3–16) contains the reflections of an individual who was in the forefront of almost all of the developments in primary prevention reflected in this Journal. It represents a special piece of the history of the field.]

SUMMARY

So, here are nearly twenty years worth of primary prevention ideas, theories, research studies, program applications, within the politics and history of our times. Capsules cannot hope to convey the richness of the whole papers, but may serve as memory prompter (or as references for your next project). To me, they represent the rising tide of primary prevention in the contemporary world, ideas that are everywhere, into everything, suggesting all sorts of possibilities. May these ideas stimulate your thinking during the second twenty years of the Journal of Primary Prevention.