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OPENING EXERCISE: A PREVENTION PARABLE

A story is told about a man at the side of a river, reaching in and hauling to shore person after person, all of whom were struggling, often drowning, as they were pulled downstream by the strong current. A woman came by, saw what he was doing, and pitched in to help. But despite their hard and constant work, for every body they pulled out, ten more went past them. The condition of those who remained in the river became more and more desperate.

As they worked, the woman asked the man, "How are these people getting into the river?" The man did not know. "Why don't you go upstream and see what the problem is?" she asked. "I am too busy," the man replied. "There is much to do here. Besides, if I stop, even more people will be lost." She thought about what he said and agreed and went back to work. But after more and more days, with the flow of people growing and their own strength diminishing, she decided to go upstream and find out what was going on. "It's true that some extra people may be lost while I am gone, but if I can stop, or even cut down the flow, we all will be better off." And so she went.

Upstream, she saw that one part of a path was leading people to a dropoff directly into the river. As she moved toward it, she realized that this was

where she would stay; her work would no longer be to fish drowning people out of the river, but rather to keep as many as possible from falling in at all. She would work to redirect people from the path and would also try to change the path. Soon others followed her example, positioning themselves just downstream from the entry point so they could get people out of the river before the current got full hold of them, making them harder to save. Finally, some decided that people needed to live so that they were not drawn to the river at all. They needed to live in a way that kept them away from taking the harmful path in the first place (after all, it did not seem as if everyone was equally likely to take it). Even those people who were reached early, however, had to be prepared so that if they did take the harmful path, they would have the support and strength necessary to resist its pull. The woman and her colleagues began to work toward those goals.

Ask yourself, "What does it mean to prevent something?" No doubt, you have had some experience as the recipient of a prevention program. Perhaps your health classes in high school, middle school, or even elementary school involved programs to prevent drug and alcohol abuse, smoking, teenage pregnancy, violence, and HIV/AIDS. Your college or university probably has programs to prevent bias, sexual harassment, drunk driving, and academic failure. What do you know about these programs? How did they go about trying to help you prevent one problem or another? Were they effective? What accounts for their strengths or shortcomings? For example, were they based in any sound theory of prevention or promotion, specifying when and how programs should take place? In this chapter, we give you some tools to start answering questions like these systematically as well as share ways in which community psychology concepts are leading to new thinking about prevention.

Before we go further, we want to emphasize that a focus on prevention and a focus on treatment can be complementary. Our parable, a version of a story often told by prevention advocates, is intended to highlight the need for a diversity of approaches to mental disorders and other psychological problems in living. Treatment of those already experiencing a mental disorder is a humane goal and often means taking into account biological and individual factors as well as social ones. Prevention, in contrast, focuses on factors that can be changed before disorder develops, whether environmental or personal. Although budget constraints often mean that prevention and treatment advocates may compete for scarce resources, their activities and choices of emphasis are complementary and worthy of mutual respect.

INTRODUCTION: PREVENTION AS A FIELD OF STUDY

What do you think needs preventing now? What two or three areas would you prioritize? Why? You will find that in different eras, different problems seem to be emphasized. In the 1960s, there was a focus on poverty and the way its

BOX 9.1 From "What's Happening?" (Camden County Youth Center, New Jersey, October 1992)*"Dreams Going Up in Smoke"*

I used to watch my dad do drugs.
Smokin his pipe. Rock of cocaine on the screen.
Light up with a match or lighter.
I wished he wouldn't.
But what could I do? Thirteen year old.
Talk to him. Hug him. He said he couldn't stop.
They wouldn't tell me how he died.

SOURCE: -T.T., age 15

"If I Gonna Die . . ."

If I gonna die . . . I want people to have good things
to say about me—not die from some gunshots or
some drug war. I wanta be something—job, church,
family—not be the one my aunts hear about shot
dead—read about in the papers.
I've got jumped. I've got shot. Next time around I
might be dead.

SOURCE: -T., age 17

consequences created disadvantage for children in schools and for all of its victims in terms of health and well-being; in the 1970s, the end of the war in Southeast Asia and the intensification of the Cold War between capitalism and communism highlighted many issues of social and economic justice. In the 1980s, there was a "war" on alcohol, tobacco, and other drugs. Many feel that this war was most successful in the area of smoking prevention. In the early and middle 1990s, the emphasis shifted to the prevention of violence. At the time of this writing, many social issues were being debated, such as abortion; so-called entitlement programs, such as welfare, Social Security, and Medicare; immigration; and racial and ethnic tolerance. These shifts were, in turn, reflected in legislative changes. Among the most noteworthy is the switch of the Drug Free Schools and Communities Act, which funded local, school, and community-initiated substance abuse programs, to the Drug Free, Safe Schools and Communities Act, which added violence to the portfolio but actually reduced the total pool of available funding. Drugs, guns, other forms of violence, and dysfunctional families are continuing sources of harmful influence and are foci for prevention efforts. (See Box 9.1 for an example of what too many youth continue to experience.)

Since September 11, 2001, the focus of prevention has shifted to include terrorism in all of its forms, including suicide bombing, assaults on individual school buildings, transportation systems, or public facilities; attacking water or food supplies with biological agents; and explosion of nuclear devices in public spaces. These concerns, amplified by the occurrence of natural disasters such as Hurricane Katrina in 2005 and the earthquake and tsunami that devastated so many Asian nations at the conclusion of 2004, have created a level of vulnerability, stress, and tension in much of the general public that is unprecedented in recent decades. Yet in many localities these global concerns do not impinge on the enduring difficulties of everyday life as the focus of prevention efforts.

In the previous chapters we presented concepts that community psychologists use to understand individuals and communities and the phenomena that challenge and sustain them. In this chapter and the two that follow we convey how community psychology values, concepts, and tools can be used in the context of preventing problem behaviors, preventing mental health difficulties, and promoting sound mental health and social competence. Because the literature on prevention

is growing faster than our ability to keep up with it, our goal is to illustrate rather than be comprehensive. In Chapter 9 we outline key concepts; in Chapter 10 we present a variety of application issues and examples and we use a family case study to highlight how clinical and preventive perspectives come together in practice. In Chapter 11 we review in detail how to “walk the talk” and implement prevention/promotion innovations in a variety of contexts.

What Is Prevention?

Prevention is a common-sense concept that derives from Latin words meaning “to anticipate” or “before something to come.” The language of prevention is found in all aspects of public endeavor. Parents try to prevent children from hurting themselves; police try to prevent crimes; the legal system is designed to prevent violation of certain rights; road signs are created and posted to prevent people from getting lost.

In the field of community psychology and community research and action, ideas about prevention have been evolving. Because the field of community psychology is linked to societal events and forces, this evolution will continue. This dynamic makes the field important and exciting, but also hard to capture in a textbook.

As you learned in Chapter 2, the concept and practice of prevention links public health and psychology. Psychiatrists Erich Lindemann and Gerald Caplan were particularly important in forging that link. An analysis of available “person-power” in the mental health field by George Albee (1959) supported the growing interest in prevention. Albee showed that there were not and could not be a sufficient number of clinicians trained to provide all of the needed mental health services for the population. Consider the implications of this extraordinary finding. Therapeutic resources are scarce and will realistically remain scarce. As in the parable that opened this chapter, need will always outstrip the supply of services. Prevention of psychological problems (reduction of need) becomes a justifiable use of scarce resources.

Another issue raised by Albee's (1959) findings concerns how scarce treatment resources are distributed. A series of epidemiological studies (Hollingshead & Redlich, 1958; Myers & Bean, 1972) showed a strong relationship among socioeconomic status, ethnicity, and services received. The poor and minority groups were more likely to receive severe diagnoses, to receive medication rather than psychotherapy, and to be seen in groups rather than individually. The preferred clients were those most like the therapists—male, Caucasian, verbal, and successful. Both preventive concepts and innovative services were central to the Community Mental Health Centers Act in 1963, advocated by President John Kennedy. In terms of the parable at the outset of this chapter, there were a growing number of reasons to move upstream and keep people from falling into the river.

Although community psychology has embraced the concept of prevention, another aspect of the concept merits consideration. Take another look at the examples mentioned earlier. Parents try to help children learn how to care for themselves safely; educators encourage learning in different forms; employers train and

supervise employees to work effectively; road signs are posted to help people get to where they want to go. These examples focus on developing desired competencies, skills, and abilities. Overall health and quality of life become the goal more than simply preventing psychiatric disorders or types of problem behaviors. Cowen (1991, 2000a) championed the term *wellness* as a more fitting goal of preventive efforts. Although wellness refers to life satisfaction or gratification in living, it is a transactional concept linked to the social ecology within which people live. Again, in Cowen's (1991) colorful words: "The pot-of-gold behind the pursuit of a wellness rainbow might be a genuine betterment of the human condition" (p. 408). Cowen's views have become central to how community psychologists think about prevention of disorder and promotion of competence and wellness.

Box 9.2 features selected quotes from a series of essays on the future of primary prevention. See which ones strike you at this point in your reading. Then, revisit them after you have read Chapters 9, 10, and/or 11 and see how your opinion has changed, if at all.

A FOCUS ON COMPETENCE: BOWER'S MODEL

A focus on the promotion of social competence, wellness, and health and the prevention of problem behavior is common to many professional disciplines. It also is a shared concern among policy makers, elected officials, educators, sports and recreation leaders, and parents. Bower (1972) proposed a useful way of conceptualizing how society is organized to accomplish these goals. He described three types of settings through which all societies prepare their young citizens for adult life, using the catchy acronyms KISS, AID, and ICE.

Key Integrated Social Systems (KISS)

Key integrative social systems (KISS) are formal and informal settings within which individuals interact from conception through childhood. The first of these is the health care system, which includes prenatal care, the management of the birthing process, and postnatal care. The second KISS system is the family, which begins to shape a child's values and outlook on life and provides opportunities to build important cognitive, affective, motor, interpersonal, and academic skills.

School is the third system, and its impact is felt at an increasingly early time as more and more children enter child care and preschools before kindergarten. Head Start, for example, is designed primarily for preschool children from impoverished families and provides not only preacademic skills, but also medical and dental services, housing, parenting support, job training and placement, linkage with social services, and transportation. It is paradoxical that as children move into the public school system, their access to these services tends to become far less organized and systematic. Nevertheless, the school years from kindergarten through twelfth grade exercise substantial influence on a diverse array of skills, of which academic abilities are only a part.

BOX 9.2 Thoughts about Primary Prevention

In its Fall 2000 issue, the *Journal of Primary Prevention* published a set of essays predicting the future of primary prevention. Several quotes capture the range of thoughts expressed:

"Prevention of mental disorders is small potatoes and usually is at the bottom of the social agenda. The Peace Corps was never asked for psychologists or psychiatrists. More immediate needs—for food, clear water, immunization—were more urgent. . . . The best mental health promotion will come with a revolution against social injustice." (George Albee, p. 9)

"With good reason, we have become increasingly concerned that we demonstrate with detail and precision the tremendous potential of prevention initiatives. . . . My concerns about the future of prevention grow, however, from my sense that the calls for precision and detail are frequently misinterpreted. Too often they seem to be equated with honing in on control and detail at the expense of maintaining the big picture. As investigators struggle to narrow in on subtle, albeit potentially important distinctions between and relationships among variables, manipulations can become so restrictive that ecological validity is lost. We risk garnering a tremendous amount of detail about contexts that are so narrowly and rigidly defined that they are highly unlikely to exist or even resemble the real world. . . . The context for human development is a highly dynamic set of interacting systems ranging from micro- to macro-levels. We can't afford to limit our work in primary prevention to any one or small group of these mutually embedded systems." (Lynne Bond, pp. 12–13)

"As one moves from micro- to macro-systems, wellness enhancement issues become more complex and diffuse, access lines to change more difficult, and knowledge about how best to promote change more diverse. Accordingly, it is easier to worship wellness as an ideal, than to achieve it. Amplifying knowledge of how, specifically, micro-, meso-, exo-, and macro-systems operate to affect wellness can solidify the generative knowledge bases needed to bring off diverse wellness enhancing steps at multiple levels. In summary: a) prevention activities, broadly defined, must play a larger role in mental health's overall framework; b) distinctions between risk-disorder prevention and wellness enhancement approaches must be sharpened and more support brought to the latter; c) individual and family strands of a wellness enhancement approach that relate to sound early child formation need further fleshing out; d) steps toward a system-grounded, life-span approach to wellness development and maintenance are needed. The concept of psychological wellness offers a heuristic framework for conceptualization, research, and program development in mental health. The pot of gold at the end of that rainbow is its potential for strengthening the adaptation and enhancing the life satisfaction of many people in modern society." (Emory Cowen, pp. 17–18)

"The world's three richest billionaires (all American, as it happens) have combined wealth greater than 600 million of the poorest people on earth. The combined income of the 200 richest exceeds the combined income of the poorest 40 per cent of the world's population. These 200 more than doubled their net worth—to

An informal KISS system with pervasive influence is peers. Aristotle was among the first to state that humans are *polis* animals, meaning that we are inherently social and that we organize ourselves around relationships. From toddlerhood on, peers serve as models and mirrors, sources of new behaviors, advice, feedback, questions, and support or discouragement. Developmental psychologists have studied how, at different time periods in one's life, peer influences vary in strength and nature. Preadolescence is a time when peer influences begin to compete with those of parents and teachers, increasing in strength into the adolescent years. Shared experiences with peers can strongly influence career, higher education, lifestyle, and religious choices.

Indeed, religion is the final KISS system discussed by Bower (1972). At the time of his writing, religious institutions were in a decline. The late 1960s and early 1970s in the United States were times of disillusionment and confusion

\$1 trillion—between 1994 and 1998. Eighty countries have less revenue than they had 10 years ago. In 1960, the richest fifth of the world's population had 30 times the income of the poorest fifth. In 1997, they had 74 times as much. Do these numbers indicate some kind of problem? If so, can anything be done about it? We know that large disparities are associated with reduced life expectancy, more crime, ill health, and so on, but that may be the least of the problems these inequities foretell." (Justin Joffe, p. 33)

"Most people agree that prevention against physical, psychical and social problems of individuals is superior to waiting passively until problems have become manifest and need cure. Most people agree that societies have an obligation to take appropriate measures in some of these areas. Most people agree that educating, convincing and helping people is superior to forcing their compliance with massive coercive interventions. Most people agree that these measures should respect the private sphere of individuals and not violate basic human rights. Most people agree that the preventive strategies chosen should be as effective and efficient as possible, particularly if public money is involved. . . . At the same time many experts are very much aware that what is expected from them and what can be done are miles apart. The reasons for this gap are easily identified but difficult to deal with. In many areas we still do not have a sufficient empirical and/or theoretical basis on which to build preventive strategies. . . . We commonly find ourselves confronted with phenomena that are hard to assess reliably, with a long latency

period between intervention and outcome, with low problem incidence in the total population, with a large number of uncontrollable simultaneous influences, and with important context factors that change rapidly over time and vary greatly from region to region. . . . In order to be able to move forward into a more professional and evidence-based direction, we have to be much more precise about terminology and concepts and we have to confront ourselves explicitly with central methodological limitations and principles.

If we put our fingers on the inherent uncertainties encountered in daily prevention and evaluation, emphasize weak spots, reject tasks that are not feasible because of economic, technical and/or ontological restraints, are precise in terminology and do not avoid methodological problems, we risk disappointing potential customers in the short run, but in the long run contribute to the improvement of prevention and evaluation, and help to create a sound foundation for a good and lasting reputation. . . . Some of us, frustrated by the complexity of our task and tempted by the need to contract projects for economic reasons, resort to opportunism or to cynical resignation, but I am very much convinced that we may be quite optimistic about what we can accomplish and about the present developments. Primary prevention and evaluation of primary prevention are challenging tasks, but if we understand our professions, despite all of these limitations, there are many promising approaches, sensible options and solutions available to prevent ourselves from depression and cynicism." (Alfred Uhl, pp. 43-45)

for many, and the role of religion and the operation of religious institutions were questioned or ignored. Yet through the late 1980s, 1990s, and into the earliest twentieth century, there has been a resurgence in the role of religion and religious organizations as sources of influence and support. This trend can be seen dramatically in the Middle East and in Eastern Europe, particularly in the countries of the former Soviet Union. Poland and Russia have seen previously outlawed religious observance flourish, with religious leaders taking strong stands on social issues and the provision of human rights.

The term *secondary KISS contexts* can be used to refer to other key aspects of socialization not mentioned as part of Bower's (1972) initial theory and include the following circumstances.

- Workplaces affect individuals through scheduling, roles and work strain, relationships and interaction, opportunities for growth or frustration.

- Leisure/recreational systems can be formal or informal: country clubs or midnight basketball games, senior citizen centers or a card game with friends, concerts or reading in a coffeehouse.
- Community organizations include parents' groups affiliated with schools; civic groups such as Kiwanis, Scouting, B'nai B'rith, and Mothers Against Drunk Driving; local business associations; and advocates for local beautification/preservation. These may influence individual development of their members or exist to help others develop (e.g., parenting groups).
- Media/Internet/cyberspace communication is eclipsing more traditional forms of communication and interaction, and "bits" of information flow more quickly. This information influences individual development in many direct and indirect ways but also reduces the control centralizing authorities (e.g., parents, governments) have over socialization messages.

Obviously, the influence of KISS either promotes or thwarts competence. If the KISS settings work as they were designed to, by providing the intended health care, schooling, parenting, friendships, and spiritual supports, individuals passing through them would develop considerable strengths. In such circumstances, KISS would be exercising a substantial preventive effect. But the reality is that KISS settings do not function flawlessly. Inequitable distribution of resources leads some schools, families, and hospitals to work less than optimally. Further, the degree of integration of these social systems with one another varies quite dramatically from country to country, state to state, and municipality to municipality. KISS systems thus may interfere with each other rather than complement each other. For many children, passage through KISS can be quite perilous.

Ailing-in-Difficulty (AID) Institutions

When difficulty is encountered in the KISS settings, society provides AID: ailing-in-difficulty institutions. Those who are not able to function as well as desired in one context of KISS can go to such places for short-term assistance. Following this help, the person is expected to be able to function well. If one thinks of KISS as the main turnpike of socialization, AID can be thought of as rest stops or service areas. Examples of AID include guidance counseling and special services in the schools, outpatient mental health facilities, local police, a short-term detention or crisis center, hospital emergency rooms, and worksite personnel counseling.

Illness Correctional Endeavors (ICE)

The final part of Bower's (1972) model is ICE: illness correctional endeavors. ICE is provided by psychiatric hospitals, prisons, and long-term health care facilities. These may appear to be places where those in need of high degrees of assistance can go so they can return to AID or KISS, but the reality is that it often can be easier to enter ICE institutions than to emerge from them back into KISS

systems. Bower viewed these institutions more as agents of social control than as venues for rehabilitation.

Present societal forces (such as greater public scrutiny of care facilities and the rise of cost-oriented managed care and short-term services) make ICE settings less effective as repositories for those felt to be social outcasts and misfits than was the case when Bower (1972) was writing. However, in certain countries, especially those run by dictatorships and other de facto totalitarian regimes, ICE institutions continue to be used overtly as holding tanks for those who do not "fit smoothly" into KISS systems. Bower's point, however, still holds: In ways subtle and not so subtle, people who are deemed "different," "defective," "inferior," "evil," or "bad" are kept away from the social mainstream that constitutes the KISS and even AID systems.

Taken as a whole, Bower's model can be expressed as follows: With a good, loving KISS early in life, people will need less AID and fewer will have to be treated with ICE. From this simple conceptualization, many implications follow about the process of socialization in a nation, community, agency or social organization, or family. If socialization occurs properly throughout life, the large apparatus of repair and diversion can be reduced. Problems of all kinds can be prevented or reduced in severity.

Linkage to Social Ecology and Developmental Psychology

It's helpful to think of KISS in terms of the social-ecological levels of analysis you learned in Chapter 1. Parents and other caregivers, as well as educators, medical personnel, and others whose responsibilities include navigating children through the KISS settings, are themselves embedded within microsystems, organizations, localities, and macrosystems that influence how well they function in their task of socializing children. The macrosystem consists of beliefs about children and child-rearing and such social policies as flexible work scheduling and paternity leave that are of general influence on parents and parenting, but the nature of that influence depends most on the microsystems, organizations, and communities within which parents interact most directly (Belsky, 1984). Among the relevant organizations or communities are religious congregations, tenant associations, neighborhood or town libraries, colleges, chamber of commerce chapters, farmer's cooperatives, neighborhood crimewatch organizations, or political clubs. Some examples of microsystems include families, a small civic group, an informal network of friends, a bowling team, a sewing or quilting group, or a small family-run business.

The social-ecological point of view provides a way of putting Bower's (1972) concepts into motion and applying them dynamically. Central to our thinking is that prevention cannot be thought of as an inoculation. Successful efforts require an ecological and developmental approach, addressing not only people but also the contexts in which they live and interact. For example, macroeconomic trends create financial pressures on corporations, which cut costs by downsizing, laying off workers, and increasing overtime for those who remain. This, in turn, reduces the time and energy of parents for their families and for volunteer organizations

related to school, civic, recreational, and religious life. When the KISS systems are deprived of resources and do not work optimally, more individuals require the services of AID stations and ICE institutions.

The practical value of Bower's focus on KISS systems is linked to advances in knowledge that improve socialization efforts. In the social-ecological model, the individual is viewed as developing and adapting at the center of numerous surrounding interactive environments (e.g., Belsky, 1980; Bronfenbrenner, 1979; Holahan & Spearly, 1980). Our biological attributes, knowledge, and attitudes in all domains, personal identity, personal history, socioemotional skills, and physical characteristics all are involved at all times. Seeing this, Masterpasqua (1981) commented on what he saw as the essential synergy between developmental and community psychology. He put forth the notion of **developmental rights** as a key integrative concept, something restated often since then as community psychologists and those interested in the intersection of law and children's rights have been addressing these issues more prominently (Melton, 1991; Wilcox, 1993).

Developmental rights means that children born into a society have the right to conditions that will allow them to grow in a healthy manner, if not also to thrive. These conditions serve as a powerful force for prevention of problem behavior and promotion of competence. Some of these follow from Bower's (1972) model, such as adequate health care in the prenatal period and sound parenting skills. However, research is necessary to constantly fill in the details, help find critical periods of growth and influence, and guide the specific timing and content of interventions and services. Research also is necessary to refine our understanding of variations caused by cultural and racial factors, gender, socioeconomic and education status, and developmental level.

Hence, it was with great wisdom that early community psychologists advised that participant conceptualization should and must precede the onset of interventions and occur throughout them. This strategy acknowledges the richness, complexity, and history of social systems, the individuals within them, and their response to change. And participant conceptualization, as the name implies, is rooted in key concepts for understanding prevention and promotion.

CONCEPTS FOR UNDERSTANDING PREVENTION AND PROMOTION

In this section we describe the historical progression of concepts from prevention of disorder, to promotion of competence, to ideas of strengths and thriving. In so doing, we define and illustrate key concepts in the contexts in which they are used.

Caplan: Primary, Secondary, and Tertiary Prevention

There is a rich history to the concept of prevention, rooted in the field of public health and the mental hygiene movement of the early twentieth century (Heller et al., 1984; Spaulding & Balch, 1983). However, Gerald Caplan is recognized as

the individual whose use of the term *prevention* led to its becoming a part of the mental health lexicon. Caplan (1964) made a distinction between the following three types of prevention.

Primary Prevention This is intervention given to entire populations when they are not in a condition of known need or distress. The goal is to lower the rate of new cases (from a public health perspective, to reduce incidence) of disorders. Primary prevention intervenes to reduce potentially harmful circumstances before they have a chance to create difficulty. Examples are such things as vaccinations, fluoridating water, and providing skill-building programs in decision making and problem solving to children in preschool. Similarly, primary prevention also can be thought of as being applied to all persons in a given setting, regardless of potential need (e.g., all fifth graders in preparation for transition to middle school or all first-year college students).

Secondary Prevention This is intervention given to populations showing early signs of a disorder or difficulty. Another term for this is early intervention. This concept is a precursor of current notions of being "at risk," which are discussed shortly. Examples of secondary prevention are programs targeted to children who are shy or withdrawn, those who are beginning to have academic difficulty, or adults who are getting into conflicts with coworkers on the job.

Secondary prevention presupposes some method of determining which individuals are at risk or demonstrating early signs of disorder. Identifying such individuals creates a potential for stigmatization, both because they do not currently have a disorder and because they might never develop one. Improving methods of risk identification represents an important area of work in community psychology.

Tertiary Prevention This is intervention given to populations who have a disorder with the intention of limiting the disability caused by the disorder, reducing its intensity and duration, and thereby preventing future reoccurrence or additional complications.

If it strikes you that it is difficult to differentiate tertiary prevention from treatment, you are not alone. But Caplan had a purpose that often is forgotten by his critics today. A child psychiatrist by training, Caplan was trying to introduce a preventive way of thinking to the treatment-oriented medical, psychiatric, mental health, and social service fields. By emphasizing the similarities of prevention and treatment, he was able to link these concerns. Ultimately, he was successful in that the idea of prevention took hold, becoming a central tenet of fields such as community psychology, school psychology, and, increasingly, clinical and health psychology.

However, Caplan's (1964) framework appealed to those seeking resources for treatment. Some early prevention grants were given to programs designed for such things as the tertiary prevention of schizophrenia: a worthy goal, but not exactly what Caplan had in mind. Yet as many have noted, prevention is a difficult concept to grasp. One is trying to keep away what is not (yet) there. Would it ever

arrive if the prevention effort were not in place? Others have stated that if prevention is to be worthwhile, then one must specify what one is preventing. An emphasis on defining specific conditions such as suicide, depression, and conduct disorder as goals of prevention reflects this point of view.

Klein and Goldston (1977) were among a number of community psychologists who attempted to clarify the issues raised by Caplan's (1964) definitions and others' interpretations. Although agreeing with the definition of primary prevention, they felt it important to relabel secondary prevention as treatment given because of early identification and tertiary prevention as rehabilitation services. These definitions help to provide a clearer distinction between prevention and treatment for specific or severe problems. Debate still ensues over whether interventions given to shy children, for example, are best thought of as prevention or treatment. But other models now have risen to prominence, and thus it pays little to dwell on past inconsistencies when current inconsistencies are available for examination.

The IOM Report: Universal, Selective, and Indicated Measures

A report by the U.S. Institute of Medicine (IOM; Mrazek & Haggerty, 1994) is likely to greatly influence thinking about prevention well into the twenty-first century. Its main conceptual contribution is the idea of universal, selective, or indicated measures or methods for prevention.

Universal Preventive Measures These interventions are good for everyone in a given population group, and they typically are administered to populations that are not in distress. This is similar to primary prevention.

Selective Preventive Measures These are desirable for people at above-average risk for developing mental disorders. That risk may be based on their environment (e.g., low income or family conflict) or personal factors (e.g., low self-esteem, difficulties in school). These risk characteristics are associated with the development of particular disorders but are not symptoms of the disorder itself.

Indicated Preventive Measures These are applied to individual people who are at high risk for developing disorder in the future, especially if they show early symptoms of the disorder. However, they do not meet criteria for full-fledged diagnosis of mental disorder.

Interestingly, the IOM Report places mental health promotion (including concepts related to competence and wellness) into a separate area, distinct from prevention. The editors viewed self-esteem and mastery as the main focus of mental health promotion, with competence, self-efficacy, and individual empowerment all terms commonly used in describing such efforts. The IOM Report defined its focus in terms of whether or not an approach prevents a specific disorder, not in terms of competence enhancement.

Weissberg and Greenberg (1997) raised some thoughtful questions about the IOM framework. For instance, should a violence prevention program be considered a universal intervention in a school with few incidents of violence, yet selective in a school where violence is more common? Because depression is diagnosed

more often among girls than boys, should a program for prevention of depression be considered universal if given to a troop of Boy Scouts but selective if given to a Girl Scout troop? For disorders such as conduct disorder, what is the boundary between predictors of a disorder (for selective prevention) and early symptoms (for indicated prevention)? Consider a program delivered to a class in which there is a diversity of students: (a) a student with conduct disorder, and another with attention-deficit hyperactivity disorder; (b) several disaffected, underachieving, unmotivated students; and (c) others with no behavioral or emotional difficulty, some even with great strengths. Is the same program considered universal for the latter group, selective for the disaffected students, and indicated for the children with diagnosed disorders? Beneath these definitional questions is a fundamental concern for the direction in which preventive efforts should be headed, both in terms of research and action.

Point/Counterpoint: Prevention of Disorder and Promotion of Wellness and Competence

As the historical overview implies, there is a continuing debate about where the emphasis of time and resources is best placed, on prevention or promotion. In addition, within these areas there are varying options for emphasis (e.g., based on age, socioeconomic status, gender, ethnicity). This must be considered against the backdrop of points raised by Uhl and others in Box 9.2. Articulate spokespersons of different points of view arise periodically, and you are urged to engage in this debate on the basis of the current state of knowledge. In general, the debate can be framed between proponents of prevention of disorder and those believing that promotion of wellness and social competence should be emphasized.

Advocates of the prevention view argue that we are learning a great deal about how to prevent specific disorders such as depression, suicide, conduct disorders, and schizophrenia. Research should be directed toward isolating and reducing the operation of risk factors most closely targeted with specific disorders. This view is most likely to be associated with selective and indicated interventions, based on the IOM Report.

Advocates for promotion note that many people are not in a state of sound psychological well-being despite not having specific disorders. We know a great deal about how to promote sound health and social competence, drawing in part from interventions in public health in such areas as prevention of cardiovascular disease, from school settings in areas such as social and emotional skill building, and from workplace efforts to increase organizational effectiveness. Research should be directed toward identifying and understanding the factors that promote health, wellness, and competence in daily living. These will differ in different living environments, cross-culturally and internationally.

Issues of prevention and mental health have never been isolated from political and ideological considerations. As you learned in Chapter 2, in U.S. society the social zeitgeist during conservative times favors individual, illness-oriented conceptions of mental health and other social problems. Prevention in those times tends to be understood in terms of preventing specific disorders. In more

progressive times, an environmental focus supports a definition of prevention closer to promotion of overall health and wellness and competence.

The United States is now in a conservative period that moderated in intensity in the 1990s but has accelerated in the shadow of the tragic attacks on September 11, 2001. Research in recent years has focused on biological factors in mental health, and the mental health field is seeking to prove itself to be rigorous (at least as rigorous as medicine is perceived to be) and cost conscious. Insurance companies and federal granting agencies prefer to pay for clear prevention outcomes rather than supporting efforts to improve health. However, organizations such as the World Federation of Mental Health and the World Health Organization tend not to share the view prevalent in the United States. Theirs is a more holistic view of health in which mental health and physical well-being—which extends to basic issues of shelter, food, and freedom from war, societal anarchy, and enslavement—are essential parts of the overall picture. Many community psychologists embrace this broader view of health.

The goals of preventing specific disorders and promoting wellness and competence are not mutually exclusive, and the techniques to pursue them may be the same in particular circumstances. There are strong parallels with physical health, where health-promoting activities such as a sound diet are valuable and may also serve to prevent such problems as cardiovascular disease—but also may not have specific preventive effects on other specific conditions or illnesses. Community psychologists try to keep a perspective on prevention that is best understood as an umbrella providing a common cover for both points of view or as a bridge linking them. Sometimes, community psychology knowledge is used to provide preventive interventions to specific populations to prevent specific disorders, at other times to general populations in KISS settings to promote overall wellness. The outcomes of these interventions are measured in terms of lowered incidence of a specific disorder and/or in terms of increased competence for coping, as appropriate.

We turn next to community psychologists' conceptual frameworks to see how they energize the work of prevention and competence promotion and provide the stimulus for the kinds of creative approaches needed to address diverse settings and circumstances.

Connecting Stress and Coping Concepts with Prevention and Promotion

In Chapter 8 we presented a stress and coping framework. Five key concepts there, *risk*, *protection*, *resilience*, *strengths*, and *thriving*, are especially useful for prevention and promotion at this time. Ultimately, the best conceptualizations of prevention and promotion are those that have the most heuristic value and lead to the most social benefit, in accordance with the values of community psychology. In this chapter we draw from our own experience of what we have found to be heuristic. This includes social ecology, sense of community, and the skill-building orientation that accompanies a stress and coping framework. In addition, we look at the areas where future work in the field is best directed as a guide for those looking

toward careers relating to prevention and promotion. The frameworks and examples we present in Chapters 9, 10, and 11 are not complete, but rather serve as webs to which many concepts, examples, and issues can be usefully connected. When our webs can no longer easily connect with current issues, theories, and research findings, we will have to make changes in our conceptualizations. Indeed, we have made some since the previous edition of this book.

As of this writing, momentum toward the concepts of strengths and thriving continues to build, given impetus by theorizing and research in positive psychology (Seligman & Csikszentmihalyi, 2000b) and growing recognition that resources do not exist to equitably deal with social problems primarily on a post-hoc, crisis basis. However, it is important to not view strengths and thriving (or risk, protection, and resilience) as static and unchanging. These concepts are best viewed as dynamic processes that are interrelated and ongoing.

Consider how a community psychology perspective on prevention and promotion is connected to strengths and thriving. A focus on strengths asks the question: What are a person's assets and how can these be used to improve quality of life, especially in times of difficulty? The Search Institute (2004) developed *Frameworks of Developmental Assets* (grouped by age) for children and adolescents. **Developmental assets** are psychosocial protective factors among youth, families, schools, and communities that have been found in research to promote healthy child and youth development. Strengthening these can be the goal of promotion programs. For instance, their youth developmental assets list includes 40 specific assets at ecological levels that vary from individual to locality. This detailed list summarizes a large body of research in practical terms for use by community members. Some examples of assets are: family support; caring adults and neighbors; a caring school climate; parent involvement in schooling; clear expectations for behavior in family, school, and neighborhood; a community that values youth and ensures their safety; access to youth, creative, and/or religious programs; youth commitment to learning and to prosocial values; social competencies such as decision making, interpersonal skills, knowledge of other cultures, and conflict resolution; and having a sense of purpose in life. Community organizations, schools, and other groups have used these assets lists in a variety of ways. The lists are available at: www.search-institute.org/assets/.

Paradoxically, ideas of strengths and thriving draw support from neurobiology, where the concept of compensatory functioning has long been understood as the brain's way of circumventing deficits in its seemingly constant attempt to maximize our functional and adaptive capacities (Sylwester, 1995). Indeed, much of rehabilitation psychology is about finding ways to restore functioning when the primary mechanisms for that functioning are damaged. Clinical and health psychology are recognizing the powerful role of humor and optimism in fighting and preventing disease (Goleman, 1995). Those involved in youth work recognize that at-risk adolescents can be "reclaimed" as their strengths are identified, enhanced, given recognition and value, and then linked to areas of difficulty (Brendtro, Brokenleg, & Van Bockern, 1990; Elias & Cohen, 1999). Community psychology research from a strengths-based perspective is likely to become more prominent in the near future.

We anticipate that the focus on strengths likely will be joined by research driven by the concept of thriving. This stems directly from applying an ecologically based concept of resilience to populations at high risk. It is exemplified by studies such as that of Abraido-Lanza, Guier, and Colon (1998), who examined the process of thriving among Latinas with chronic illness living in impoverished neighborhoods. An individual is deemed as thriving to the extent to which she appears to experience positive growth despite her adverse life circumstances and, additionally, finds strength, insight, or meaning in life as a result of what she goes through. Although the authors acknowledge many methodological complexities in their research, the main finding seems clear: thriving is related to positive affect and self-esteem and represents something beyond coping, or even resilience.

The work of two other investigators sheds some light on ecological factors that might account for individual differences in thriving. O'Leary (1998) reviewed the literature on developing strength in the face of adversity. She identified three stages of response to severe stressors: survival, recovery, and thriving. Thriving is defined as a transformation of one's personal priorities, sense of self, and life roles. Interestingly, this phenomenon was observed by Erich Lindemann and served as the impetus for his work in crisis intervention.

O'Leary (1998) also identified microsystem and organizational level resources that foster thriving. Social relationships appear to be especially powerful for women, to the extent to which having and perceiving strong support is linked with improved immune system functioning. Certain conditions within organizations such as workplaces and schools provide opportunities for thriving to take place. These include caring, openness of communication, encouragement of individual contributions and growth, and organizational risk taking. Under such conditions, individuals appear to be free to contemplate new roles, to make changes in their jobs and roles and still feel accepted within an organization, and to feel involved in organizational decision making.

Thriving also appears to be fostered by nations that respond to challenges in certain ways. O'Leary (1998) reviewed the emergence of the African National Congress and democracy in South Africa, concluding that collectivist traditions and a strong set of positive, supportive, reaffirming rituals in the face of setbacks led to results that have gone beyond recovery to transform a nation. Another example can be found in Armenia (Karakashian, 1998). Over a period of four millennia, Armenia has endured calamities that have led neighboring countries and civilizations to crumble. What accounts for this endurance? Karakashian (1998) identified four main factors that she pointedly labels not as prevention (which implies absence of illness) and not as resilience (which implies a return to former health, a "bouncing back" to prior equilibrium) but thriving (which implies continued strengthening and growth beyond that equilibrium). These factors include (a) development of identity-affirming family traditions and community life; (b) an identity as *dogal*, associated with survival of adversities such as forced deportations and migrations; (c) strong family education in Armenian history, culture, and values; and (d) parenting approaches that appear to equip Armenian children with as much feeling of support and being loved as children from other countries as well as skills of alternative thinking, overcoming obstacles, and communicating their feelings. The latter are among the skills identified as

essential aspects of emotional intelligence (Goleman, 1995). By focusing on cultural traditions and practices, Karakashian (1998) identified processes that go beyond individual resilience.

For community psychologists interested in prevention and promotion, strengths and thriving are concepts that hold great promise. They enable us to move beyond an individual perspective and see how prevention, social competence, wellness, and related outcomes result from a convergence of influences at multiple ecological levels. Next, we use the vehicle of the prevention equations to provide a feasible way of conceptualizing and enhancing ecological influences that are associated with the generic term *prevention* but also are linked to a broader set of wellness-related goals.

THE PREVENTION EQUATIONS: INTEGRATIVE GUIDES FOR RESEARCH AND ACTION

If children are to experience healthy relationships and occupy meaningful and productive roles in society as adults, they must be competent at communicating and working cooperatively with others. They need to be able to express their own opinions and beliefs, to understand and appreciate the perspective of others who differ from them in background, needs, or experiences, and to become skilled at reasoned disagreement, negotiation, and compromise as methods of solving problems when their own needs or interests conflict with those of others. Indeed, in the face of decreasing resources and increasing global interdependence, it can be argued that such qualities are essential to our survival. The question, then, is not whether we must enhance children's social competencies, but rather how to accomplish this goal. (Battistich, Elias, & Branden-Müller, 1992, p. 231)

The complexity of ecological, developmental, and transactional models and their application to notions of risk, protection, resilience, strengths, and thriving can seem daunting. Some simplification strategies are necessary to help make directions for research and action more clear. Prevention equations serve this role.

Two Prevention Equations

The literature concerning social competence promotion over the past decade can be summarized in terms of the prevention equations of Albee (1982) and Elias (1987; see Table 9.1). Albee's (1982) formula is framed at the individual, person-centered, level; its focus is on reducing the likelihood of disorder (or improving the likelihood of wellness) in a single person. Individual risk is heightened to the extent that the individual experiences stress and/or physical vulnerabilities, and is lowered to the extent that the individual possesses coping skills, perceives him or herself as well supported, and has positive self-esteem. For each term in the equation, there is a corresponding approach to intervention that one might take. These are numbered 1-5 in Table 9.1.

TABLE 9.1 Individual and Environmental Level Prevention Equations**Individual Level (Albee, 1982)**

$$\text{Incidence of behavioral and emotional disorder in individuals} \\ = \frac{\text{stress(1) + physical vulnerability (2)}}{\text{coping skills (3) + social support (4) + self esteem(5)}}$$

Interventions derived from individual equation:

1. Reduce/better manage perceived stress
2. Reduce the negative impact of a physically/biologically based vulnerability
3. Increase coping skills, problem-solving/decision-making, social skills
4. Increase perceived social support
5. Increase self-esteem/self-efficacy

Environmental Level (Elias, 1987)

$$\text{Likelihood of behavioral and emotional disorder in settings} \\ = \frac{\text{stressors(6) + risk factors in the environment(7)}}{\text{positive socialization practices(8) + social support resources (9) + opportunities for positive relatedness and connectedness(10)}}$$

Interventions derived from environmental equation:

6. Reduce/eliminate stressors in key socialization settings, other aspects of environment
7. Reduce operation/presence of physical risk factors in the environment that result in increased physical/biological vulnerability
8. Improve socialization practices, ways in which key socialization settings carry out their tasks
9. Increase accessible social support resources
10. Increase opportunities for positive relatedness to others and connectedness to positive social institutions, positive social groups, agencies, and other formal and informal settings

Elias (1987) extended these ideas to the level of environments to complement Albee's (1982) equation. In social learning theory, predicting individual risk actually would involve a set of equations for the multiple settings one inhabits. Further, these equations would have to be modified to reflect developmental changes in the individual. Additionally, community psychology calls for ways of examining the risk (and protective) processes for populations and communities, not just for individuals.

The environmental level formula in Table 9.1 indicates that risk is increased as a function of stressors and risk factors in the environment, and decreased to the extent to which protective processes are enhanced: positive socialization practices in key socialization environments, access to social support and socioeconomic resources, and opportunities for positive relatedness and connectedness of the kind that allow for prosocial bonding and the development of a sense of being valued. Note that these terms are attempts to denote properties of settings, not attributes of individuals. The derivative interventions shown in Table 9.1, numbers 6–10, are correspondingly focused on ecological levels that surround individuals.

It might occur to you that the numerators of each equation summarize the literature on risk processes and the denominators do the same for protective processes. Good! It occurred to us, as well! In what follows, we use introductory examples to show how the equations can be used to guide both research and action as well as to illustrate the complementary nature of terms used at the person and environmental levels. Reflecting the perspective of positive psychology, Meyers and Meyers (2003) have introduced an interesting elaboration of the prevention equations to emphasize wellness and positive functioning. Combining individual and environmental levels and integrating recent research in positive psychology (Huebner & Gilman, 2003), they expand the equations to include such elements as:

- Subjective Well-Being: self-concept, life satisfaction, hope
- Competence: emotional and social competence, social cognition, flow, moral sense
- Supports: organizational climate and structure; acceptance; social, educational, functional, and health resources

The implication is that promotion of competence is an end in itself worthy of pursuit by community psychologists without any reference to the prevention of any disorder. Further, it introduces hope, moral sensibilities, supportive organizational conditions, and health resources as essential elements for optimal functioning.

Defining the Terms in the Prevention Equations

Stress (in the individual-level equation) has been linked clearly to individual distress and various types of psychopathology. Although it is recognized that the absence of stress can be as debilitating as an excess of stress (Goleman, 1995), it is generally noted that stress past an optimal level of arousal inhibits optimal performance of specific tasks or life roles. Techniques that teach individuals how to better manage their stress, such as meditation (Kabat-Zinn, 1993) or relaxation training (Cartledge & Milburn, 1989), reduce the likelihood of disturbance, although of course many factors impinge on this.

In a similar way, stressors (in the environmental-level equation), aspects of environments or contexts that engender stress in their inhabitants, are associated with dysfunction. School transitions, especially to kindergarten, to middle school or high school, as a transfer student, and out of high school, are accompanied by increased rates of referrals for mental health and related services as well as decreased academic performance that can set off a trajectory of negative accomplishment and school failure (Carnegie Corporation of New York, 1994; Chung & Elias, 1996; Reyes et al., 1994). Although each student is not automatically affected by these conditions, overall rates of dysfunction increase at times of transition. Programs directed at reducing the factors that engender stress during those transitions, such as the STEP program discussed in Chapter 5, often change structural features of the setting in which transition occurs. As with STEP, that often results in lower rates of problems for students (Elias et al., 1986; Felner & Adan, 1988).

Biologically based vulnerabilities in individuals have many causes but one common effect: they make it more difficult for a person to participate in

mainstream KISS contexts. This says far less about the capabilities of such individuals than it does about the willingness and flexibility of social settings to accommodate to their special needs. Person-centered interventions reduce the impact of such vulnerabilities by providing tools that can allow better mainstream access as well as strengthening an individual in areas where help is needed. One positive effect of Head Start for many children is that it gets them earlier access to services for visual, hearing, dental, and health impairments. If children attend school with these vulnerabilities undetected, they encounter academic and social difficulties, loss of motivation, frustration, or self-doubt.

Risk factors in the environment refer to such conditions as lead in paint and water, malnutrition, and poor prenatal care, all of which create physical and psychological vulnerabilities that, in turn, hamper coping and development. Examples include exposure to hazardous wastes that lead to increased incidence of cancer in children. Epidemiological research that uncovers such situations is important in community psychology, as are interventions to correct such factors or ameliorate their effects. For instance, Levine (1982) studied community responses to discovery of the effects of a toxic waste dump at the Love Canal in New York State. When child advocacy groups such as the Association for Children of New Jersey, the National Association of Child Advocacy Organizations, and the Children's Defense Fund advocate against state or federal legislation regarding lead or housing policies that allow children to live in dangerous environments, they are operating within the spirit of intervention term number 7 in the environmental level prevention equation.

Coping skills in individuals are perhaps the most widely studied aspect of prevention. All manner of programs to build individuals' social, emotional, and cognitive skills fall under this term. These represent interfaces with clinical, school, and other branches of applied psychology and allied fields. Many of these focus on teaching skills such as problem solving, communication, self-regulation, and social approach behaviors. Social skills training occurs in schools, mental health programs, and workplaces and with individuals being strengthened for the future as well as those who are experiencing problems and disabilities.

Positive socialization practices denotes the way in which KISS systems fulfill their socializing functions. Much of this involves how caregivers are prepared for their roles and equipped to help individuals learn and use coping and social skills. As Bower (1972) observed, are those in a position to give a good KISS able and willing to do so? Are parents prepared for what they are called upon to do by society? Are teachers? We know, for example, that nearly 50 percent of beginning teachers leave the profession within five years because they are not equipped to handle the behavior of their students and to turn their classes into constructive learning environments. This does not reflect poor capacity on the part of new teachers as a group (although, as in any field, some people are not destined to be teachers and will not find out until they attempt it). The cause is just as much failure of the socializing agents that are supposed to prepare and support them for teaching and oversee the conditions under which they work.

More and more emphasis is being given to the workplace as an ecological context with great relevance for mental health and overall wellness. Think about

various jobs you have held. How did your employer prepare you and other new employees for effective role performance? What kinds of ongoing socialization existed? To the extent relevant, how was your family prepared for the nature of working life? As an example, two of your authors (JHD and MJE) vividly recall carrying beepers in earlier clinical jobs, and neither of us was told about the impact of the beeper on our lives and the lives of our spouses. On the other hand, the likelihood of psychological difficulties in such workplaces as factories decreases when supervisors as a group are skilled in training and developing those who work under them. Communities are healthier when, for instance, their teachers know how to deal with children's hearts as well as their minds, and the school administrators know to do the same with their teachers.

In Chapter 8 we discussed the concept of social support as a coping resource, primarily at the individual and microsystem (social network) level. Albee's (1982) individual-level equation recognized this resource. Yet social support resources are accessible and easily used in some settings, but missing or inaccessible in others. Their strength and availability is an important setting characteristic.

Self-esteem and self-efficacy are concepts with long-standing links to positive mental health outcomes. Rotter (1982) and Bandura (1982) showed that individuals with negative expectancies for their ability to impact on their environments and a poor recognition and appreciation of their strengths are more likely to develop a variety of psychological disorders. Similarly, settings vary in the extent to which they provide opportunities for relatedness and connectedness and positive contributions by the people within them (Barker, 1968; Cottrell, 1976; Sarason, 1974; Wicker, 1979). Those settings that do provide such opportunities are likely to have more individuals who feel a positive sense of efficacy; in turn, rates of disorder will be lower in them than in comparable types of settings that do not provide such opportunities.

Recall from Chapter 5 that behavior settings that are optimally populated (Barker & Gump, 1964; Schoggen, 1989) are less likely than underpopulated settings to promote individuals' development and sense of connectedness. Individuals in environments with overpopulated behavior settings are likely to be less loyal, be more disgruntled, feel left out, and leave sooner. You no doubt can think of some settings in which you have had similar feelings. Organizations with many underpopulated behavior settings, however, generate greater perceptions of involvement, connectedness, and individual satisfaction. Many things need doing in an underpopulated setting, and those who do them often recognize they are providing something worthwhile for the setting. Hopefully, you have had this kind of experience as well.

Integrating Person and Environment

Perry and Jessor (1985) have been leaders in linking health and mental health outcomes to risk and protective processes at the person and environmental levels. They identified four domains of health and competence: *physical*, referring to physiological functioning; *psychological*, referring to subjective sense of well-being; *social*, referring to effectiveness in fulfilling social roles; and *personal*, referring to realization

of individual potential. Within each domain, knowledge, attitudes, and behaviors comprise health-compromising (risk) or health-enhancing (protective) processes.

In Perry and Jessor's model, three facets of intervention must converge to maximize likelihood of success: environmental contexts, personality, and behavioral (coping) skills. Personality serves an important integrative role, mediating between individual behavioral skills and environmental contexts that influence how the person applies those skills. Subsequently, Jessor (1993) advanced the construct of healthy lifestyles as an elaboration of the role played by personality in his earlier models. Lifestyles embody the meaning and direction that an individual attaches to events, relationships, and one's future. As the way in which one interacts with all aspects of his or her environment, lifestyles imply the embeddedness of problem behaviors in various life contexts. Once these behaviors begin, forestalling their advancement is not simply a matter of addressing a discrete set of skills. Interventions must recognize that a shaped lifestyle is not easily abandoned, and problem behaviors are often reinforced in peer networks. Future work in community psychology is likely to build on integrative models such as Perry and Jessor's.

APPLYING THE CONCEPTS IN THE REAL WORLD: SOME CAVEATS

Our use of equations is not intended to suggest precision regarding prevention and promotion concepts and interventions. As participant conceptualizers, community psychologists are very aware of the complexity of individuals and settings. The prevention equations are merely guides to exploration in a messy, challenging, exciting world.

Moreover, prevention/promotion interventions that work in their original settings may fail miserably in other contexts. Even highly effective interventions will not automatically generalize to new circumstances. As the sage Hillel commented many centuries ago, one can never stand in the shoes of another because time does not stand still. No two situations are identical. Yet we know there are continuities within the diversity of ecological contexts. Respect for uniqueness is balanced with aspects of shared humanity, diversity with commonality, present circumstances with transcendent realities.

How better to think of these high concepts than in terms of a pizza? When we take a bite of a pizza with "everything," it has a certain taste that is hard to attribute to any particular ingredient. What really makes the pizza great? The sauce? The cheese? The spices? The crust? The way it was cooked? The water used to make the dough? Whether we tossed the dough wearing gloves or not? The kinds of toppings used, how much, and where they were placed? Many factors come together to influence an overall outcome. Yet there is still something most can agree is pizza; although it cannot be defined precisely, we can still agree on what great pizza tastes like.

Community psychologists are not content with eating great pizza. We want to know what made it great, who might not have thought it was so great and why not, and how we can make sure that more great pizza reaches more people

more consistently. Take as an example Seidman's (1991) Adolescent Pathways Project. His interest is in understanding ways in which five sets of outcomes occur: psychological symptoms, antisocial behaviors, academic achievement, extracurricular achievement, and sound health. For a community psychologist, drawing patterns often occurs from examining a series of cases. Seidman (1991) reviewed studies of 32 elementary and middle/junior high schools in low-income urban areas. Among the findings was the importance of ethnic diversity in understanding pathways. For example, low involvement/participation is significantly related to a negative developmental outcome, antisocial behavior, when one examines the data for the entire sample. Yet when one looks at subgroups, one finds the relationship is not significant for Black and White females, but is so for Latina females.

This is one of many caveats to applying the prevention equations without considering how ethnicity and other mediators refine what predicts developmental outcomes and, therefore, what kinds of preventive efforts are likely to be most effective for what kinds of contexts. Clearly, no single pizza recipe will work across all nations and their ecologies and inhabitants.

From the basic recipes of prevention and competence promotion theory, different ingredients must be added to address the diversity of situations. Often, and appropriately, those additions will reflect the chef, the chef's mentors, the circumstances, the ingredients available, and the nature of the order. The great chefs know the basic recipes, but their greatness comes in knowing how to modify and improvise without compromising the essence of what is being prepared.

In the next two chapters we look at some great recipes and ingredients in the form of effective prevention and promotion programs as well as the challenges of improvisation that arise in particular settings. In Chapter 10 we visit exemplary and promising approaches to promoting competence and preventing problem behaviors applied across different ecological levels, both in the United States and internationally. We begin to answer the question, "How does prevention work?" and examine the application of prevention in everyday life through a family case study. In Chapter 11 we take a more detailed look at implementation and identify key components and processes that are characteristic of viable prevention and promotion efforts.

CHAPTER SUMMARY

1. Prevention is an evolving field of study in community psychology and related disciplines. We began with a parable that illustrates in common sense terms the logic of taking a preventive approach to dealing with mental health problems.
2. Bower's (1972) model illustrates how individual development through the socialization process is related to prevention. These include key integrated social systems (*KISS*), ailing-in-difficulty (*AID*) settings, and illness correctional endeavors (*ICE*) institutions. *KISS* settings are the focus of preventive efforts. These include prenatal care, schools, parents, peers, religious organizations, and the Internet. The related concept of *developmental rights* emphasizes that persons have rights to conditions that will allow them to cope and thrive.

3. The social-ecological approach stresses the importance of environment, a person's individual attributes, and how these elements interrelate and also impact on the effectiveness of preventive efforts. Prevention occurs not through inoculation but as people pass through social institutions that are strengthening and supportive.
4. Caplan's (1964) concepts of *primary*, *secondary*, and *tertiary prevention* were an early and highly influential conceptualization of prevention. In 1994, the IOM Report defined prevention in terms of *universal*, *selective*, and *indicated* approaches. Prevention has become a term that denotes two complementary foci: *prevention* of disorder and problem behavior and *promotion* of wellness and social competence.
5. Concepts for understanding and strengthening prevention and promotion efforts include *risk*, *protection*, *strengths*, *resilience*, *thriving*, and *developmental assets*. These dynamic processes are important guides for interventions.
6. Albee (1982) and Elias (1987) created two prevention equations useful for integrating the concepts presented. From these equations, one may derive 10 specific types of intervention at either the individual or environmental levels. These are listed in Table 9.1.
7. Community psychology recognizes real-world complexity and tries to avoid overgeneralizing from one context to another. Nevertheless, there are continuities across contexts in prevention and promotion. Understanding prevention and promotion, with all their facets, is like understanding all that goes into making a great pizza.

BRIEF EXERCISES

1. For your community, identify the KISS, AID, and ICE settings. Explain why you placed each setting in each category. A phone book, services directory, or even a walk around the community can help identify settings, as does doing this with a partner. Try to find settings in the health, mental health, educational, justice, and other human service systems. Some of these, especially ICE settings, may serve your community yet be located elsewhere.
2. Look up the Search Institute's Developmental Assets for youth (<http://www.search-institute.org/assets>). Note that not all assets need be present in an individual's life, but that all are resources for a community. For external assets, consider how these could be strengthened in your hometown or the neighborhood where you live now. For internal assets, consider how these could be better cultivated in children and youth there. Discuss your impressions with neighbors or classmates.
3. One aspect of KISS that has mushroomed since Bower (1972) is media/cyberspace/Internet. This raises critical questions for the future, including the following. Consider these individually and discuss them with classmates or others.

- How can our system of education, both for children and adults, be transformed to take into account the changes in information availability?
 - How we can do this in a way that is equitable with regard to communities and individuals of various income levels and conditions of physical or learning abilities?
 - How can KISS systems respond to the penetration of information in various forms into our homes, cars, and brains? Is the media/cyberspace/Internet system reducing our involvement in our families, social networks, and communities, or increasing it (or both)?
 - Are there differences between a sense of community based on direct personal contact and that derived from cyberspace encounters? Will video technology, such as face-to-face e-mail chats across huge distances, change such perceptions?
 - How do families deal with this influx of information into the home? To what should children be exposed? At what ages? For that matter, to what should adults be exposed?
4. Generate some examples of prevention/promotion interventions, and discuss them with a classmate.
- Choose a problem in living that is at least partly psychological in nature. The problem may be defined by symptoms or behaviors (e.g., depression, anxiety, health problem, poor school performance, criminal arrests) or by a stressful situation (e.g., bereavement, divorce, loss of job, poverty). Also choose an age group in which you are interested that experiences this problem; and a community with which you are familiar, where this problem occurs.
 - For this problem, age group, and community, list the risk and protective processes that you can identify. Write a sentence to define each process; tell why each protective process is protective. Use Table 9.1, the prevention equations, to help identify risk processes (numerators in the equations) and protective processes (denominators).
 - For this problem, age group, and community, identify examples of primary prevention activities and secondary prevention or early treatment activities. List activities that exist and some that you can suggest. Write a sentence or two to describe each existing or suggested intervention. Include what setting that intervention would be based in (e.g., school, neighborhood, workplace). Tell why it represents primary or secondary prevention.

RECOMMENDED READINGS

- Albee, G. (1982). Preventing psychopathology and promoting human potential. *American Psychologist*, 37, 1043-1050.
- Elias, M. (1987). Establishing enduring prevention programs: Advancing the legacy of Swampscott. *American Journal of Community Psychology*, 15, 539-553.

- Maton, K., Schellenbach, C., Leadbeater, B., & Solarz, A. (Eds.). (2004). *Investing in children, youth, families, and communities: Strengths-based research and policy*. Washington, DC: American Psychological Association.
- Mrazek, P., & Haggerty, R. (1994). *Reducing risks for mental disorders: Frontiers for preventive intervention research*. Washington, DC: National Academy Press. ["The IOM Report."]



RECOMMENDED WEBSITES

Collaborative for Academic, Social, and Emotional Learning
<http://www.casel.org>

National Mental Health Association
<http://www.nmha.org/children/prevent/index1.cfm>

Prevention First
<http://www.prevention.org>

Search Institute
<http://www.search-institute.org>

U.S. Center for Substance Abuse Prevention
<http://www.samhsa.gov/csap/index.htm>

U.S. Center for Mental Health Services
<http://www.samhsa.gov/cmhs/cmhs.htm>

Information on Social Issues Related to Prevention:

United Nations Children's Fund
<http://www.unicef.org>

U.S. Federal Interagency Forum on Child and Family Statistics
<http://childstats.gov>

Annie E. Casey Foundation: Kidscount (influential yearly report on U.S. social indicators regarding children)
<http://www.aecf.org/kidscount>

National Center for Children in Poverty
<http://www.nccp.org>

Children's Defense Fund
<http://www.childrensdefense.org>

(See also Recommended Websites for Chapter 10.)



INFOTRAC® COLLEGE EDITION KEYWORDS

competence(ies), health, intervention, prevention(ive)(ing), primary prevention, promotion(ing), protection(ive), risk, secondary prevention

INTERCHAPTER EXERCISE



Touring the Prevention/ Promotion Literature

The literature in prevention and promotion is expanding far more rapidly than any textbook will ever capture. Relevant literature comes from many fields, including the mass media and the Internet. Particularly for the latter outlets, it becomes important to know how to recognize high-quality work that is useful for prevention/promotion purposes.

The purpose of this exercise is to provide you with ways to do your own investigations of the literature so you can keep up to date and determine what is worth studying in more detail. We invite you to look at a wide array of outlets for examples that reflect prevention and promotion. In addition to research journals, articles in major newspapers and newsmagazines regularly address the social issues that are the central concern of community psychology, although you will rarely see community psychology mentioned. One reason for reading them is our responsibilities as citizens to inform ourselves about those issues. Prevention and promotion are linked to areas that come up for public consideration in the media and in our legislative bodies. The prevention/promotion literature also can inform many college and university policies that impact considerably on students.

The analytic method we recommend is summarized here. It reflects our view that reviews of the literature, as well as your own reviewing of the literature, are best done in a particular context and for particular purposes. We find it is more valuable to read purposefully than generically.

The framework also draws from Bower's (1972) KISS-AID-ICE distinction, social ecological concepts, and the literatures on risk and protective processes and implementation. It provides readers with a way of capturing essential information about articles in a way that we and our students have found useful.

You may find that you will want to add additional questions that are relevant to your particular interests. You might want to keep track of certain problem areas, make a separate file for work done in different parts of the United States and the world, or have a special focus on mass media and Internet sources or

doings in your current community or home town. You may find that initial sources you examine will not have the information you need to answer a number of the questions we suggest and that you need to read further. Part of the participant-conceptualizer role of community psychologists is to shed light on knowledge needed for responsible citizenship.

Guidelines for Reviewing Prevention/Promotion Articles/Materials

1. Record full reference information to be sure you know the source and context of this work.
2. What is the purpose of the work? Does it discuss a community or social issue that could be addressed by prevention/promotion initiatives? Or does it report on a specific prevention/promotion intervention?
3. If a prevention/promotion intervention is described, what protective processes is the program trying to strengthen? What risk processes is the program trying to weaken?
4. What population is being focused on? How were particular participants chosen? Some criteria may include age, gender, race or ethnicity, socioeconomic status or class, urban/suburban/rural location or geographic area, nation, or historical/political/cultural context.
5. What Key Integrative Social System(s) is involved? Health care (includes prenatal/birth/postnatal care), parents/families, peers, schools, religious settings, workplaces, leisure/recreational, community organizations, media/Internet/cyberspace, other?
6. What ecological level or levels of analysis does the article address? Individual, microsystems, organizations, localities, and/or macrosystems? What specific persons or groups does it address at that level? Is it targeted at the right level(s)?
7. If a prevention/promotion intervention is described, does it respond to a planned or predictable life situation (such as an education-related transition) or to an unpredictable life event (a reaction to a stressful or crisis event, such as divorce, bereavement, unemployment)?
8. Does the article focus on a wider community or social issue, such as poverty, social injustice, prejudice, or drugs? How might "small wins" thinking be applicable in prevention/promotion efforts on that issue?
9. If a prevention/promotion intervention was conducted, who planned it? How much were various constituencies and stakeholders involved? At what points? Were the persons most affected by decisions made in this program involved in making those decisions? Was there sufficient sensitivity to cultural and contextual factors?
10. How was the intervention implemented? Where? By whom? Under what conditions? When was it carried out? How often? Over what period of time?

Did the program developers check to see if the program was actually implemented as planned?

11. What is the evidence for the effectiveness of the intervention? What are the sources of that evidence?
12. Which of the objectives were clearly met? Not met? Met partially? Did it have an impact on the wider community? How?
13. Was the intervention implemented in multiple settings or contexts? Was it effective in all settings?
14. Are you convinced that the authors' interpretations or claims of effectiveness are true? Why or why not?
15. What are the most important things you think can be learned from what you read? What important questions does it raise?