# Revolutions and Counterrevolutions in Prevention

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*The new prevention science put forward by the National Institute of Mental Health and by the Institute of Medicine advocates strict experimental interventions with controls to reduce risks for psychiatric disorders. Articles by R. F. Muñoz, P. J. Mrazek, and R. J. Haggerty (1996, this issue), K. Heller (1996, this issue), and D. Reiss and R. H. Price (1996, this issue) support, elaborate, and discuss this agenda. Issues that seem controversial include (a) the use of risk reduction of psychiatric disorders as the criteria for acceptable research, (b) rejection of studies of competence promotion as not aimed at specific disorders, and (c) rejection of prevention studies, done before the counterrevolution that occurred in 1980 and thereafter, that advocated social and political change aimed at achieving social equality for disadvantaged groups. Arguments against the restricted new approach are presented.*

The preceding articles present commentaries on the latest position of the Institute of Medicine (IOM) and the National Institute of Mental Health (NIMH) on emerging strategies for the prevention of mental disorders. As science thrives on critical exchange of views, some comments and criticisms may be in order.

Primary prevention efforts to reduce the rate of mental disorders are supported largely by money derived from taxes. People do not pay directly for most prevention programs. Decisions about strategies for prevention efforts are based on the models explaining the causes of mental disorders. These decisions are made largely by powerful bureaucrats who control tax-generated research and training funds. The top bureaucrats, in turn, are appointed by politicians who sometimes have definite ideas about causation and who exert direction and control. At other times politicians are preoccupied with larger issues and leave things to the experts. When all is said and done, it is the powerful bureaucracy that endures and controls.

Control is less critical in affecting efforts to prevent real physical illnesses through public health. Real illnesses are objective; they almost always have an objective physical marker, and successful prevention efforts are clearly demonstrated by a decline in incidence. There are many examples of these successes at prevention—smallpox, polio, and childhood diseases such as mumps, measles, and whooping cough come easily to mind.

But mental disorders present a more complicated situation. Despite extensive and expensive research efforts, most mental disorders have not yielded an underlying objective marker. Indeed, as Wootten (1959/1978) pointed out in an elegant essay, it is

> anti-social behavior that leads to mental treatment. But at the same time the fact of the illness is itself inferred from this behavior; indeed it is almost true to say that the illness is the behavior for which it is also the excuse. (p. 225)

The problem with applying to mental conditions the conventional public health approach used in the prevention of real disease derives from the strong possibility that many mental disorders are socially acquired maladjustments, learned patterns of undesirable behavior that result from a pathological social environment. Indeed, epidemiological data strongly suggest that many mental disorders result from stresses associated with poverty; from the physical and sexual abuse of children; from child neglect, social isolation, and exploitation; from the low self-esteem associated with involuntary unemployment; and from low social status, being female in a patriarchal society, being African American in a society dominated and controlled by Caucasians, or being gay in a homophobic world. The key concept is that stress engendered by these experiences leads to behavior that is socially disapproved. And we label these patterns of behavior *mental illnesses.*

There was a clear turnabout in the early 1980s and thereafter in NIMH policy toward research into the causes and prevention of mental disorders. The 1960s and 1970s had seen widespread concern with the devastating emotional consequences of poverty, prejudice, sexism, and all forms of inequality. The President's [Jimmy Carter's] Commission on Mental Health report (1977/1978) had made education and social engineering its major prevention strategies. It stressed the devastating effects of societal ills stemming from "poverty and the institutionalized discrimination that occurs on the basis of race, sex, class, age and mental and physical handicaps" (p. 2). The report also stressed "malnutrition, inadequate housing, poor schools, unemployment . . . common to all minorities" (p. 4).

With the 1980s came the counterrevolution. The Mental Health Systems Act, passed in 1979, was repealed. The first three directors of NIMH had been psychiatrists trained in public health. Since the 1980s, the directors of NIMH have all been organically oriented psychiatrists with a biological bias. Research grants oriented toward studying the pathologics of society have given way to studies of the biology, neurology, and genetics of mental

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disorders. A recent director of NIMH, Lewis Judd, proclaimed the 1990s to be the Decade of the Brain, during which ways will be found to diagnose and treat "functional abnormalities of the brain," a view he expressed in detail in a letter to Ann Landers that was reprinted in her column (various dates, March 1994). Millions of her readers were told that our scientists were going to find these brain defects causing mental illnesses and find ways to treat them. And the National Advertising Council produced many public service announcements that proclaimed that all mental disorders are "medical illnesses."

Judd had ordered a review of prevention research. The effort began in 1990. The review and conclusion resulted in *The Prevention of Mental Disorders: A National Research Agenda* (NIMH Prevention Research Steering Committee, 1993). A much longer study, *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research* (Mrazek & Haggerty, 1994), was published by the IOM at the request of Congress. Both reports cover the same ground and deliver similar messages: Careful scientific prevention research from a developmental perspective must seek out and identify risk factors and conduct controlled intervention studies to reduce these risks of definable mental disorders. Also, both agreed to avoid consideration of the area of mental health promotion as not relevant because it was not aimed at specific disorders listed in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM–IV;* American Psychiatric Association, 1994).

The preceding four articles in this *American Psychologist* section further support the messages of these IOM and NIMH publications. They largely concur with the conclusions and recommendations of the IOM and NIMH. The research agenda for the future is established for prevention.

Is there anything wrong with the model and the new agenda? They have the support of many respected people. But before we close the door on prevention as it was conceptualized prior to the 1980 counterrevolution, it may be worthwhile to look at a few areas that still seem controversial.

One of the core issues for the new preventionists was whether to include mental health promotion efforts as part of the overall strategy. This issue, perhaps more than any other, separates the new from the old. Muñoz, Mrazek, and Haggerty (1996, this issue) echo the theme: "The major focus of promotion programs is to achieve optimal states of wellness" (p. 1121). Says who? Is immunization designed to achieve more robust health? Is finding social support for frail elderly adults aimed at reaching optimal wellness? The IOM report specifically and deliberately "has chosen not to include mental health promotion within the spectrum of interventions focused on mental disorders. [The reason:] health promotion is not driven by a focus on illness but rather a focus on the enhancement of well-being" (Mrazek & Haggerty, 1994, p. 27). Promotion does not have "a disorder orientation," say Muñoz et al. But does not a feeling of well-being, of positive self-esteem, of enhanced social competence strengthen resistance to stress? Of course it does, as a great many studies demonstrate. Are these not protective factors in another guise? But evidence for competence-enhancing strategies does not fit the IOM and NIMH agenda that focuses on reducing risk factors for specific *DSM–IV* categories.

A related question for the field of prevention is whether we are trying to identify specific risks for specific *DSM–IV* diseases or alternatively increasing social competencies and thereby reducing emotional disorders across the board. These different strategies reveal a disagreement over the question of whether there are discreet, reliable, and specific mental illnesses (as there are discreet physical illnesses) or whether mental disorders are more general learned patterns of behavior that get reinforced by success in avoiding or reducing the pain associated with stress.

The *DSM–IV* discrete disease model sends investigators on a search inside the body of the suffering person, looking for genetic, biochemical, or other physical defects, and into the environment for causes that trigger these internal defects. On the other hand, the stress-learning model focuses the search on environmental factors such as poverty, exploitation, and prejudice that produce augmented stress. This latter model accepts efforts to strengthen resistance to stress, such as social competency training, improving self-esteem and self-confidence, and providing support systems. The latter model also calls for social and political action to reduce the stresses of involuntary unemployment, exploitation, and discrimination against women, minorities, homosexuals, and elderly adults.

Clearly, the discrete disease model is consistent with the kind of prevention science programs urged by the IOM and NIMH plans for research. A good example is the program suggested by a recent director of the Alcohol, Drug Abuse, and Mental Health Administration who proposed the study of a large number of inner-city males at risk for violence and hypersexuality, with special attention to genetic and biochemical determinants.

Heller (1996, this issue) goes even further: "Until the last decade [mid-1980s on?], anything even approaching a true prevention science did not exist" (p. 1124). The term *prevention science* was coined at the 1991 NIMH-sponsored National Prevention Conference, so maybe it is only the past half-Decade of the Brain that true prevention science has existed. If prevention science is defined exclusively as the search for, and reduction of, risk factors for *DSM–IV* disorders through experimental and control-group research in a developmental context, then it is true that anything done in the past does not count. This judgment occurs frequently in the preceding articles and in the IOM (Mrazek & Haggerty, 1994) and NIMH (1993) publications. It is hard for some of us to turn our backs on major early prevention studies, such as Skodak's (1984) study of the effects of growing up in a caring family rather than in an orphanage, Harlow and Harlow's (1962) careful experimental work on the social world of infant monkeys and their later adjustment, Bowlby's (1969) study of attachment, Broussard's (1976)

continuing studies of the consequences of mother–neonatal perceptions, Cowen's (1994) work on competence enhancement, Dooley and Catalano's (1979) work on economic change and behavior disorder, Fryer's (1995) detailed review of the mental health consequences of unemployment, or David's (1992) "Born Unwanted: Long-Term Developmental Effects of Denied Abortion." The list could be extended for pages; however, all of these studies occurred before the creation of scientific prevention research.

Heller (1996) has an ambivalent reaction to the argument of Perry and Albee (1994), who agreed with the view that effective prevention will require societal change and political action to achieve equal rights and to reduce the stresses of discrimination and exploitation. Heller responds, "articulating a moral position without evidence of intervention effectiveness is not enough, because an equally compelling morality for many persons is one that champions individual initiative and responsibility as the primary ingredients needed to overcome social adversity" (p. 1124). This statement hearkens back to a time when many Americans embraced the romanticized Horatio Alger myth that anyone could pull themselves up by their bootstraps. Environmental factors were largely ignored, and factors located inside the individual were heavily weighted. This simplistic worldview means, in effect, that five million migrant farm laborers (with the highest rate of schizophrenia and alcoholism) should show more individual initiative and hurtle over the environmental barriers they confront, as should unemployed workers who are downsized, unemployed inner-city teenagers, and poverty-stricken older women, as well as all of the other groups known to be at high risk. Because we have more knowledge of the effects of structural obstacles and their effects upon individuals and groups than we did half a century ago, the myth is no longer credible.

Shore (1994), a former president of the American Orthopychiatric Association and editor of its journal, was active before prevention science was discovered. He said,

> We must always remember that the prevention initiatives that have had the most profound effects on mental health have been the women's movement, Social Security, Medicare, the Civil Rights Laws, and PL-94-142 The Right to Education for All Handicapped Act. (p. 16)

There were many people, such as Shore, active in the prevention of mental disorders before prevention science and before the Decade of the Brain, even though their work does not merit inclusion as part of the foundation of NIMH's new prevention research agenda. Leon Eisenberg (1962) in his Presidential Address to the American Orthopsychiatric Association spoke these ringing words:

> As citizens we (professionals) bear a moral responsibility, because of our specialized knowledge, for political action to prevent socially induced psychiatric illness. This implies fighting for decent subsistence levels in public housing, health care, education, and the right to work for all. (p. 790)

This statement typifies the thesis of prevention's earlier revolution (the 1960s and 1970s). Eliminate poverty and help achieve equality for all, and mental disorders will decline.

Even if the development of prevention science is disregarded, it is difficult to dismiss the public health strategy called "strengthening the resistance of the host," a global strategy of positive enhancement of health. Senator Daniel Inouye (1984), speaking at a conference on International Health Promotion in Honolulu, suggested that one of the greatest inventions in the history of public health was an adequate sewer system. Other speakers cited safe drinking water, better and varied nutritious food, and loving attention to infants and children as forces that all combined to improve dramatically the quality of human life and health and that reduced morbidity and mortality. It is instructive to note that none of these positive interventions is disease-specific. Building stronger, more secure, and more optimistic people makes them resistant across the board.

People who grow up feeling secure, loved, competent, safe, and supported have low rates of both physical and mental disorders. According to Cassel (1976), a South African physician who did research for many years at the School of Public Health, University of North Carolina, people with tuberculosis and schizophrenia, with alcoholism and early death, are far more likely to be socially isolated. (His studies were not scientific prevention research; therefore, they do not fit the new criteria for accepting or rejecting research findings.)

It is not necessary to search the scientific literature for evidence that water runs downhill. Nor do we require elaborate epidemiological studies to validate the observation that economically exploited groups are regarded as inferior, even subhuman, by the exploiters. And it is clear that these groups have higher rates of both physical illness and mental/emotional disorders. Logically, prevention programs should include efforts at achieving social equality for all (Albee, 1995), but such efforts threaten the status quo and so are not part of the prevention agenda.

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