Prevention Activities in Professional Psychology:
A Reaction to the Prevention Guidelines

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In this reaction article, the authors provide a historical context for prevention activities and their place in psychological practice. They then discuss the prevention guidelines in the Major Contribution authored by S. M. Hage et al. (2007 [this issue]) and provide their critique. Finally, the authors offer ideas for the future specific applications of these general guidelines and illustrate with a case example.

Hage et al. (2007 [this issue]) are to be commended for their comprehensive, thorough, and thoughtful contribution. They have managed to pull together the relevant literature regarding prevention efforts and its supporting research, as well as organize this work into a set of aspirational guidelines. The scope of their efforts is truly impressive—a scope that has its own problems as well as its obvious successes. This response will first provide a brief historical context for prevention activities, and then provide a general response to these guidelines. We will conclude with ideas of our own for future applications of these guidelines and prevention in general.

HISTORICAL OVERVIEW OF PREVENTION

Hage et al. (2007) correctly state that prevention activities have historically been an important aspect of the practice of counseling psychology (p. 497). This is consonant with counseling psychology's developmental approach to mental health as compared with the more remedial approach of clinical psychology and the more case management approach of social work. Community psychology as a professiponal psychological specialty was

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originally intended to focus more on prevention (and ironically consists primarily of clinical psychologists), but it has never had the impact its founders envisioned. Although prevention has been an important part of counseling psychology since its early years, the authors note the paradoxical finding that despite a growing interest in prevention, counseling psychologists' actual prevention activities are quite limited (Hage et al., 2007, p. 498). The reasons, we suspect, are largely economic. The field of mental health, like that of physical health to which status it has consistently aspired, is now and always has been remedial in orientation. There is little money to be made in prevention, and during the 1970s and 1980s counseling psychology attempted to play "catch-up" to clinical psychology in obtaining third-party reimbursements for its services to individuals. Third-party payers in both medicine and psychotherapy typically do not pay for prevention, although in the long run it is cheaper than remediation. Therefore, advocating for preventive mental/physical health activities is likely to be a hard sell indeed, especially given the comprehensive, multiple causal factors, contexts, and domains to which Hage et al. argue we should devote our efforts (p. 529).

REACTION TO THE GUIDELINES

Overall, the guidelines appear to be well grounded in research, and the authors do a superb job of building their case for prevention. They demonstrate how the development of these guidelines evolved over time and were based in sound research as well as systemically discussed by key stakeholders before they were promulgated. This process gives the guidelines much more credence and potential for acceptance by the entire psychological community. The authors have taken a complex and convoluted area of practice/research and narrowed it down to guidelines that can help psychologists conceptually organize how they might best begin to engage in prevention work. While the guidelines are phrased in very cautious language that may make them more politically acceptable in some quarters, they may also fail to provide forceful guidance for significant change in the practice of psychology.

The authors' categorization of the guidelines into four conceptual areas (practice, research and evaluation, education and training, and social and political advocacy) is critical because it sets up the conceptual framework for the areas in which psychologists should be engaging in order to do prevention (Hage et al., 2007, p. 501). These domains will be discussed in more detail in the following sections.

Practice

The practice guidelines set the broad overarching guidelines for the practice of prevention. Guidelines 1–5 describe the basic elements necessary for the practice of prevention. Hage et al. (2007) use this section to call for psychologists to actively engage in the practice by (a) developing proactive programs that prevent human suffering; (b) basing prevention programs in empirical research; (c) using culturally relevant prevention practices as well as engaging key stakeholders in all levels of the planning and implementation process; (d) addressing both individual and social contextual factors; and (e) focusing on both reducing risks and promoting the strengths of the targeted groups (pp. 501-519). These best practices build upon the general principle of justice and respect for people's rights and dignity (Hage et al., 2007, p. 495). We agree that these should be the core components in the practice of prevention, and are especially pleased that culturally relevant prevention was included as one of the top three guidelines. It is critical that programs targeting marginalized groups such as ethnic minorities, the hearing impaired, Appalachian, lesbian/gay/bisexual/transgender, and other cultural groups adapt their programs to meet the cultural and linguistic needs of the population as well as involve the stakeholders from these communities at all levels of the planning and implementation process (Reese & Vera, 2007).

Research and Evaluation

This domain (Guidelines 6–9) was the most difficult for us to "wrap our heads around" conceptually; in part, this may be because of the sheer complexity of prevention literature. Although the term *prevention science* was coined at a National Institute of Mental Health prevention conference in 1991, it does not appear to have infiltrated the field of psychology to its fullest extent. Thus, psychologists may not be as familiar with the field as other disciplines such as public health and social work (Hage et al., 2007, pp. 519-533). Undoubtedly, the field of psychology needs to actively engage in prevention efforts that are accurately targeted, efficiently executed, rigorously evaluated and that focus on the systemic empirical study of risk and protective factors impacting health and psychological dysfunction (Bloom, 1996).

We liked the authors' use of the National Institute of Mental Health's categorization of prevention research that classifies prevention research into three functions (preintervention epidemiology, preventive intervention [primary, secondary, and terciary], and prevention service delivery system) and three levels (biological, psychological, and sociocultural; Hage et al., 2007, p. 520). This classification matrix can guide prevention researchers toward literature

they need to examine prior to conducting their studies, as well as help them identify future directions for research based on their findings (Waldo & Schwartz, 2003).

We agree wholeheartedly with Guideline 7 that calls for psychologists to be competent in a variety of cross-disciplinary research methods, both qualitative and quantitative. We want to point out that the potential number of contextual variables and the possible interaction effects that Guideline 8 alludes to, which may occur in prevention research, are truly mind-boggling. Guideline 9 (ethical issues) is very important and perhaps deserves a domain of its own because prevention research can be fraught with ethical dilemmas.

Education and Training

This domain (Guidelines 11 and 12), in our estimation, is one of the most important sections because psychologists must be educated early in their training on the how and why to engage in prevention and social justice issues, if they are to do so later in their careers. The guidelines appear to be geared toward psychologists who have completed their PhD training rather than current PhD students. We would like to see prevention theory, research, and practice worked into the curriculum of every psychology student at all levels (BA, MA, PhD, and PsyD) in order to prepare future psychologists in the prevention field, much like social work has done in the National Association of Social Workers' policy statement on mental health (National Association of Social Workers, 2003–2006). This prevention training should seek to expand psychologists' repertoire of skills to include cross-disciplinary training in advocacy, grant writing, program development, and grassroots community involvement needed by psychologists to perform prevention work (Bluestein, Goodyear, Perry, & Cypers, 2005). It could also include training on the ecological prevention approach espoused by the field of social work (Kriste-Ashman, 2000).

SOCIAL AND POLITICAL ADVOCACY

This domain is made up of Guidelines 13–15, which are equally as critical because they call for psychologists to step out of their traditional roles and engage in political processes in order to improve the world in which they live. Many decisions affecting physical/mental health care are made on the basis of political considerations, rather than on scientific or educational merit. Whether because of insecurity, disinterest, or disdain, it is tempting for psychologists to leave this work to others, not recognizing that psychologists are the experts in behavior change. The skills psychologists possess

could be applied to any arena in which behavior change is warranted, including but not limited to the political process as well as the more traditional areas of schools, health care, violence prevention, and so forth. Psychologists need to become part of solving these serious social problems facing our country and world (Albee, 1986). Unfortunately, these are exactly the areas in which our efforts may be most controversial and, thus, uncomfortable for our profession.

WHERE DO WE GO FROM HERE?

Although these guidelines provide an overarching set of best practices, they fall short in that they do not provide the necessary information for "how to" do this work. These guidelines are broadly stated and therefore may not provide the direction or structure a psychologist may need in order to become competent in prevention work. Nevertheless, the guidelines serve as the springboard for further investigation into how the field of psychology will actually train, cultivate, and develop psychologists who will engage in proactive, socially just prevention work.

The choice to have a clinical and a counseling psychologist as well as a social worker respond to this article was purposeful. Clearly, each of us brings a unique experience and set of skills that are needed to begin to address the serious societal problems facing our country and our world. We must work together as professional disciplines, sharing our skill sets, lessons learned, and methodology to bring about real social change. As eloquently argued by Hage et al. (2007), prevention work needs to be at the forefront of a comprehensive mental health agenda (p. 494). We would argue, however, that the term *prevention* may need to be expanded in order for this to occur. Prevention is often juxtaposed with remediation, as if they were dichotomous constructs. It is our premise that prevention and remediation lie on a continuum, with group-based interventions occupying a space somewhere in between.

We would argue that prevention should be viewed as one of the tools on the continuum of therapeutic/treatment services and that the paradigm shift should consist of the acknowledgement that some of what we are labeling as prevention could actually be considered therapeutic interventions that are empirically based, well grounded in theory, and developed from a thorough assessment of need (Nation et al., 2003). For example, the first author (a clinical psychologist), along with her training director and fellow counseling psychology interns, while on their American Psychological Association internship at the University of Akron's Testing and Career Center, developed a grassroots career and college preparation program called Latinos on the Path to Higher Education (Rivera-Mosquera, Phillips, Castelano, Martin, &

Mowry, 2007). The goals of the program were to reduce the dropout rate and improve the college entrance of Latino youths—both serious societal problems facing the United States. The interns, utilized the first author's strong clinical assessment and treatment skills, in addition to the counseling psychology interns strong career development and educational prevention skills, to design and implement the program in a local Hispanic church. Most of the students recruited for this program could have been treated individually by any number of disciplines within psychology in an office environment, and the therapist could have secured third-party payment based on issues of learning/academic difficulties. The difference was that insurance covered interventions provided under the individual remedial model and not under the prevention model. It is our premise that prevention programs that are grounded on clinical and counseling theories of psychological behavioral change are actually psychotherapeutic in nature and, thus, should be called psychotherapeutic prevention programs that could be reimbursed as treatment interventions by third-party payers.

The question then becomes: How do psychotherapeutic prevention programs differ from group therapy? The goal of group therapy is, of course, for the group process to facilitate behavior change in the individuals in that group. This is also true for psychotherapeutic prevention. Perhaps the primary difference is the targeted audience. Psychotherapeutic prevention programs are generally larger in scope, may address more issues simultaneously, and usually reach a larger audience. We propose that well-researched and well-designed psychotherapeutic prevention programs be viewed as a form of group therapy and, thus, be considered as psychological treatment interventions. Viewing prevention as a treatment tool opens the doors for innovative programs to be developed and funded that may not only prevent symptoms from developing in targeted populations but could also provide a group therapeutic process to change behavior on a larger scale.

There are several skills that psychologists will need to develop in order to conduct prevention work, particularly when working with difficult-to-reach communities such as ethnic minorities. First and foremost, psychologists need to develop a strong personal relationship with the targeted community. The success of the Latinos on the Path to Higher Education program was based primarily on the quality of the relationship between the first author and the community. We recommend that psychologists and other mental health providers go out into the community and cultivate these essential relationships of trust early on in their training so that the stage will be set for program development later. Professors and students must venture out of the "ivory towers" and into the community (churches, mental health clinics, and social service agencies) to explore and experience the social environment and issues surrounding them. Ethically, psychologists should not develop prevention

programs if they have not ever ventured into or experienced firsthand the community in which they plan to research or work.

In addition to developing a trusting relationship, psychologists will also need to cultivate a number of other skills such as advocacy, program development, grant writing, cultural competence/cultural humility, social justice, and qualitative and quantitative evaluation skills—just to name a few (Romano & Hage, 2000). Unfortunately, these skills are not necessarily taught in traditional psychology programs, not even at the doctoral level. Psychology programs should embrace a cross-disciplinary model and allow students to take courses in other fields that focus on systemic change and/or advocacy such as social work, public health, nursing, anthropology, and forth. Training models such as the one used in the Latinos on the Path to Higher Education program could be readily taught and integrated into doctoral training programs. The program benefited all of those involved because the youths and their parents obtained a set of self-efficacy skills, and the interns had an enriched training experience that enhanced their skills in the area of community engagement, outreach, advocacy, and cultural competence. In addition, models of training such as the two pedagogical strategies (service learning and problem-based learning), which Hage et al. (2007) discuss in their article, could be quite effective in teaching psychotherapeutic prevention models in psychology courses (p. 539). The authors even include a mock syllabus for one of the strategies, making it easier for instructors to develop a prevention course. Throughout their article, Hage et al. offer practical advice and exposure to practical prevention research, which can be quite useful to psychologists seeking to engage in prevention work.

CONCLUSION

Hage et al. (2007) have provided a valuable service to the field of psychology by providing a set of guidelines that can be used as a springboard for further research and development in the field of prevention. Undoubtedly, an increased emphasis on prevention will require that the field cultivate psychologists who are community-oriented and committed to social justice as well as to political advocacy so that psychotherapeutic prevention programs may flourish. Students of psychology must be exposed to important issues faced by American society early in their training. Practical experiences with marginalized individuals such as ethnic and cultural minorities, the hearing impaired, lesbian/gay/bisexual/transgender groups, and others are needed so that students can begin their training on psychotherapeutic prevention development and programming. Psychology students should first understand and acquiesce to the social justice model as well as develop an empathic connection with the

movement of marginalized groups or affected societal segments before they can effectively develop, plan for, and engage in psychotherapeutic prevention work. Psychology students also need to volunteer and become active in the targeted group in order to develop a strong relationship of trust with that community. This relationship is the cornerstone for the effective delivery of prevention work. Psychology departments, as well as placement and internship sites, must make a concerted effort to not only integrate prevention into their curriculums but also to help students connect to and engage in experiential learning in the targeted communities. In addition, psychologists need to become active and lobby for the funding of psychotherapeutic prevention programs as treatment interventions. Fortunately, the President's New Freedom Commission, which President George W. Bush established in 2002, seems to be leading the charge for establishing prevention as a viable treatment tool in the arena of mental health. This prevention-focused paradigm shift may have finally begun to take root.

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