PRIMARY PREVENTION: THE ONLY COURSE OF ACTION

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Abstract
The present paper discusses some of the distinguishing features associated with behavioral prevention methodology, e.g., the design, implementation, and evaluation of preventive programs. It is argued that Behaviorists for Social Action has already implicitly identified target populations (those at high risk of being objects of social injustice and those at risk for engaging in inequitable social behavior) for preventive intervention; and that the two distinct populations which have been identified can form the focus of preventive endeavors. Various research skills which behaviorists must acquire in order to competently initiate and evaluate prevention programs are sophistication with epidemiological research, group designs, longitudinal methodology, sampling techniques, and psychometric principles. Finally, it is suggested that primary prevention represents a sensible and cost-efficient approach which can effectively and comprehensively deal with critical social problems.

In various position papers presented at the 1978 organizational meeting of Behaviorists for Social Action, a special interest group of the Association for Behavior Analysis, references were repeatedly made to the need for prevention programs. Despite the expenditure of billions of dollars, the mental health profession has yet to achieve its goal of reducing the prevalence of behavior disorders. Only a small proportion of the population in need of mental health services actually receives some assistance (Report of the Joint Commission, 1969). For those individuals who do receive treatment, the outcome research does not provide convincing evidence for the effectiveness of the intervention (Hartmann, Roper, & Gelfand, 1977). With respect to social injustice, as the number of victims increases remediation on a case by case basis becomes progressively less feasible and the need for behaviorists to adopt a preventive orientation increases. In addition to being sensible and cost effective (Albee, 1979) preventive approaches possess great promise for promoting and insuring the well being of previously victimized populations.

In order effectively to institute and evaluate prevention programs, behaviorists must acquire certain skills. The purpose of the present paper is to discuss briefly behavioral prevention as it relates to the Behaviorists for Social Action and to present some of the key skills which behaviorists must develop in order to make the transition to a preventive orientation.

The most widely accepted definition of prevention is presented by Caplan's (1964) concept of "primary prevention." Caplan describes three types of prevention: Primary prevention attempts to prevent a disorder from occurring. Secondary prevention identifies and treats at the earliest possible moment so as to reduce the length and severity of the disorder. Tertiary prevention attempts to reduce to a minimum the degree of handicap or impairment that results from a disorder that has already occurred. As Wagenfeld (1972) has pointed out, secondary and tertiary prevention are synonymous with the more traditional terms of treatment and rehabilitation. Treatment denotes intervention after the onset of the disorder; and rehabilitation indicates an attempt to reverse the damage and to rebuild the systems that have been disrupted by the disorder.

The development, implementation, and evaluation of previous prevention programs have generally adhered to a common methodology. The first step is the identification of a target behavior or problem whose occurrence is to be prevented. Once the target behavior has been specified, epidemiologists collect data on the prevalence rate and on potential risk factors associated with the appearance of the disorder. Finally, a target population is selected. Preventive efforts may be directed to community-wide, milestone, or high risk populations (Bloom, 1968). In community-wide prevention all residents of a community are the recipients of the program. Milestone prevention refers to intervention directed toward critical development periods or situations; for example, immunizing preschool children for childhood diseases, providing birth control to adolescents, and providing pre-retirement counseling all constitute milestone prevention. Individuals currently in those situations constitute the milestone population. While the focus in the milestone approach is on specific situations or events, high risk programs are aimed at vulnerable populations. Groups vulnerable to specific disorders are identified and are subject to special programs designed to reduce or prevent the incidence of dysfunction. Upon selection of the target population, the prevention program is introduced and its effects examined after predetermined time periods.

In one such example, primary prevention of coronary artery disease might be considered. Community-wide or milestone intervention for those approaching middle age (since most individuals with coronary artery disease experience problems after age 40) could be effected. It is likely that epidemiological factors might indicate that treating an at-risk population is the most cost effective strategy. After selecting the at-risk population to be treated, demographic factors associated with being at-risk should be identified. A family history of heart disease, a high stress occupation, low exercise tolerance, smoking, and obesity, would all contribute to being identified as being at-risk. Then, specific variables which can control or moderate the factors placing the individual at-risk could be identified and combined into treatment plans. Subsequent phases would include refinement of the intervention procedures, packaging the intervention, pilot interventions in one or more communities, and finally multi-community screening, implementation, and evaluation.

Behaviorists who are concerned with initiating constructive social change have already begun the type of prevention methodology just described, although the order of the components has differed from traditional prevention research (Report of Kalamazoo Chapter, Note 1). The first step has already been taken with the implicit identification of two at-risk populations: (a) minorities, economically disadvantaged, and socially stigmatized groups are recognized as populations at high risk for being objects of social injustice, discrimination, etc. (b) a variety of individuals occupying positions of economic and social power might be deemed to be at-risk for engaging in inequitable social behavior.

The first step in any prevention program is the identification and specification of a target behavior. Providing a precise operational definition for all forms of social discrimination is a difficult, if not impossible task. However, many components of social injustice are easily identifiable and quantifiable as target
behaviors. Unemployment and underemployment form only one example of a class of social problems which could be the focus of primary prevention. Behaviorists could focus on two dissimilar populations—those individuals who are most at-risk for employment problems or those individuals most at-risk for discriminatory hiring.

The first population could receive an intervention designed to facilitate the acquisition of skills and behaviors which will make the individual less susceptible to unemployment or underemployment. Such a prevention approach requires epidemiological work which will identify: (a) multiple prevalence rates of factors associated with the likelihood of being vulnerable to socially unjust hiring practices, (b) segments of the population and critical periods which are of the greatest risk for precursors to unemployment and (c) behaviors or skills which reduce the probability of the individual being victimized. For example, it may be determined that individuals of a certain at-risk ethnic minority who possess adequate problem-solving, coping skills, and vocational skills and who are not plagued by addictive behaviors are less susceptible to victimization. Therefore, a number of interventions would be introduced to prepare members of the target population for dealing with problematic (Spivack, Note 2) and stressful (Barrios & Shigetomi, Note 3) situations, and addictive substances (Marlatt, Note 4). Treatment could be directed toward milestone prevention within at-risk groups to deal with the precursors of unemployment such as ill health, poor education, and lack of access to a job. The job-finding club developed by Azrin, Flores, and Kaplay (1975) is an example of an empirically sound program which could be introduced for preventive purposes. Prevention could be enacted in the form of preschool education, remedial education and vocational planning in early adolescence, and job skills training and placement for the young adult. Finally, population-wide programs might also be implemented within high risk communities.

Such preventive efforts need not impose the cultural values of the prospective employers on the treated populations. Prevention programs for impoverished and culturally different populations are often subjected to criticism for their implied assumption that deviations from the majority - group norms constitute some sort of deficit or inferiority (Ginsburg, 1972). It is possible for prevention programs to maintain individuals' pride in their cultural heritage and to equip them with behavioral skills which will decrease the probability of experiencing problems in the physical, educational, psychological, vocational, and economic areas. Garcia and his associates (Garcia, Trujillo, & Batista, in press) have established a bilingual bicultural nursery school for Chicano children. With consultation from psychologists, educators, and psychologists, the mothers determine the school curriculum and also teach the classes. Preliminary results indicate: (a) that the mothers use both Spanish and English in their instructions; (b) that they gain confidence in their teaching skills; and (c) that the children do master the material presented in each instructional unit. This bicultural program strives to preserve cherished elements of the family's cultural background while preparing the child for entry into conventional public schools. It exemplifies both milestone prevention for children who will avoid an early educational disadvantage and community-wide prevention for the Chicano mother, who receives useful teaching skills.

A second prevention approach might take a very different strategy to remediate social problems created by unemployment and underemployment. This approach might be directed toward populations at high risk for acquiring and exhibiting discriminatory and unjust hiring practices. Epidemiological research would be required in order to identify: (a) prevalence rates, (b) multiple factors connected with the probability of engaging in discriminatory hiring and (c) segments of the population and critical periods which are of the greatest risk for the development of the bases for societally inequitable behavior. Interventions would strive to facilitate acquisition of unbiased and just social behaviors. Modeling procedures (Bandura, 1977), cognitive behavior modification techniques (Cautela, Walsh, & Wish, 1971), and dissemination of factual information (Farina, Fisher, Getter, & Fisher, 1978) could be utilized to accomplish these aims. Cautela and his colleagues, (Cautela, Walsh, & Wish, 1971; Cautela & Wisocki, 1969), for example, have improved attitudes towards retardates and the elderly by employing a covert reinforcement procedure. In addition to effecting attitude change, a variety of incentives such as community purchasing power, monetary incentives for nondiscriminatory hiring and on the job training, and documentation of improved on-the-job performance would be likely to have a strong effect on hiring practices.

Primary prevention by behaviorists thus has a wide variety of applications through which social change can be instituted. The combination of primary prevention strategies and behavioral training may provide a unique combination of skills necessary to enact large-scale social change. Behavioral training has associated with it a number of aspects which should facilitate the execution of prevention work and the achievement of its goals (Hartmann, Shigetomi, & Barrios, Note 4; Peterson, Hartmann, & Gelfand, 1978). Among these are:

1. Behavioral techniques are based on sound, carefully developed procedures rather than on unproven, traditional clinical procedures and hunches. Typically behavioral techniques have gone through a series of laboratory tests or analogue conditions that insures their efficiency, or reveal limitations.

2. Behaviorists' emphasis on design structure, procedural specification, and reliability assists in insuring that the behaviorally based techniques can be characterized, and procedures as well as results can be replicated.

3. Behavioral procedures are generally directed to clearly defined observable problem behaviors.

4. In most instances, the rationale and components of behavioral techniques can be easily comprehended by clients, and can be administered by moderately trained individuals or by the client him - herself. Behavioral procedures meeting these requirements possess a monetary advantage over those traditional intervention techniques that require substantial professional time to administer.

5. Behaviorists tend to emphasize clinically significant and socially valid results. Critical aspects of clinical and social significance include the durability and generality of intervention effects, as well as the absence of undesirable side effects.

Despite the aforementioned strengths of behavioral training, behaviorists must acquire certain skills in order effectively to develop, implement, and evaluate prevention programs for large scale social problems. Behaviorists must become sophisticated in: (a) epidemiological research, (b) experimental and quasi-experimental group designs, (c) longitudinal methodology, (d) inferential and descriptive statistics, (e) the problems of statistical power, (f) sampling techniques, (g) discontinuous assessment, (h) psychometric principles and (i) assessment instruments which lend themselves well to prevention research. Systematic implementation and evaluation of prevention programs require knowledge and expertise in these areas. For example, the identification of populations at-risk and those demographic factors associated with being at-risk might profit from that aspect of epidemiology concerned with case identification and with exploratory or hypotheses generat-
ing designs and techniques. The packaging of preventive interventions and conducting pilot and large scale evaluations would benefit from the use of sampling procedures, longitudinal techniques including methods of maintaining contact with subjects over some length of time, handling missing data, and statistical procedures.

The present paper has discussed some of the unique aspects associated with behavioral prevention methodology, and has identified a number of research skills behaviorists should acquire. Remediation is an approach which Behaviorists for Social Action can ill afford to adopt. Opponents of preventive programs contend that resources should be directed toward rectifying the imbalance between demands for mental health services and the service supply. One recommended strategy is to increase the number of service providers by using paraprofessionals and peer therapists in addition to the traditional professional staff. Unfortunately, history has revealed the inadequacy of this approach. The initiation of new treatment services and expansion of the mental health work force has stimulated rather than decreased the demand for services (Gelfand, Note 6). It is apparent that a change in focus from expanding the supply of services to decreasing the need by prevention of new occurrences is called for. Ostensibly, remediation efforts will continue. However, it is recommended that behaviorists begin directing more of their efforts to the prevention of socially inappropriate behaviors. In order to deal efficaciously and comprehensively with the pressing social problems which confront society, primary prevention represents a sensible course of action for behaviorists to take.

Note

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Reference Notes


References


Albee, G. Preventing Prevention American Psychological Association Monitor, 1979, 10, 2.


