Preventing Psychopathology

In theory, much mental and emotional distress can be prevented before it develops. In practice, true prevention is often more a dream than a reality.

BY ROBERT J. TROTTER

Miasma—the sickly, slimy vapors that seep through the sewers and swamps; the poisonous, putrid air that pollutes and befouls; the noxious, choking air that emanates from decaying organisms.

In the 19th century, miasma—bad air—was thought to be a major cause of infection, disease and death. Working within the miasma theory, forward-looking scientists attempted to prevent disease by calling for the cleanup of the miasma-producing piles of garbage and sewage that contaminated many city streets.

The miasmatists were right about sanitation. They were wrong about miasma. The work of Lister, Pasteur and others proved that disease is spread by microorganisms and germs in the air, not by the air itself. Once researchers began to isolate and identify the specific causes of disease, it became possible to take serious steps toward the prevention of disease.

Now it appears that psychologists and mental health professionals may be at the same stage medical scientists were when they began to abandon the miasma theory. Psychologists are getting down to the identification of some of the specific causes of mental and emotional disturbance. The Listers and Pasteurs of psychology have begun to isolate some of the causative factors that are part of an overall mental miasma or psychic pollution. With the identification of these factors, it becomes increasingly possible to take serious steps toward the prevention of psychopathology. And the prevention of psychopathology should, logically, be one of the major goals of psychology. Achieving this goal, however, is something that psychology has only recently begun to take seriously.

Evidence that prevention is being taken seriously came this summer when, for the first time, a group of mental health professionals met formally to exchange research results and information on prevention programs. The meeting, the Vermont Conference on the Primary Prevention of Psychopathology, was sponsored by the University of Vermont in Burlington and funded by the Waters Foundation.

Preventive efforts are generally divided into three separate areas. Writing in the *Annual Review of Psychology* (Vol. 26, 1975), Marc Kessler and George W. Albee, both of the University of Vermont, say that "primary prevention is the steps taken to prevent the occurrence of a disease, secondary prevention is early treatment of the disease once it has occurred and tertiary prevention is the attempt to minimize the long-term effects of the disease." But, they emphasize, "it is public health dogma that no widespread human disease is ever brought under control by the treatment of afflicted individuals. Smallpox was not conquered by treating smallpox patients; neither was treatment of the individual the answer to typhoid fever, nor polio, nor measles. Every plague afflicting humankind has been controlled when discovery of the cause led to taking effective steps to remove it. This process is primary prevention."

That psychopathology can be similarly prevented is most obvious in the organic syndromes. Lead poisoning from the ingestion of lead paint by a child, for instance, produces measurable changes in the blood and damage to the brain, with long-term consequences for the child's ability to learn and to behave normally. German measles during the first three months of pregnancy can produce retardation in the child. Chromosomal abnormalities can lead to Down's Syndrome (mongolism) and to other structural mental diseases.

But blood changes, chromosomal abnormalities, disturbed reflexes, and so forth, are all objective and measurable in the infant or young child. They usually are associated with conditions that bring the child to a medical setting where records are made and observations are quantified and stored. Later investigators, explain Kessler and Albee, can go back and find these objective records and correlate them with current problems. Preventive programs can then be designed—blood tests, genetic screening for chromosomal abnormalities, lead-free paint.

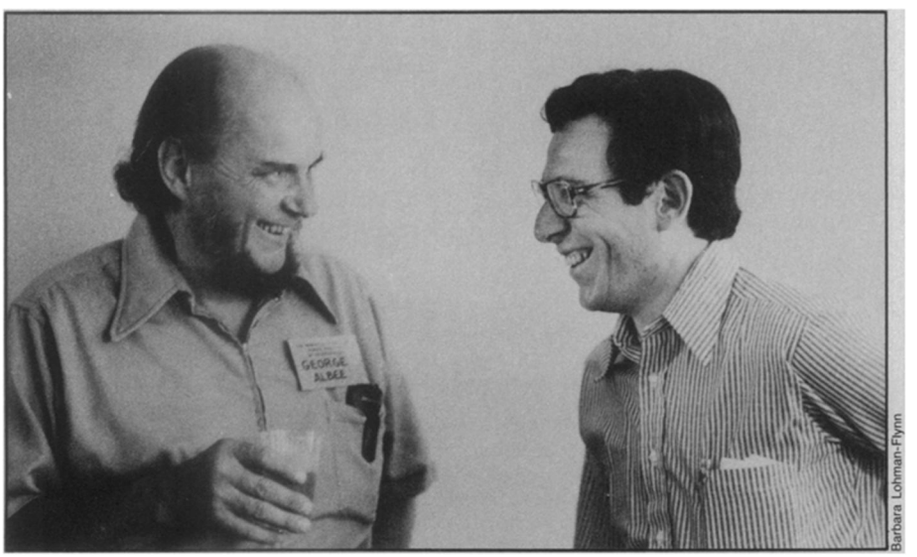
Successful programs directed at the prevention of organic syndromes, however, represent only a few bright spots or islands of solid ground in what Kessler and Albee call the murky swamp of primary prevention. Most clinicians are convinced that psychological influences—social experiences and events—are responsible for much psychopathology. But the correlations in this area are not always clear. "The ambivalent alternation of affection and rejection by the mother, the child's experience of being left frequently with a negligent baby sitter, the effects of the sudden withdrawal of love and attention at the time of arrival of a new sibling—where are these events recorded, how are they retrieved?" ask Kessler and Albee. Only recently have attempts been made to collect such information on a systematic basis.

Even when specific social and psychological factors are identified as causes of psychopathology, how do mental health professionals intervene? Parts of the mental miasma, for instance, have long been identified. The Jarvis report or the *Report of the Commission on Lunacy and Idiocy in Massachusetts, 1855*, cited poverty as part of the pollution. Jarvis saw poverty as "an inward principle, enrooted deeply within the man, and running through all his elements . . . and hence we find that, among those whom the world calls poor, there is less vital force, a lower tone of

life, more early death, more weakness, more idiocy and insanity and more crime than in the independent."

While some (like Jarvis) feel that both poverty and various forms of pathological behavior might be due to some common underlying defect, "the predominant weight of evidence supports the position that poverty causes social disability," say Kessler and Albee. But even with the evidence, how effective can psychology be in eliminating poverty?

Another part of the miasma was identified by Freud. The "psychogenic hypothesis" held by a majority of present-day clinicians relates adult disturbance to childhood expericence. "If the evidence is accepted that certain experiences in early childhood have positive or negative effects on adult functioning, then efforts at prevention should attempt to maximize the early positive experiences and minimize or eliminate the negative experiences. Evidence supporting these relationships, we believe," say Kessler and Albee, "is so voluminous as to defy summarization." But even with voluminous evidence, do psychologists have the ethical right (or even the ability) to interfere with the freedom of parents to raise their children as they see fit?



Albee and Kessler: Searching for signposts in the swamp of primary prevention.

Questions about primary prevention go far beyond parenting and poverty. Kessler and Albee conclude that "practically every effort aimed at improved child rearing, increasing effective communication, building inner control and self-esteem, reducing stress and pollution, etc.—in short, everything aimed at improving the human condition, at making life more fulfilling and meaningful—may be considered to be part of primary prevention of mental or emotional disturbance. . . . Primary prevention in many areas may require social and political changes to improve the 'quality of life.' "

Data to back up such utopian statements as well as programs directed at enhancing the quality of life, were discussed in detail at the Vermont conference. But even the most enthusiastic participants at the conference were sobered when reminded of the fomidable obstacles that still stand in the way of implementing primary prevention programs on a large scale. Some of the problems were outlined by Robert L. Okin, commissioner of the Vermont Department of Mental Health.

A considerable degree of skepticism, for instance, still exists about the possibility of preventing psychopathology. "This skepticism," explains Okin, "frequently greets a commissioner of mental health when he requests of the legislature that it provide resources for a particular primary prevention program. In the absence of extremely convincing evidence to the contrary, legislators are unwilling to allocate funds to prevent future problems in the face of insufficient monies to solve present ones."

Much of the research discussed at the Vermont meeting was of a quality to dispel skepticism (SN: 7/19/75, p. 41), but good data are not always enough. The entire socioeconomic structure of society, says Okin, often works against prevention. For instance, "the eradication of poverty which plagues millions of people in this country would require a fundamental transformation of society, a significant redistribution of income and wealth among classes, and a substantial diversion of society's resources into social services. This is one of the major reasons for our continuing emphasis on treatment rather than prevention. The former can be largely accommodated within the status quo, while the latter shakes the very foundations of our socioeconomic order."

To make matters worse, Okin goes on, mental health providers, themselves, are not sufficiently committed to prevention. They have little financial incentive to spend their time on prevention. They are paid for treating existing problems, not for preventing possible future problems. Health insurance programs in general and mental health insurance plans in particular pay for time spent on treatment, not on prevention. Patients are reimbursed upon developing illness, not for staying well.

Many of the problems discussed by Okin are, of course, social, economic and political rather than purely psychological. But, he concludes, "we must recognize that we own parts of this problem and begin to systematically involve ourselves in the broader issues of social policy in very pragmatic ways."

One way of attacking the broader social issues is from the top, from within the mental health establishment. It appears that some headway has been made in that direction. There are indications that the National Institute of Mental Health is beginning to take some serious steps toward primary prevention. Stephen E. Goldston of the Center for Studies of Child and Family Mental Health at NIMH says he has been involved in primary prevention for 15 years. But in the past, NIMH has put forth little more than rhetoric. "I've been banging my head against the wall," he says, "and all of a sudden things are zooming. . . . I'd say that within the highest echelons at NIMH there is considerable interest, support and recognition of the need to implement the plan which calls for an emphasis on prevention."

Goldston admits that many political, social and research problems remain to be solved. But, he says, "I think that people have to be made aware that we are not talking about smoke or corralling a cloud. We are talking about the application of scientific research findings, translating them into programmatic terms and delivering meaningful kinds of service and training. They have to realize that we're past the rhetoric stage—far past it."

So, even though there are many problems yet to be solved and many of the specific causative factors within the miasma have yet to be identified, it appears that the primary prevention of psychopathology may be a viable and growing force within the field of mental health. As Kessler and Albee put it, "The most compelling reason for continuing efforts at primary prevention is suggested by the success of the miasmatists. Cleaning up the waste turned out to be the way to prevent disease. While elements of the theory were wrong, the results were right." □