Ann. Rev. Psychol. 1987. 38:427–60

SOCIAL AND COMMUNITY INTERVENTIONS

Ellis L. Gesten

Department of Psychology, University of South Florida, Tampa, Florida 33620

Leonard A. Jason

Department of Psychology, De Paul University, Chicago, Illinois 60614

CONTENTS

INTRODUCTION

This chapter examines recent efforts by psychologists and others to enhance the well-being of groups and communities. The origins of psychology's systematic involvement in such activities is fairly recent, traceable in many respects to both critical events and the overall Zeitgeist of the 1960s. At the opening of the decade the Joint Commission on Mental Health and Illness (1961) suggested new mental health interventions and institutions were

0066-4308/87/0201-0427$02.00

needed. This came at a point in history when the federal government had both the will and resources to respond. Influenced by the politics and climate of the times, mental illness was seen as a social problem with intrapsychic manifestations but environmental underpinnings susceptible to influence through planned intervention. At the decade's close, in his 1969 presidential address to the American Psychological Association, George Miller (1969) urged its membership to "give psychology away" not through psychotherapy, but by translating research into applied strategies to help people help themselves (Chavis et al 1983).

The 1965 Swampscott Conference (Bennett et al 1966) represents another marker event of that era which helped to both energize and structure new intervention-related roles for psychologists. Organized around dissatisfaction among clinical psychologists with the scope and efficacy of traditional mental health treatment models, one key result of those deliberations was the emergence of community psychology as a new discipline, blending applied science and an abiding commitment to promoting human welfare. Though rooted historically in the service delivery traditions of clinical psychology, community psychology was to overcome those influences and create new prevention-oriented paradigms targeted to groups and the development or enhancement of social systems. Related to this was a commitment to examine the nature of communities in which we intervene and the linkages and reciprocal influences between persons and settings.

We began this review during the 20th anniversary of Swampscott, a time of self-conscious reflection on its legacy and the status and achievements of its offspring. In this context, the extent to which preventively oriented community concepts, values, and technologies have both affected and been incorporated into other fields has been viewed by some with a mixture of pride and alarm (Bloom 1984, Felner 1985, Shinn 1987). Others, by contrast, remind us of how far we must go and overcome to realize the ideals of the discipline (Sarason 1983, Elias 1987). Altman (1987) views the field as entering its adolescence needing both to validate its accomplishments and make necessary mid-course adjustments before moving forward. He also provides a helpful set of guidelines to assist in this process.

Whereas one-to-one therapeutic encounters can and do take place anywhere, between and among a wide variety of persons, the design and implementation of social and community interventions (SCIs) generally require more resources, a special tenacity, and a larger research team. Despite the strong support of the National Mental Health Association (1986), securing necessary funding is made especially difficult by the lack of a natural constituency for prevention services (Hollister 1982). On a positive note, the recent establishment of five NIMH-sponsored Preventive Intervention Research Centers (PIRCs) has created a type of research setting well suited for

such larger scale, interdisciplinary, long-term intervention efforts. Governmental commitment to prevention funding, never very strong or consistent, is now threatened further in the current national budget crisis, dimming prospects that all twelve originally planned PIRCs will eventually be funded.

For this fifth review of social and community interventions we have chosen to feature programs with a primary or early secondary preventive—rather than restorative—focus, which offer as well some empirical data regarding impact. In some newly developing areas these criteria were more flexibly applied. Areas chosen for review are: *Primary Prevention: An Overview; Competence Building; Social Support; Empowerment; Mutual Help; Behavioral Community Psychology; Diverse Cultures and Groups; Research;* and *Public Policy*. These topics, while distinct in some ways, clearly overlap in others. Moreover, some may take exception with the decision to classify certain multifaceted SCIs in one as opposed to another category.

PRIMARY PREVENTION: AN OVERVIEW

Bower (1977), in a chapter written for the first of many fine volumes to emerge from the Annual Vermont Conference on Primary Prevention of Psychopathology, described primary prevention as a field of "unstructured spaciousness [in which] one searches eagerly for places to grab or stand . . . a friendly and virtuous territory of high abstraction and low practicality" (p. 24). Kessler & Albee (1975), in a more colorful, if sinister, view of the field, likened primary prevention to the great Okefenokee Swamp. "Attractive from a distance and especially from the air; it lures the unwary into quagmires, into uncharted and impenetrable byways" (p. 558). Both analogies capture something of the essence of primary prevention in the late 1960s and 1970s during which time much of its literature centered upon issues of turf, definition, and its legitimacy as a framework for conceptualizing mental health problems and delivering services.

In the 13 years since these observations were made, modest but significant progress has been made in our understanding and implementation of primary prevention programs. We are, for example, closer to agreement about primary prevention's essential definition and goals. Although Cowen's (1983) description of primary prevention as "group or mass targeted before-the-fact efforts to promote competence or prevent psychological dysfunction in essentially well people" may appear overly restrictive to some (Joffe 1982), this concept offers a clear challenge to mental health's traditional underlying assumptions and practices.

Although no major psychological condition from the *Diagnostic and Statistical Manual of Mental Disorders (DSM III)* has been thus far eliminated, the

quality and quantity of documented primary preventive interventions have grown rapidly in the past four years. At least three comprehensive reviews of the field can be cited. Despite rigorous application criteria, Cowen received 49 abstracts which eventually yielded nine intervention studies constituting the *American Journal of Community Psychology's* Special Issue on Primary Prevention (Cowen 1982). Buckner et al (1985) compiled an annotated bibliography of 1008 published references on primary prevention in mental health spanning the past three decades. A critical comparative evaluation of primary prevention programs is currently being conducted by an APA task force seeking to identify some 15 exemplary, research documented programs from among 318 submissions. Finally, at least five significant volumes have appeared summarizing and evaluating both seminal and new research in the field. From the Vermont Conferences comes a book of readings (Joffee et al 1984) and a review of the past decade of progress in prevention (Kessler & Goldston 1986). Three edited volumes by Felner et al (1983b), Roberts & Peterson (1984), and Edelstein & Michelson (1986), though not limited in focus to primary prevention, provide a wealth of information regarding prevention theory, practice, and research.

Controversy continues over: 1. whether prevention should (or can) be disorder-specific or targeted more globally to the prevention of any psychopathology (Bloom 1985); 2. the extent to which psychopathologies to be prevented should be limited to *DSM III* "mental illnesses" as opposed to psychological conditions that do not meet those criteria. These and related issues were discussed in a provocative debate—*"Primary Prevention: Fact or Fallacy"*—among leaders in mental health who were both supportive and antagonistic toward primary prevention (Marlowe & Weinberg 1985).

Those who would tie prevention to specific disorders seemingly ignore the fact that most psychological disorders are associated with multiple causes and any given "cause" may yield multiple outcomes. A second set of concerns resides in the very nature of *DSM III* type disorders, many of which are neither enduring nor reliable, well-defined entities. We find ourselves sympathetic to a position outlined by Muñoz, who points out that while the prevalence rates of (for example) severe affective disorders are relatively small (6%), mild to moderate levels of depressive symptomatology are quite prevalent (9–26%). It thus seems reasonable to hypothesize that the prevention of depressive symptomatology would ultimately lead to decreased incidence of full-blown depression (Muñoz 1982, 1987).

In a field that continues to suffer from the lack of broad integrative theories, one notable exception is provided by the work of life stress researchers. According to Dohrenwend's (1978) model, stressful life events are associated with psychopathology with the degree of relationship moderated by risk and protective variables residing in both the individual and the environment.

Felner and others (1983a) adopting a life-span perspective have emphasized the role of critical life events both anticipatable and nonanticipatable for development of psychopathology or positive, adaptive outcomes. Applying a public health perspective to this model yields at least three generic primary preventive strategies: (*a*) modifying the *environmental surround* in which these events occur to, for example, increase social support and reduce the effects of stress; (*b*) eliminating the *agent* as, for example, reducing the incidence of abuse via legislative, religious, or psychological intervention; or (*c*) strengthening the competence of the *host* to deal with specific stressors or classes of stress. Although these goals may be pursued via intervention targeted at various levels to either persons or social systems, much of the published research reviewed for this chapter was person centered (Cowen 1985).

Both the quality and quantity of primary preventive SCIs continue to improve along with accumulating evidence of their impact. Although "our places to stand have not moved the earth" (Rappaport et al 1975), they have provided a clear vantage point from which to venture forward.

COMPETENCE BUILDING

Many person-centered interventions either explicitly or implicitly embrace a competence building model. In such approaches clusters of personal and/or social skills are taught systematically, followed typically by an assessment of skill acquisition and/or related mental health outcome(s). What follows is an overview of programs designed to enhance the competence of: (*a*) individuals in high risk family or community environments, (*b*) persons experiencing a significant life crisis or transition, and (*c*) groups of well individuals for whom the program is most clearly a preventive innoculation or enhancement opportunity.

Several interventions designed to increase young children's cognitive skills and social adjustment were identified (Slaughter 1983, Berrueta-Clement 1984, Pierson et al 1984, Jordan et al 1985). The Houston Parent-Child Development Center program for Mexican-American children ages 1–3 and their parents (Johnson & Breckenridge 1982) is representative of this class of studies targeted to families at risk because of their low socioeconomic and minority status. Via a 500^+ hour intervention spread over two years, mothers were trained in a variety of personal and child-rearing competencies with special emphasis upon promoting language and cognitive development. Results of 1–4 year follow-ups indicate gains in cognitive development, mother-child interaction, and decreased aggressive behavior for boys. Recent 5–8 year follow-up teacher ratings reflect a continued pattern of improvement, this time for girls as well as boys (Johnson & Walker 1985). Notwithstanding

limitations of this and similar studies because of subject attrition (Jordan et al 1985), this pattern of results is encouraging in light of the costs and obstacles associated with such multifaceted interventions. Fifteen-year follow-ups of first generation programs such as Head Start now also reveal measurable effects on achievement and adjustment despite the erosion of initial IQ gains (Lazar & Darlington 1982, Consortium for Longitudinal Studies 1983).

Children of chronically disturbed parents represent a high risk group that has been the focus of considerable descriptive, longitudinal research (Barocas et al 1985), but few well-designed preventive interventions (Goodman 1984a). One exception is the Family Support Project (Lyons-Ruth et al 1984) which compared the effectiveness of professional and paraprofessional staff in delivering home-based comprehensive support services to multirisk families. Mothers of infants in the project had experienced psychiatric hospitalization (31%), major depression (47%), and/or spouse abuse (55%). Competence targets related to infant-mother interaction and attachment as well as infant developmental quotient. Preliminary analyses indicate that although both groups evidenced gains in attachment and IQ, the drop-out rate for the professional program was more than double (32% vs 14%) that of the paraprofessional program. This finding is consistent with a substantial body of literature supporting the equivalence (or superiority) of paraprofessionals vs professionals for a wide variety of helping roles (Hattie et al 1984).

A related project still underway (Goodman 1984b) uses a competence building approach emphasizing social problem-solving and reality testing with severely disturbed inner city mothers. Impressive in terms of the number of intervention components included, this project illustrates the trade-offs involved in multifactorial "total push" (Rolf 1985) interventions, e.g. maximizing ecological validity and reach makes it difficult to isolate the most critical treatment component(s). Lack of such information may critically restrict the potential for generalizing program benefits to less well resourced settings.

Conducting and evaluating programs for children and families of divorce has been a productive primary prevention arena in recent years. Incidence statistics combined with an enormous body of findings documenting its short and longer term adverse effects for many (Wallerstein 1983) suggest that divorce is part of the fabric of American life that envelops us all directly or indirectly. Training designed for couples prior to or shortly after marriage to prevent break-up by enhancing problem solving and communication skills is a clear example of primary prevention strategy. Cognitive behavioral relationship enhancement programs which teach specific communication skills (e.g. expressive, empathic, discussion/negotiation, problem/conflict resolution, etc) via highly structured videotape and modeling based exercises, hold much potential in this area (Giblin et al 1985, Guerney 1987, Markman et al 1986).

Two problems associated with such interventions, however, are the low levels of motivation to enter and complete such training during early ("honeymoon") stages of the relationship life cycle plus the need for long-term follow-up. Increased use of court-ordered mediation provides an opportunity for preventionists at another stage of the marriage/divorce process. Slaikeu & Culler (1986) describe a pilot coding system developed to discriminate between successful and unsuccessful mediation strategies.

By far the most promising divorce interventions have been with parents and/or their children subsequent to separation or the filing of a formal court petition. Bloom et al (1985) report a 30 and 48 month follow-up of their 6 month intervention with recently separated adults, designed to promote competence and provide social support in five areas found to correlate with postdivorce adjustment. Significant self-reported adjustment benefits were obtained as long as four years later. A somewhat similar program conducted by Warren and her associates (1984) included direct assessment of child benefits and a more comprehensive initial screening and recruitment of subjects through the use of family court records. Efforts of those investigators made to assess systematically parent-child interactions were unique among divorce interventions reviewed. Postprogram adjustment gains for both children and parents which disappeared at one year follow-up highlight both the advisability of longer term evaluations and the need to strengthen skill-building technologies utilized.

Rarely, it seems, are programs replicated and refined by cross-setting collaboration among investigators. One notable exception is the school-based Divorce Adjustment Project (DAP). Stolberg & Garrison (1985) used a quasi-experimental design to compare the differential impact of: (*a*) a 12-session structured children's support group for 7–13 year olds, (*b*) a single parents' group, (*c*) their combination, and (*d*) a no-treatment control group. Children in the support group alone condition improved in self-concept, but made only limited other adjustment gains, whereas the parent group alone forestalled the adjustment deterioration found in the other groups at post-testing. The absence of positive outcomes for the combined groups is attributed to matching problems, illustrating one unfortunate consequence of non-random assignment in this type of research design.

The Children of Divorce Intervention Program (CODIP) is a 10-week small group intervention for 9–12 year olds which, while dropping the parent group, added an affective component to the DAP and strengthened its skill-building units (Pedro-Carroll & Cowen 1985). Converging evidence of program benefits were derived from improved parent, teacher, and child ratings of various adjustment indices. These initial positive results were further enhanced by confirmatory findings from a replication study (Pedro-Carroll et al 1986). As the authors point out, however, parents had been separated for two and four

years respectively in these studies. Moreover, children in the second study were functioning initially significantly less well than a matched control group from intact families. Whether CODIP or any other model is properly seen as primary or secondary prevention thus depends in part upon the length of time between onset of the stress and program entry.

In a very different arena, Muñoz et al's (1982) skill-building approach to preventing depression in the general population via a two-week television mini-series and a structured eight-session course with medical outpatients (Muñoz 1987) is important both in terms of substantive findings and research design issues posed. Postintervention surveys of television viewers indicated no reduction in depression among the general population, but significant reduction was reported (secondary preventive) among symptomatic subjects. Muñoz argues that to demonstrate preventive outcomes requires not only that the incidence of the targeted disorder be above certain thresholds, but that risk groups, and even higher risk subgroups, be identified using documented markers. By so doing the intervention is effectively pushed closer to the borderline point on the primary/secondary prevention continuum. To maximize generalizability of program findings Muñoz cautions us to specify more clearly the potential pool from which our randomized samples are drawn and points to inconsistencies with which this is currently done.

For a society that considers itself child-oriented, our inability to contain and ultimately eliminate child abuse is a particularly wrenching concern. Rosenberg & Reppucci (1985) describe competence-building prevention efforts in this area, the most comprehensive of which (Olds 1984) appears promising. Arguably the most unique competence-oriented approach uncovered is reflected by the work of Illusion Theater, a theatrical company in Minneapolis, to educate children about sexual abuse (Harvey 1985). Plays and other outreach efforts teach children the difference between good and bad touching and model specific behavioral strategies for dealing with various abuse situations. Whether this unusual approach alone or in combination with other intervention components can reduce the 25–34% incidence of child victimization (Swift 1987) is as yet unknown. Attempts by social and community researchers to participate collaboratively in such natural experiments would provide the empirical data needed to strengthen program practices over time and possibly secure more stable funding.

Social problem-solving training represents a competence building approach which has been systematically evaluated and adapted to a wide variety of target groups and settings. Beginning with the seminal studies of Spivack & Shure (1974) at Hahnemann in the early 1970s, more than 50 child- and adolescent-focused interventions have been conducted based upon the premise that social-cognitive problem solving skills mediate adjustment (Weissberg 1985). Results from the Hahnemann group's early studies with inner-city

preschoolers demonstrated that: (*a*) A relationship existed between certain cognitive problem-solving skills and teacher-rated adjustment; (*b*) these problem-solving skills could be taught by teachers and mothers, and their acquisition would improve children's adjustment; and (*c*) program benefits are retained up to two years (Shure & Spivack 1982). While numerous studies report relationships between SPS skills and adjustment (Richard & Dodge 1982, Rubin et al 1984), Durlak's recent review (1983) cites failed intervention replications and concludes on a discouraging note.

The current status of this competence-building approach is neither as negative as Durlak suggests nor as positive as might have been hoped for based upon earlier reports. At least two successful (Mannarino et al 1982, Feis & Simons 1985), and one unsuccessful replication (Sharp 1981) of Shure and Spivack's intervention were published in this last review cycle. Additionally, results from recent meta-analyses (Denham & Almeida 1987) support a link between social problem-solving and adjustment, provide evidence of observation-based problem-solving skill gains, and significant but less strong evidence of teacher-rated adjustment benefits. It has been hypothesized that adjustment gain depends in part upon the extent to which problem-solving interventions and activities are incorporated by teachers into the ongoing classroom routine (Shure 1985).

Recent efforts to modify and extend SPS training to 7–12 year old children have led to significant problem-solving and adjustment improvement (Weissberg et al 1981, Gesten et al 1982). Producing benefits for older children has required a more intensified program with: (*a*) greater emphasis upon *behavioral* and *affective* as well as *cognitive* problem-solving components, and (*b*) more explicit attention given to issues of generalization. Results from one, two, and three-year follow-up studies indicated that some, but not all, program benefits were retained. Moreover, pre to postprogram SPS skill acquisition was significantly correlated with pre to follow-up improvements in 5 of 13 blind teacher and peer adjustment ratings (Liebenstein 1981).

Consistent with Durlak's advocacy of task specific rather than generic problem-solving training, Elias and his associates (1986) have embarked on a large-scale effort to prepare preadolescents for the transition to middle school. The *"Improving Social Awareness" (ISA)* project is a classroom-based two year curriculum with an instructional phase followed by a creative application phase designed to integrate problem solving into the broader school curriculum and facilitate generalization. Attention given to the impact of broader system and school climate variables, plus precautions taken to insure the fidelity of replication, add special interest to reports emanating from this ongoing project.

Further developments necessary to clarify findings in this area include: (*a*) improvements in the psychometric qualities of SPS measures; (*b*) integration

of social skills and problem-solving training models; (*c*) expansion of a narrow competence-building approach to include intervention at the school or systems level; (*d*) efforts to understand prior implementation failures, including delineation and evaluation of any required "informal" training activities; and (*e*) work in progress to conduct training on a larger scale basis and to place problem solving in the context of a more comprehensive competence and coping model of adjustment (G. Spivack, personal communication).

A wide variety of preventively oriented competence building technologies are now available. Future efforts will be strengthened by clear specification of training activities (and costs), as well as examination of the extent to which specific program components and acquired competencies relate to measured adjustment gain. Assessing outcomes in terms of well-being or positive affect as well as reduction in psychopathology also merit consideration in light of the nonclinical nature of participants, and partial independence of these adjustment dimensions.

SOCIAL SUPPORT

The largest body of research reviewed for this chapter was related to social support. A staggering 450 studies have been published in psychology alone in the two years since "Social Support Networks" was entered as an index term in *Psychological Abstracts* (Brownell & Shumaker 1984a). Enthusiasm for the construct over the past two decades derives researchwise from its presumed relationship to life stress and adjustment (Bloom 1985), the activities of informal caregivers (Gottlieb 1983), and communitywise, from a growing sense of isolation associated in part with fragmentation of the family. The enormity of the social support literature base, spread across multiple journals representing diverse disciplines, makes it possible for unwary readers to reach contradictory conclusions, depending on the specific materials reviewed.

The manner in which social support affects functioning has important implications for designing preventive SCIs. Evidence for direct effects encourages the development of programs for entire (normal) populations; by contrast, confirmation of the "buffering hypothesis" (i.e. that social support serves a health protective function only under stressful conditions) would make groups at risk more appropriate, impactful targets. In fact, evidence in support of both positions has been reported (Mitchell et al 1982), with the percentage of variance in psychological functioning accounted for by social support ranging from 2–17% (Rook 1984b). These contradictory findings appear to result from both methodological issues and variations in how social support is measured and conceptualized. Nonetheless, with the publication of several recent edited books (Cohen & Syme 1985, Sarason & Sarason 1985),

review articles and chapters (Cohen & Wills 1985, Kessler et al 1985), and special journal issues (Brownell & Shumaker 1984b, Shumaker & Brownell 1985, Heller 1986) a more coherent, albeit complex, understanding of social support is beginning to emerge.

Efforts to measure social support have been hampered by disagreements about how the construct is best conceptualized. Recent taxonomies have been distinctly multidimensional, embracing a variety of potentially useful interpersonal resources that can be shared (Gottlieb 1987), including four common support contents or functions: emotional, instrumental, information, and appraisal or feedback (House 1981). Tardy (1985) reviewed the underlying conceptualizations of support and the psychometric properties of eight frequently utilized measures. Although each has unique strengths and weaknesses, no single questionnaire, with acceptable reliability and validity, measures all or even most of the key support components associated with positive health outcomes.

Whereas some measures, e.g. the Inventory of Socially Supportive Behaviors (ISSB) (Stokes & Wilson 1984), assess supportive *behaviors,* others focus on *qualitative* dimensions such as perception (Procidano & Heller 1983, Oritt et al 1985, Vaux et al 1986) or satisfaction with support (Sandler & Barrera 1984), and still others stress *structural* characteristics of the social network (Wellman 1981). Some of the strongest stress-buffering findings, as for example among highly stressed caregivers of Alzheimer's victims (Fiore et al 1986), have been associated with qualitative or subjective measures of support. Support like beauty appears to reside in the eyes of the beholder. Moreover, that subjective view does not correlate perfectly with support assessed by objective methods. Shinn et al (1984) consider problems associated with structural measures that ignore the quality of interactions (e.g. network size, density). Studies of elderly widows (Rook 1984a,b) and adult cancer patients (Dunkel-Schetter 1984) indicate that members of one's intimate network may, not surprisingly, be a source of stress and thus contribute to negative as well as positive outcomes.

Cohen & Wills' (1985) detailed, well-integrated review concludes that one's concept of social support is an important determinant of the type of support effects obtained. Whereas evidence favoring a buffering model is found when support is measured qualitatively from the perspective of the recipient, when structural measures of support are used, the evidence is better explained by the main effect model. Although being part of a social network may be beneficial generally, it is not necessarily helpful in the face of stress except under certain conditions. The preceding pattern of results has been fairly consistent even in the face of such methodological problems as: heavy reliance upon cross-sectional vs longitudinal designs; confounds among measures of stress, support, and psychopathology; and differences in how in-

teractions are computed (Dohrenwend et al 1984, Cohen & Wills 1985, Depue & Monroe 1986).

Whether social support is seen as an environmental or individual variable has important implications for intervention (Rook & Dooley 1985). Conceptualized as a resource outside the individual, support can be increased by promoting group membership and other vehicles for meaningful social interaction. Such an approach has been used with adolescent mothers, among other target groups, with positive outcomes in several adjustment domains (Henninger & Nelson 1984, Unger & Wandersman 1985a). Felner et al (1982) increased social support among adolescents entering high school using a system intervention that: (*a*) changed roles of selected school personnel, and (*b*) modified the social ecology of the environment. The adjustment and school performance benefits reported by those authors are particularly impressive in light of the inherent simplicity and cost-effectiveness of the intervention. Wright & Cowen (1985) attempted to promote cooperative social interactions in 5th grade classrooms using a peer teaching or jigsaw technique. Improvements in classroom climate, teacher-rated adjustment, and academic performance were reported, but not in self-esteem or sociometric status.

Roskin (1982), also conceptualizing social support as primarily a environmental variable, described a support program for adults who had experienced multiple life crises. Interestingly, in addition to overall group benefits, those who had experienced the death of a family member or close friend improved most. Those findings highlight the need to consider characteristics of the context (Bowers & Gesten 1986) in which support interventions are designed in order to maximize person-environment fit (Shinn et al 1984). Cohen & McKay (1984) go even further in hypothesizing that persons under stress can best be helped by providing stressor-specific supportive resources.

Recognizing the active role that people play in the perception and construction of their social environment in general, and in their supportive interactions specifically, helps identify alternative intervention strategies. Rather than providing support directly by modifying the environmental surround, groups can be trained by using the types of social competence building approaches mentioned earlier, among others (Danish et al 1983), to construct their own support system.

Two pilot support interventions are of special interest paradigmatically because of their unique methodologies. Guerney (1985) describes the "Phone Friend Child Helpline" designed to serve varied support functions for children under 13 responsible for their own care after school—a critical social problem. Thirty to forty calls were received weekly; 44% of the callers reported feelings of loneliness or boredom. Unfortunately, difficulties in evaluating this potentially useful service limit the consumer feedback and effectiveness data needed for program dissemination.

"Friends Can Be Good Medicine" (Taylor et al 1984) is a multimedia mental health promotion campaign conducted statewide in California in 1982. The program's main goals were (*a*) to educate people about the links between supportive personal relationships and lowered rates of both disease and psychopathology, and (*b*) to encourage the development of supportive ties. Millions were exposed to the basic message and thousands to the 1300 specific "Friends" activities generated. Those who participated in a program activity or read program literature reported greater gains in knowledge, attitudes, and socializing intentions than controls which were maintained at one year follow-up. Efforts like this to make use of the mass media in preventive programming would benefit from incorporation of validated procedures to translate heightened community awareness into meaningful behavior change. The highly structured follow-up interventions used in the Stanford Heart Disease Project provide a useful model for this process (Farquhar et al 1985).

As the "Friends" project well illustrates, many preventive interventions combine both social support and competence building components. Evaluations which tease apart their separate and interactive contributions would be helpful. The provision and receipt of social support is a dynamic, interactive process whose health protective impact is mediated by context and source of assistance, as well as the conceptual stance and measurement strategy used. More complex research design and assessment strategies will be required to disaggregate these effects in the next generation of support-based SCIs.

EMPOWERMENT

Empowerment theorists view most mental health interventions as typically utilizing "top-down" approaches in which persons with specialized training provide "expert" help to those less fortunate, seen variously as patients, clients, or subjects. This model, described as paternalistic (Swift 1984), often fails to acknowledge the unique strengths and diversities of persons and communities we seek to help. Proponents of this new movement argue that empowerment strategies that enhance justice and peoples' sense of control over their own destinies are preferable to prevention or treatment approaches to strengthen individuals (Rappaport 1981). Moreover, by understanding how persons and groups solve their problems and meet their needs naturally, it is argued we will be in a far better position to leverage our own helping potential.

The imagery of empowerment implies a more symmetrical relationship or alliance with those with whom we work than has traditionally been the case. In this context, the credit that professionals take for outcomes is deemphasized as we explicitly acknowledge and foster a sense of competence and control (i.e. empowerment) among others. According to Rappaport

(1985a), who has written eloquently and provocatively on the topic, empowerment may or may not turn out to prevent diagnosable mental illness and should not be evaluated solely on that basis. The empowerment view is based on a somewhat different set of values about optimal actions and interventions for SCIs, and indeed about appropriate criteria for evaluating their efficacy.

A concept as new and in some ways as difficult to define as empowerment can best be understood in terms of specific research and program exemplars. One of the best recent resources is the *Studies in Empowerment* special journal issue (Rappaport et al 1984), which includes eight diverse descriptive, theoretical, and intervention efforts based on the concept of empowerment. As a whole this collection should encourage those who believe that complex problems cannot be ignored simply because they don't easily fit our standard designs. Authors in this series of articles used varied research strategies, e.g. participant observation, including some from anthropology and other disciplines. Maton & Rappaport (1984) identified the correlates of empowerment in a religious setting while Fawcett et al (1984) described seven separate studies of empowerment technologies used to assist diverse community groups, e.g. welfare families and community boards, to gain better control of their lives. In each of the latter cases behavioral principles were employed in the design, conduct, and evaluation of individual interventions. One of the most unique empowerment interventions reviewed was reported by Glidewell (1986), who in a five-year program trained members of a community in negotiation skills. Among the observed program outcomes were increased influence attempts in school board meetings and higher self esteem.

Roberts & Thorsheim (1986) report a longitudinal effort, the "Bottled Pain Project," combining social support and empowerment technologies to prevent alcohol abuse. Nearly 10,000 people participated as 24 Lutheran congregations were randomly assigned to receive alcohol abuse information, information plus social support oriented activities, or to a no-treatment control condition. The empowerment component derived from multiple strategies was used to develop program resources and ownership from within each congregation. The authors assumed a consultative role helping leadership teams in each setting generate program activities and involvement among congregates. Alcohol abuse and emotional distress decreased for both treatment groups compared to controls. The fact that increased social support from family members was associated with positive outcomes, whereas increased support from friends had the opposite effect, highlights the importance of unpacking the social support construct. These at first puzzling findings became much clearer as a consequence of formal post hoc interviews with congregates "at risk" which revealed strong associations among stress, help-seeking, friends who *themselves* drink heavily, and alcohol use. Such

followup discussion with participants in our interventions has much to commend it.

While the goal of empowerment is ambitious, results from initial studies in this arena are encouraging. For the moment, however, it is too early to tell whether the impact of the empowerment thrust will be the development of methodologically distinctive interventions, or instead a conceptual framework and set of process guidelines that can inform a wide variety of SCIs. Further elaboration of the empowerment construct will also benefit from agreement on the specific variables or classes of variables used to assess outcomes.

MUTUAL HELP

One of the most potentially impactful clusters of SCIs has developed largely independently of professional input. The mutual help movement has grown enormously over the past decade to include over 500,000 groups and 15 million people (Riessman 1985). A National Self-Help Clearinghouse and many others operating at the state and local levels offer information about available support groups and networks and, in some cases, provide training for indigenous leaders. Interest in such groups derives from the potential benefits to members as well as society's unwillingness in the economic and political climate of the 1980s to finance major new mental health initiatives. In the face of this growing "revolution" (Gartner & Riessman 1984; Riessman 1985), questions have been raised about both the efficacy of mutual help and the proper role for community researchers regarding such organizations.

Whereas social support interventions are conceived and run primarily by professionals, most mutual help groups are autonomous or represent a hybrid of professional and grass roots collaboration (Powell 1985). Attempts to evaluate outcomes associated with "pure" mutual help organizations have yielded generally positive results. Illustratively, parents confronted with the early death of a child who participated in a Compassionate Friends group exhibited less depression than those who did not (Videka-Sherman 1982a). Similarly, scoliosis peer support group membership yielded several positive psychosocial outcomes for the most severely disabled adults (Hinrichsen et al 1985). The absence of positive results for adolescent group members however, reinforces the need to be sensitive to person-by-environment interactions and avoid the assumption that participation will have uniformly positive results. The potential benefits to be derived from mutual help may be negated by the threat such groups pose for adolescents who seek a sense of identity and approval from their non-scoliotic peer group.

In those instances where professionals play a more active role in group design, leadership training, and/or assist in the running of groups, the research design may improve, although questions can be raised concerning whether such groups truly represent self-help (Powell 1985). One such issue

relates to whether random assignment is equivalent to voluntary association and, if not, what implications this may have for results obtained. Such questions notwithstanding, Edmunson et al (1984) assigned recently discharged patients to a professionally supported mutual aid network featuring a wide variety of social and recreational activities in which emotional and instrumental support were exchanged. At ten month follow-up network members as opposed to controls required 50% fewer rehospitalizations, a one-third shorter average length of stay, and were half as likely to have required professional help. George & Gwyther (1985), working in a more preventive mode with at-risk caregivers for memory-impaired elderly, report similar results. In this case, group membership was associated with greater knowledge of Alzheimer's disease and more importantly, less loneliness.

Mutual help groups embody the themes of empowerment both in terms of process and goals. For this and other reasons, Rappaport (1985a) advocates that community researchers serve and build a constituency among the membership of these organizations. Future efforts to achieve that goal may be informed by the outcome of longitudinal collaboration underway between GROW, a mutual help organization for former mental patients, and researchers at the University of Illinois (Rappaport et al 1985). With the active cooperation of GROW leaders and members, a comprehensive research design is being used to examine process and outcome variables relating to social ties, symptoms, and competencies, as well as organizational development and dissemination issues. Participant observers using a continuous coding procedure during group sessions are collecting unique information not previously available about the basic nature of these groups and interactions among members. Preliminary analyses indicate that high percentages of helping behavior occur in groups consistent with GROW ideology. As Riessman's helper-therapy principle (1965) predicts, it is hypothesized that relationships will be found between help giving and positive outcomes. Evidence from groups as diverse as Weight Management (Wallston et al 1983) and Compassionate Friends (Videka-Sherman 1982b), indicate that more active members who both give as well as receive help achieve the best outcomes. This finding holds important implications for the design of a wide range of helping interventions.

The emerging strength and scope of the mutual help movement poses both an opportunity and a dilemma for the community researcher. Effective alliance with such grassroots efforts may strengthen their impact and broaden the base of support for mental health services. To do so requires an uncommon sharing of control and degree of collaboration. Also needed are research designs that respect the voluntaristic essence of the phenomenon being studied. Tampering in the name of training may also diminish the spontaneity and intimacy critical to such groups' functioning. Finally, pro-

fessional support for mutual help may have the unintended consequences of accelerating governmental cutbacks in mental health budgets (Pilisuk & Minkler 1985) and providing an excuse for "blaming the victim" (Ryan 1971).

BEHAVIORAL COMMUNITY PSYCHOLOGY

The term "behavioral community psychology" refers to the combination of the methodology of behaviorism— its utilization of objective, reliable measures and its careful investigation of functional relationships—with the conceptual framework and goals of community psychology (Jason & Glenwick 1984). Although some behavioral community interventions have targeted mental health outcomes (Klingman 1985), most seek to modify a wide range of personal and interpersonal behaviors whose connections to mental health are neither spelled out nor obviously relevant (e.g. increasing blood donations, Ferrari et al 1986; promoting recycling, Jacobs et al 1984). Behavioral community interventions include some of the best large-scale behavior change efforts (Greene & Neistat 1983) directed at community-level problems (e.g. increasing inoculation rates among preschoolers, Yokley & Glenwick 1984).

One serious problem with important mental health implications facing our planet is that more than a half billion people don't have adequate food. Reductions in the world population as well as more equitable and efficient distribution of food supplies are needed to resolve this issue (Willems & McIntire 1982). Limited efforts toward those goals by behavioral community psychologists have been directed at alleviating malnutrition. Guthrie et al (1982) rewarded Philippine mothers with lottery tickets for engaging in a variety of steps designed to insure adequate weight gain in their infants (e.g. supplementing breast milk adequately, planting green leafy vegetables near their home, etc). Although the program reduced the percent of malnourished infants, reactions among mothers were mixed because some had acquired many coupons but won nothing, whereas others had earned only a few coupons and won major prizes. Thus, an unintended but unfortunate consequence of this ingenious study was that the lottery actually reinforced learned helplessness in many mothers. When this procedure was replaced with a trading stamp approach, mothers' participation and enthusiasm increased.

Shortages in petroleum and energy supplies is another nonmental health problem that behavioral community psychologists have addressed imaginatively (Winkler & Winett 1982). Pavlovich & Greene (1984), for example, successfully trained boy scouts in step-by-step procedures for weatherizing homes. At the community level, Winett et al (1985) showed families a 20-minute home-based energy conservation television program that

led to an 11% reduction in energy use. Shippee & Gregory (1982) gave small commercial-industrial firms newspaper publicity for participating in an energy conservation program; that feedback led to moderate reductions in natural gas usage.

Another area receiving increasing attention among behavioral community investigators is accidents, the number one cause of child morbidity and mortality in the United States (Rivara 1985, National Center for Health Statistics 1985). Examples of this work include Peterson & Mori's (1985) use of paraprofessional volunteers to train children in diverse safety responses (e.g. responding to fires, serious cuts, etc), and Tertinger et al's (1984) use of parent instructions, feedback, and demonstrations to decrease home hazards. Other behavioral community research teams have documented ways of reducing highway accidents, motivated by the shocking statistic that 2¼ million people are injured or killed in motor vehicle accidents each year. Thus, Van Houten & Nau (1983) found that the combination of signs (feedback), warning tickets, and informational feedback markedly reduced vehicular speeding (Van Houten et al 1985). Geller and colleagues have been effective in increasing the percentage of drivers wearing seat belts by using lottery tickets as reinforcers (Geller 1984, Rudd & Geller 1985) while Roberts & Turner (1986) increased use of safety restraints with children at day care centers. Geller's suggestion that buckle-up programs must be reintroduced intermittently over long time periods to produce enduring behavior change has been supported by data from Jonah & Grant (1985). Assessing the impact of higher order interventions (e.g. legislation) to improve child safety restraints is another effective strategy used by behavioral community psychologists (Fawcett et al 1986).

Other large-scale behavioral community interventions include Stunkard et al's (1985) and Elder et al's (1986) community-wide projects to reduce cardiovascular risk factors (hypertension, smoking, nutrition). Both projects attempted to maximize public participation by offering inexpensive behavioral technologies couched in local terms and modeled by key community members (Elder et al 1985). Jason et al (1986) distributed 50,000 behavioral self-help manuals concurrent with a 20-day behavioral smoking cessation program televised on the evening news of a major network-affiliated station. Adding biweekly support groups at worksites to accompany the media campaign doubled smoking quit rates of participants (41% vs 21%).

The behavioral community interventions reviewed have provided investigators a methodology for analyzing environments and evaluating program outcomes systematically (Glenwick & Jason 1980). It remains unclear, however, whether these programs can provide a more "ecologically" valid view of human behavior, i.e. one that studies environment-behavior relations over extended time periods, analyzes simultaneously sources of reinforce-

ment, and recognizes that contingency control may not always be a productive way to view the influence of environment on behavior (Epling & Pierce 1983). Nor is it yet clear whether local-level agencies can effectively manage such programs or whether they can be widely disseminated (Kazdin 1980, Backer et al 1986). Interventions that are less expensive to maintain and less demanding of peoples' time have greater likelihood of being accepted and adopted. Unfortunately, at this time few behavioral community projects involve laypersons in program design or implementation; such involvements can lead to a stronger sense of "ownership" and thus more enduring changes (Jason & Glenwick 1984). Consultation with relevant policymakers in designing intervention techniques can also increase the application of research findings.

Behavioral community programs must consider carefully what values underlie an intervention. Failure to do so, as in the Guthrie et al (1982) study (cf above), may inadvertently damage the resiliency and coping of the target population (Fodor 1983). Put another way, the norms and traditions of the community and family must be considered carefully in planning behavioral community interventions; programs that undermine those values can produce long-term detrimental effects including loss of meaning, isolation, and alienation (Woolfolk & Richardson 1984).

Behavioral community psychologists as suggested in several prior program citations frequently target interventions toward lifestyle change. Many such behavioral patterns (e.g. smoking, alcohol and drug use, lack of exercise, accidents) now claim more lives in this country than infectious diseases (Lau et al 1980). Lifestyle factors now account for 43% of all deaths (Milsum 1980).

Increasingly health psychologists have also become interested in studying the social and psychological contributions to health and life-style patterns (Baum et al 1984, Rosen & Solomon 1985). Whereas behavioral community psychologists and health psychologists are both interested in life-style patterns, the former have been oriented more to prevention and large-scale interventions. Although health psychology has embraced several key concepts of community psychology (e.g. stress and coping, social support, and self-help), most of its programs and research are conducted within the framework of social and clinical psychology models, emphasizing individual differences and individual-level interventions (Albino 1983, Revenson 1985). It seems apparent, however, that a one-to-one treatment model will not be sufficient to improve the health of the general population let alone the health of undereducated, unemployed, and at-risk populations.

Some health-oriented psychologists have included prevention in an expanded conceptual framework at both the theoretical and intervention level. Space limitations permit only brief mention of several clusters of studies.

Interventions to prevent smoking and drug abuse, no less than delinquency prevention programs, must rely on more than the fear appeals used in many public health campaigns. The most effective approaches are embedded in an understanding of how, ecologically, target behaviors are acquired and maintained by people in general, particularly among high risk groups (Chassin & Presson 1985). Skill-building programs conducted without such information may be less than effective. Illustratively, teaching adolescents skills to refuse a drink or cigarette while at the same time not understanding that some adolescents seeking the approval of their peers may not wish to say "no" (Leventhal & Cleary 1980) can weaken an otherwise potent strategy.

With 1.1 million teenage pregnancies and over half a million births in the United States annually (National Center for Health Statistics 1983), leaders from all sectors, including minority communities, are searching for ways to prevent adolescent pregnancy. The psychological and health risk for many mothers and children in these circumstances are documented elsewhere (Chilman 1983). Successful recent efforts to modify contraceptive attitudes and behavior (Gerrard et al 1983) address one aspect of this national dilemma. A large-scale study by Hilton and her associates (1983), however, points to the important psychological and survival needs met in many cases by pregnancy, a recognition of which needs must form the foundation of any truly large-scale prevention effort in this arena. Moreover, as Levine (1985) points out, the nature of such programs belies the fact that the choice of which competencies (e.g. sex education, contraception, "saying no," etc) to promote both reflects and has implications for our values—in this case, that of privacy and our liberty to choose.

The downward trend for cardiovascular deaths in the United States since 1968 seems attributable to the American public engaging in preventive, health-protective practices. For example, from 1963 to 1975, butter consumption decreased 32%, animal fats and oils decreased by 57%, and cigarette consumption decreased by 22% (Arnold 1981). Most individuals who have initiated, completed, and maintained reductions in risk factors have done so on their own. Unfortunately, many health programs developed by psychologists have not succeeded in maintaining changes over long periods of time (Glasgow & Klesges 1985). Krantz et al (1985) posit two major obstacles in attempts by health psychologists to bring about lifestyle modification: (*a*) the fact that immediate rewards are more effective than delayed ones (i.e. the health threats posed by smoking are long-term whereas smoking frequently yields immediate gratification), and (*b*) that potent social and economic pressures strongly influence the adoption of unhealthy behaviors (e.g. peer pressure and advertisements that lead teenagers to smoke). Program effectiveness is also limited by the lack of knowledge about basic processes in health development and maintenance. For example, we do not know how such

factors as age or duration of poor health habits relate to intervention outcome (Leventhal et al 1985).

Regulatory means, such as citizen-initiated change efforts to get government to protect at-risk families from toxic chemical dumps (Hess & Wandersman 1985) and to motivate lawmakers to pass laws to eliminate the production of unsafe products and foods (Laskin & Pilot 1982), have much potential for promoting health (Mechanic 1985). Illustratively, based upon the elasticity of demand for cigarettes, a 10% increase in cigarette prices will lead to a 4% decrease in consumption (Warner & Murt 1985). A fourfold increase in the 1982 excise tax of $.08 per pack could decrease teenage consumption by more than 50% and adult consumption by 15%. Although such strategies are both intriguing and hold promise for comprehensive health promotion programs, they require roles for which psychologists are unprepared. Negotiating with community leaders and politicians, mobilizing support for legislative initiatives, and introducing data-based studies into the political arena represent a few of the new roles which might need to be considered.

While behavioral community psychologists have made considerable progress in understanding how lifestyle practices are learned and maintained, only rarely have they involved community groups and public officials in the design and conduct of their interventions. Such collaboration can make the next generation of these SCIs more sensitive to local values and norms, more likely to produce enduring behavioral gains, and more capable of supporting higher order change.

DIVERSE CULTURES AND GROUPS

The study of different cultures and minority groups offers unique perspectives for understanding how mores, norms, and values affect patterns of adjustment and adaptive and nonadaptive responses to life stressors. Unfortunately, such studies, particularly those of empirically based SCIs focusing on minorities or special groups, have been underrepresented in the literature. Loo et al's (1986) analysis of published research in the community psychology journals revealed only 5% of the articles focused exclusively on ethnic minorities while such groups represent 20% of the U.S. population. Lefley (1984) described a successful program to sensitize professionals to stressors, support systems, and copying styles of minorities. After trainees returned to their agencies, minority use of services increased and significant reductions occurred in overall dropout rates.

Procidano & Glenwick (1985) described *Unitas,* an innovative ongoing intervention combining peer support and a "mentoring" model. Older teenagers and adults served as surrogate parents or mentors for high risk inner-city Hispanic youngsters. Groups of 10–15 youth were formed around each older

mentor, creating a surrogate family providing nurturance, discipline, and a sense of belonging. Through regularly held meetings as well as informal interactions, "family" members discussed problems and generated alternatives. Program participation led to significant increases in social support satisfaction, an important finding in light of the high level of disorganization among the youngsters' natural families.

By the year 2030, people who are 65 or older will comprise 20% of the population; and approximately 86% of that age group, living in the community, will have one or more chronic diseases (Gatz 1985). Knight et al (1982) described an interdisciplinary effort to keep seniors from being institutionalized unnecessarily and to make mental health services more accessible to them. Consultation programs were established with agencies serving seniors, self-help groups were established, a minority task force for seniors was formed, and an additional bilingual staff person was hired. As a result of these comprehensive efforts, the percent of seniors seen in area outpatient clinics rose from 2% to 6.4%; simultaneously, the numbers of seniors in a local state hospital decreased.

Women in our society face unique social and psychological problems which need to be carefully analyzed in order to develop ecologically sound interventions. Rickel et al's (1984) recent volume describes a variety of empowering preventive and community strategies and interventions. As an example, Shure (1984) over a two-year period trained 40 black inner-city mothers in interpersonal problem-solving skills. The parents were able to improve problem-solving skills in their children in only three months, and improvements in behavior were observed by their teachers in school.

The articles reviewed sample only a few of the most promising SCI interventions increasingly being implemented with special populations. Other preventive interventions, reviewed in Gonzales et al (1983), indicate that barriers to working with such groups can be overcome. This is best accomplished when needs and interventions have been defined and articulated by the intended recipients of services.

RESEARCH

The design, implementation, evaluation, and dissemination of preventive SCIs often requires the use of flexible and nontraditional research designs. Price & Smith (1985) and Lorion (1983) present guides to many evaluation and design issues, the former including examples of a variety of quasi-experimental methods derived from the recent literature. Models being used include time series analyses (Steiner & Mark 1985), nonequivalent group designs, and social impact assessment (Meissen & Cipriani 1984) among others. Lawler et al (1985) challenge traditional research assumptions in their

book based upon a unique conference on research which meets both conventional standards of theoretical excellence and practitioner standards of usefulness. Susskind & Klein (1985) present alternative methods for studying community phenomena from both qualitative and quantitative perspectives.

While there has been a recent proliferation of prevention demonstration projects, most such community interventions are targeted to persons and groups (Cowen 1983) and largely neglect the community or context in which they are embedded. Innovative interventions are essentially grafted onto existing social structures with limited attention to issues of process sufficient to secure permission and cooperation with program conduct. As a result, these SCIs are "in" but not "of" the community. To paraphrase Elias (1987), such interventions may be efficacious to a degree, but are rarely durable or enduring.

In contrast, the theoretical writings and interventions of Kelly, Trickett, and their associates (Kelly 1986a–c, Trickett et al 1985) reflect a steadfast commitment to social systems and person-environment issues consistent with the ideals of the Swampscott conference (Bennett et al 1966). Borrowing the concept of ecology from biology with its focus upon complex interactions among interdependent "community" members and structures, they have sought to develop a new paradigm for community assessment and intervention. The ecological paradigm informs us *how* to analyze and "take the environment into account" (Trickett 1984) and also restructures the nature of the relationship between subject and researcher. In contrast to the positivist's emphasis on keeping subjects uninformed (and thus presumably unbiased), the alternative contextualist approach attempts to integrate objective and subjective views of the environment and behavior. Subjects to a real degree thus become collaborators in the research process (Chavis et al 1983).

Recent descriptions of the emergent ecological paradigm (Kelly 1986a) provide concrete illustrations of how its principles can be applied to strengthen current research areas via attention to the *process* of research and the manner in which setting or situation variables support or undermine program goals (Trickett 1984, Trickett et al 1985). Case examples of preventive consultation guided by this research model are provided in a special issue of *Prevention in Human Services* (Kelly 1986b). The contribution by Roberts & Thorsheim (1986) illustrates well how the requirements of science and an ecological approach to conceptualizing problems and structuring solutions can be combined.

In a quest for universal interventions, investigations have often neglected setting and person variables and their interaction (Rolf 1985). Illustratively, the Jordan et al (1985) study (cf above) found positive follow-up effects for boys but not girls. Anecdotal evidence suggests this may be due to teacher discomfort with girls' increased curiosity and demands for participation.

Moos's (1984) attempt to combine context and coping in a unified conceptual framework suggests strategies to minimize such tensions between person- and environment-centered approaches. Intervention assessments that go beyond an exclusive focus on person-centered competencies to include person-environment transactions, though complex, hold much potential for illuminating change processes in preventive interventions.

Outcome assessments based on meta-analysis appeared in the SCI literature for the first time during this review period. That there are now (arguably) enough preventive interventions to make use of this technology is at one level a positive sign. Illustratively, effect sizes for consultation—representative of those obtained in other areas, e.g. primary prevention (Baker et al 1984), secondary prevention (Stein & Polyson 1984), social problem-solving training (Denham & Almeida 1987), and couple/family enrichment (Giblin et al 1985)—indicate that consultees and clients showed improvement greater than 71% and 66% of untreated comparison groups (Medway & Updyke 1985). These findings, while not overwhelming, are positive and encouraging.

Unfortunately, the availability of these data has led to inevitable, and we think inappropriate, comparisons with effect sizes from psychotherapy outcome research (Smith et al 1980). The latter are in some cases 50% or more larger. Such comparisons overlook the facts that: 1. psychotherapy is older and more established than the field of social and community intervention, 2. clinical groups may by their very nature have more room for improvement, and 3. direct treatment might be expected to have more impact than that mediated by a third party (Medway & Updyke 1985).

The ecological paradigm holds much promise for the design of more durable interventions. Its underlying values are consonant with those of empowerment and mutual help methodologies. Future interventions undertaken in the ecological spirit should describe advantages as well as strategies for overcoming dilemmas or limitations posed by the intimate involvement of setting inhabitants in the design, conduct, and evaluation of SCIs.

PUBLIC POLICY

Kiesler (1985) estimated that 15–35% of the population needs mental health services at any one time. In addition, contrary to popular opinion, the rate of psychiatric hospitalizations has been increasing in a linear fashion for the last 15 years. Despite the intent of deinstitutionalization, more patients are now treated in institutions than ever before if one includes nursing homes, which presently house about 350,000 mental patients (Shadish 1984). Even though evidence indicates more favorable outcomes for alternative treatment in the community, 70% of funds for mental health care are still directed to hospital treatment (Kiesler 1982). Other stark mental health epidemiological data

reported by Zigler & Finn (1982) include these facts: 30% of children in the United States receive inadequate medical care; 2 out of 5 children are not immunized against childhood diseases, 500,000 children are adrift in the foster care system, 2000 children die yearly from abuse or neglect; and two million children age 7–13 come home after school to an empty home. Although 3.2 million children evidence major emotional problems, more than 90% will receive no treatment (Alpert 1985). Half of the seven million children with major learning problems will not receive any help.

Statistics such as these highlight the need for community psychologists to become involved at some level in public policy. The development of small effective pilot programs such as those reviewed in this chapter represents a first step, but one which is bound to prove inadequate if unaccompanied by efforts to accomplish change at a higher order system level. A special issue of the *American Journal of Community Psychology* devoted to training (Lorion & Stenmark 1984) includes several articles which examine historical reasons and current resistances to psychologist involvement in public policy matters. Levine (1981) argues convincingly for training psychologists with greater sophistication in the political process. Continuing to view ourselves as disinterested scientist-professionals *outside and apart from* the political and economic system will leave us ill prepared for the tasks of the future.

A look at that future can help social and community psychologists identify mental health related issues that are likely to soon require our attention. If the incidence and prevalence of mental health disorders is the same in 2005 as in 1980, the number of people with mental health disorders will increase from 33 million to 40 million (Kramer 1982). This extraordinary increase reflects the number of people who will be in age groups at high risk, as well as the prolonged duration of chronic diseases because of the successful application of techniques for lengthening the lives of affected individuals. Also forecast are increased numbers of dependent elderly, single-parent households, and households with a working mother. Sundberg (1985) suggests that a future involving high technology and high population density could produce information overload, increased unemployment, and a loss of privacy and autonomy. Future social and community interventions will need to deal with the mental health implications associated with these changes.

On a more positive note, the future might also be a time when traditions are rediscovered and revalued (Berkowitz 1982), when neighborhoods and neighboring take on new interest (Unger & Wandersman 1985b), and when new interactive communication modalities provide quicker access to emotional exchanges and a broader network of community participants (Turkat 1983). Such prospective trends also offer roles and opportunities for the design of SCIs.

Psychologists in the past have largely avoided participation in public policy matters. The concerns of the future may render such involvement on the

part of a significant subgroup far more essential. We seem nonetheless uncertain about how or whether to prepare for the attendant new roles.

FINAL THOUGHTS

There are at least two standards against which progress in the loosely organized "field" of social and community interventions can be viewed. Seen in relation to the limited reach and social impact of traditional mental health services, considerable progress has been made in the decade and a half since the first review of this area was undertaken (Cowen 1973). A wide variety of prevention program models, targeted to groups numbering at times into the thousands, now exist; these have demonstrated short, and in some cases longer term effectiveness.

Measured in relation to the full complexity and magnitude of social problems many SCIs seek to address, or the ambitious agenda established at Swampscott, progress has been understandably more modest. Creating or modifying social systems—indeed, simply evaluating the long-term impact of more limited interventions—requires longitudinal, programmatic commitment to settings and issues, plus levels of organization, both *intra* and *inter*disciplinary cooperation, and resources difficult to secure, particularly in the current economic and political era.

Needed for the next generation of SCIs are fewer individual and more collective efforts designed in concert with the groups and communities we seek to assist. Designing and conducting such programs with greater ecological sensitivity to issues of process and context will help insure that effective interventions endure after initial results have been published. We are encouraged by signs that some steps in this direction are being taken.

ACKNOWLEDGMENTS

The assistance provided by many colleagues who shared their work with us was much appreciated. We regret only that space limitations did not permit the inclusion of more material. We gratefully and warmly acknowledge constructive feedback received from Emory Cowen, Maurice Elias, Jim Kelly, George Spivack, David Stenmark, Steve Walfish, Roger Weissberg, and Richard Winett. This chapter is the better for their reviews. We also thank Nita Desai, our typist, and Lynda Scalf-McIver, who aided in the search for materials. Their patience, competence, and good humor helped enormously. Finally, we thank the Department of Psychology at the University of South Florida and De Paul University and the Florida Mental Health Institute through Hewitt B. ("Rusty") Clark for their support.

Literature Cited

Albino, J. 1983. Health psychology and primary prevention: National allies. See Felner et al 1983b, pp. 221–33

Alpert, J. L. 1985. Change within a profession: Change, future, prevention, and school psychology. *Am. Psychol.* 40:1112–1121

Altman, I. 1987. Community psychology 20 years later: Still another crisis in psychology? *Am. J. Community Psychol.* In press

Arnold, C. B. 1981. Clinical strategies for chronic disease prevention. In *Advances in Diseases Prevention*, ed. C. B. Arnold, L. H. Kuller, M. R. Greenlick, 1:1–28. New York: Springer. 306 pp.

Backer, T. E., Liberman, R. P., Kuehnel, T. G. 1986. Dissemination and adoption of innovative psychosocial interventions. *J. Consult. Clin. Psychol.* 54:111–18

Baker, S. B., Swisher, J. D., Nadenichek, P. E., Popowicz, C. L. 1984. Measured effects of primary prevention strategies. *Pers. Guid. J.* 62:459–63

Barocas, R., Seifer, R., Sameroff, A. J. 1985. Defining environmental risk: Multiple dimensions of psychological vulnerability. *Am. J. Community Psychol.* 13:433–47

Baum, A., Singer, J. E., Taylor, S. E., eds. 1984. *Handbook of Psychology and Health: Social Psychological Aspects of Health*, Vol. 24. Hillsdale, NJ: Erlbaum. 376 pp.

Bennett, C. C., Anderson, L. S., Cooper, S., Hassol, L., Klein, D. C., Rosenblum, G., eds. 1966. *Community Psychology: A Report of the Boston Conference on the Education of Psychologists for Community Mental Health*. Boston: Boston Univ. Press

Berkowitz, W. R. 1982. *Community Impact: Creating Grassroots Change in Hard Times*. Cambridge, MA: Schenkman. 297 pp.

Berrueta-Clement, J. R., Schweinhart, L. J., Barnett, M. W., Epstein, A. S., Weikart, D. P. 1984. *Changed Lives: The Effects of the Perry Preschool Program on Youths through Age 19*. Ypsilanti, MI: High/Scope Educ. Res. Found.

Bloom, B. L. 1984. Community mental health training. *Am. J. Community Psychol.* 12: 217–26

Bloom, B. 1985. *Primary prevention: An overview*. Presented at Ann. Meet. Am. Psychiatric Assoc., Dallas

Bloom, B. L. 1985. *Stressful life event theory and research: Implications for primary prevention*. DHHS Publ. (ADM) 85–1385. Washington, DC: GPO. 110 pp.

Bloom, B. L., Hodges, W. F., Kern, M. B., McFaddin, S. C. 1985. A prevention program for the newly separated: Final evaluations. *Am. J. Orthopsychiatry* 55:9–26

Bower, E. 1977. Mythologies, realities, and possibilities. In *Primary Prevention of Psychopathology*, Vol. 1: *The Issues*, ed. G. W. Albee, J. M. Joffe, pp. 18–41. Hanover, NH: Univ. Press New Engl.

Bowers, C. A., Gesten, E. L. 1986. Social support as a buffer of anxiety: An experimental analogue. *Am. J. Community Psychol.* 14:447–51

Brownell, A., Shumaker, S. A. 1984a. Social support: An introduction to a complex phenomenon. *J. Soc. Issues* 40:1–9

Brownell, A., Shumaker, S. A., eds. 1984b. Social support: New directions in theory, research, and intervention. Part I: Theory and research. *J. Soc. Issues* 40:1–144

Buckner, J. C., Trickett, E. J., Corse, S. J. 1985. *Primary prevention in mental health: An annotated bibliography*. DHHS Publ. (ADM) 85–1405. Washington, DC: GPO. 425 pp.

Chassin, L. A., Presson, C. C., Sherman, S. J. 1985. Stepping backward in order to step forward: An acquisition-oriented approach to primary prevention. *J. Consult. Clin. Psychol.* 53:612–22

Chavis, D. M., Stucky, P. E., Wandersman, A. 1983. Returning basic research to the community: A relationship between scientist and citizen. *Am. Psychol.* 38:424–34

Chilman, C. 1983. *Adolescent Sexuality in a Changing American Society*. New York: Wiley

Cohen, S., McKay, G. 1984. Social support, stress, and the buffering hypothesis: A theoretical analysis. See Baum et al 1984, pp. 253–67

Cohen, S., Syme, L., eds. 1985. *Social Support and Health*. New York: Academic. 390 pp.

Cohen, S., Wills, T. A. 1985. Stress, social support, and the buffering hypothesis. *Psychol. Bull.* 98:310–57

Consortium for Longitudinal Studies. 1983. *As the Twig is Bent: Lasting Effects of Preschool Programs*. Hillsdale, NJ: Erlbaum

Cowen, E. L. 1973. Social and community interventions. *Ann. Rev. Psychol.* 24:423–72

Cowen, E. L., ed. 1982. Special issue: Research in primary prevention in mental health. *Am. J. Community Psychol.* 10:239–367

Cowen, E. L. 1983. Primary prevention in mental health: Past, present, and future. See Felner et al 1983b, pp. 11–30

Cowen, E. L. 1985. Person-centered approaches to primary prevention in mental health: Situation-focused and competence enhancement. *Am. J. Community Psychol.* 13:31–48

Danish, S. J., Galambos, N. L., Laquatra, I. 1983. Life development intervention: Skill training for personal competence. See Felner et al 1983b, pp. 49–61

Denham, S. A., Almeida, M. C. 1987. Children's social problem-solving skills, behavioral adjustment, and interventions: A meta-analysis evaluating theory and practice. *J. Appl. Dev. Psychol.* In press

Depue, R. A., Monroe, S. M. 1986. Conceptualization and measurement of human disorder in life stress research: The problem of chronic disturbance. *Psychol. Bull.* 99: 36–51

Dohrenwend, B. S. 1978. Social stress and community psychology. *Am. J. Community Psychol.* 6:1–15

Dohrenwend, B. S., Dohrenwend, B. P., Dodson, M., Shrout, P. E. 1984. Symptoms, hassles, social supports, and life events: Problem of confounded measures. *J. Abnorm. Psychol.* 93:222–30

Dunkel-Schetter, C. 1984. Social support and cancer. Findings based on patient interviews and their implications. *J. Soc. Issues* 40:77–98

Durlak, J. A. 1983. Social problem-solving as a primary prevention strategy. See Felner et al 1983b, pp. 31–48

Edelstein, B. A., Michelson, L., eds. 1986. *Handbook of Prevention.* New York: Plenum. 383 pp.

Edmunson, E., Bedell, J. R., Gordon, R. 1984. See Gartner & Riessman 1984, pp. 195–204

Elder, J. P., Howell, M. F., Lasater, T. M., Wells, B. L., Carleton, R. A. 1985. Applications of behavior modification to community health education: The case of heart disease prevention. *Health Educ. Q.* 12: 151–68

Elder, J. P., McGraw, S. A., Abrams, D. B., Ferreira, A., Lasater, T. M., et al. 1986. Organizational and community approaches to community-wide prevention of heart disease: the first two years of the Pawtucket heart health program. *Prev. Med.* 15:107–17

Elias, M. 1987. Considerations in establishing durable, efficacious prevention programs. *Am. J. Community Psychol.* In press

Elias, M. J., Gara, M., Ubriaco, M., Rothbaum, P. A., Clabby, J. F., Schuyler, T. 1986. Impact of a preventive social problem solving intervention on children's coping with middle-school stressors. *Am. J. Community Psychol.* 14:259–76

Epling, W. F., Pierce, W. D. 1983. Applied behavior analysis: New directions from the laboratory. *Behav. Anal.* 6:27–37

Farquhar, J. W., Fortman, S. P., Maccoby, N. et al 1985. The Stanford five-city project: Design and methods. *Am. J. Epidemiol.* 63:171–82

Fawcett, S. B., Seekins, T., Cohen, S., Elder, J., Jason, L. A., et al. 1986. *Child passenger legislation evaluation project.* Unpublished

Fawcett, S. B., Seekins, T., Whang, P. L., Muiu, C., Suarez de Balcazar, Y. 1984. Creating and using social technologies for community empowerment. See Rappaport et al 1984, pp. 145–71

Feis, C. L., Simons, C. 1985. Training preschool children in interpersonal cognitive problem-solving skills: A replication. *Prev. Hum. Serv.* 4:59–70

Felner, R. D. 1985. Prevention. *Community Psychol.* 19:30–34

Felner, R. D., Farber, S. S., Primavera, J. 1983a. Transition and stressful events: A model for primary prevention. See Felner et al 1983b, pp. 199–215

Felner, R. D., Ginter, M., Primavera, J. 1982. Primary prevention during school transitions: Social support and environmental structure. *Am. J. Community Psychol.* 10:277–90

Felner, R. D., Jason, L. A., Moritsugu, J. N., Farber, S. S. 1983b. *Preventive Psychology: Theory, Research and Practice.* New York: Pergamon. 341 pp.

Ferrari, J. R., Barone, R. C., Jason, L. A., Rose, T. 1986. The use of incentives to increase blood donations. *J. Soc. Psychol.* 125:791–93

Fiore, J., Coppel, D. B., Becker, J., Cox, G. B. 1986. Social support as a multifaceted concept: Examination of important dimensions for adjustment. *Am. J. Community Psychol.* 14:93–111

Fodor, I. E. 1983. Behavior therapy for the overweight woman: A time for reappraisal. See Rosenbaum et al 1983, pp. 378–94

Gartner, A., Riessman, F., eds. 1984. *The Self-Help Revolution.* New York: Hum. Sci. Press. 266 pp.

Gatz, M. 1985. *Prevention and aging: Community programs.* Presented at the NMHA commission on the prevention of mental and emotional disability. Alexandria, VA

Geller, E. S. 1984. A delayed reward strategy for large-scale motivation of safety belt use: A test of long-term impact. *Accident Anal. Prev.* 16:457–63

George, L. K., Gwyther, L. P. 1985. *Support groups for caregivers of memory impaired elderly: Easing caregiver burden.* Presented at Ann. Vermont Conf. Primary Prev., Burlington, VT

Gerrard, M., McCann, L., Fortini, M. E. 1983. Prevention of unwanted pregnancy. *Am. J. Community Psychol.* 11:153–68

Gesten, E. L., Rains, M. H., Rapkin, B. D., Weissberg, R. P., Flores de Apodaca, R., et al. 1982. Training children in social problem-solving competencies: A first and second look. *Am. J. Community Psychol.* 10:95–115

Giblin, P., Sprenkle, D. H., Sheehan, R. 1985. Enrichment outcome research: A meta-analysis of premarital, marital, and family interventions. *J. Marital Fam. Ther.* 11:257–71

Glasgow, R. E., Klesges, R. C. 1985. Smoking intervention programs in the workplace. In *Health consequences of smoking, cancer and chronic lung disease in the workplace.* A report of the Surgeon General, US Dept. of Health and Human Services, Public Health Services, Off. Smoking and Health. Rockville, MD

Glenwick, D. S., Jason, L. A., eds. 1980. *Behavioral Community Psychology: Progress and Prospects.* New York: Praeger

Glidewell, J. C. 1986. *Psychosocial empowerment in community action.* Vanderbilt Univ. Unpublished

Gonzales, L. R., Hays, R. B., Bond, M. A., Kelly, J. G. 1983. Community mental health. In *The Clinical Psychology Handbook,* ed. M. Hersen, A. E. Kazdin, A. S. Bellack, pp. 735–58. New York: Pergamon

Goodman, S. H. 1984a. Children of disturbed parents: The interface between research and intervention. *Am. J. Community Psychol.* 12:663–87

Goodman, S. H. 1984b. Children of disturbed parents: A research based model for intervention. In *Intervention with Psychiatrically Disabled Parents and their Young Children,* ed. B. Cohler, J. Musick, pp. 33–51. San Francisco: Jossey-Bass

Gottlieb, B. 1983. Social support as a focus for integrative research in psychology. *Am. Psychol.* 38:278–87

Gottlieb, B. 1987. Using social support to protect and promote health. *J. Primary Prev.* In press

Greene, B. F., Neistat, M. D. 1983. Behavior analysis in consumer affairs: Encouraging dental professionals to provide consumers with shielding from unnecessary x-ray exposure. *J. Appl. Behav. Anal.* 16:13–27

Guerney, B. G. 1987. Family relationship enhancement: A skill training approach. In *Families in Transition: Primary Prevention Programs that Work,* eds. L. Bond, B. Wagner. Beverly Hills, CA: Sage. In press

Guerney, L. F. 1985. *Phone friend child helpline: A community primary prevention service.* Presented at Ann. Vermont Conf. Primary Prev., Burlington, VT

Guthrie, G. M., Guthrie, H. A., Fernandez, T. L., Estrora, N. D. 1982. Cultural influences and reinforcement strategies. *Behav. Ther.* 13:624–37

Harvey, M. R. 1985. *Exemplary rape crisis programs: A cross-site analysis and case studies.* DHHS Publ. (ADM) 85–1423. Washington, DC: GPO. 195 pp.

Hattie, J. A., Sharpley, C. F., Rogers, H. J. 1984. Comparative effectiveness of professional and paraprofessional helpers. *Psychol. Bull.* 95:534–41

Heller, K. ed. 1986. Special Series: Disaggregating the process of social support. *J. Consult. Clin. Psychol.* 54:415–70

Henninger, D. G., Nelson, G. 1984. Evaluation of a social support program for young unwed mothers. *J. Primary Prev.* 5:3–16

Hess, R. E., Wandersman, A. 1985. What can we learn from Love Canal? A conversation with Lois Gibbs and Richard Valensky. In *Beyond the Individual: Environmental Approaches to Prevention,* ed. A. Wandersman, R. Hess, pp. 111–23. New York: Haworth. 211 pp.

Hilton, I., Abrons, P., Dye-Holmes, T., Fishler-Hedgepeth, P., Kunkes, C. 1983. *Teenage pregnancy: Causes, effects, and alternatives—implications for social policy.* Presented at 91st Ann. Meet. Am. Psychol. Assoc., Anaheim

Hinrichsen, G. A., Revenson, T. A., Shinn, M. 1985. Does self-help help? An empirical investigation of scoliosis peer support groups. *J. Soc. Issues* 41:65–87

Hobbs, N., Dokecki, P. R., Hoover-Dempsey, K. V., Moroney, R. M., Shayne, M. W., Weeks, K. H. 1984. *Strengthening Families.* San Francisco: Jossey-Bass. 365 pp.

Hollister, W. G. 1982. Fiscal myopia or constituency building. *J. Primary Prev.* 3:3–5

House, J. S. 1981. *Work, Stress, and Social Support.* Reading, MA: Addison-Wesley

Jacobs, H. E., Bailey, J. S., Crews, J. I. 1984. Development and analysis of a community-based resource recovery program. *J. Appl. Behav. Anal.* 17:127–45

Jason, L. A., Glenwick, D. S. 1984. Behavioral community psychology: A review of recent research and applications. In *Progress in Behavior Modification,* Vol. 18, ed. M. Hersen, R. M. Eisler, P. M. Miller. New York: Academic. 277 pp.

Jason, L. A., Gruder, C. L., Martino, S., Flay, B. R., Warnecke, R., Thomas, N. 1986. Worksite group meetings and the effectiveness of a televised smoking cessation intervention. *Am. J. Community Psychol.* In press

Joffe, J. M. 1982. Let a thousand flowers bloom? *J. Primary Prev.* 3:52–55

Joffe, J. M., Albee, G. W., Kelly, L. D., eds.

1984. *Readings in Primary Prevention of Psychopathology*. Hanover, NH: Univ. Press. New Engl. 493 pp.

Johnson, D. L., Breckenridge, J. N. 1982. The Houston parent-child development center and the primary prevention of behavior problems in young children. *Am. J. Community Psychol.* 10:305–16

Johnson, D. L., Walker, T. 1985. *The primary prevention of behavior problems in Mexican-American children.* Presented at Soc. Res. Child Dev., Toronto

Joint Commission on Mental Illness. 1961. *Action for Mental Health.* New York: Basic Books

Jonah, B. A., Grant, B. A. 1985. Long-term effectiveness of selective traffic enforcement programs for increasing seat belt use. *J. Appl. Psychol.* 70:257–63

Jordan, T. J., Grallo, R., Deutsch, M., Deutsch, C. P. 1985. Long-term effects of early enrichment. A 20-year perspective on persistence and change. *Am. J. Community Psychol.* 13:393–416

Kazdin, A. E. 1980. Implications and obstacles for community extensions of behavioral techniques. See Glenwick & Jason 1980, pp. 465–70

Kelly, J. G. 1986a. Context and process: An ecological view of the interdependence of practice and research. *Am. J. Community Psychol.* 14: In press

Kelly, J. G. 1986b. An ecological paradigm: Defining mental health consultation as a preventive service. In *The Ecology of Prevention: Illustrating Mental Health Consultation, Prev. Hum. Serv.*, eds. J. G. Kelly, R. Hess. New York: Haworth. In press

Kelly, J. G. 1986c. Seven criteria when conducting community based prevention research: A research agenda and commentary. In *Community Based Prevention Research, Natl. Inst. Ment. Health.* Washington, DC: GPO

Kessler, M., Albee, G. W. 1975. Primary prevention. *Ann. Rev. Psychol.* 26:557–91

Kessler, M., Goldston, S., eds. 1986. *Decade of Progress in Primary Prevention.* Beverly Hills: Sage. In press

Kessler, R. C., Price, R. H., Wortman, C. B. 1985. Social factors in psychopathology: Stress, social support, and coping processes. *Ann. Rev. Psychol.* 36:531–72

Kiesler, C. A. 1982. Mental hospitals and alternative care. *Am. Psychol.* 27:349–60

Kiesler, C. A. 1985. Prevention and public policy. See Rosen & Solomon 1985, pp. 401–13

Klingman, A. 1985. Mass inoculation in a community. The effect of primary prevention of stress reactions. *Am. J. Community Psychol.* 13:323–32

Knight, B., Reinhart, R., Field, P. 1982. Senior outreach services: A treatment-oriented outreach than in community mental health. *Gerontologist* 22:544–47

Kramer, M. 1982. The continuing challenge: The rising prevalence of mental disorders, associated chronic diseases, and disabling conditions. In *Public Mental Health,* ed. M. O. Wagenfeld, P. V. Lemkau, B. Justice, pp. 103–30. Beverly Hills: Sage

Krantz, D. S., Grunberg, N. E., Baum, A. 1985. Health psychology. *Ann. Rev. Psychol.* 36:349–83

Laskin, C. R., Pilot, L. J. 1982. Defective infant formula: The neo-mull-say-cho-free incident. In *Prevention in Human Services,* ed., H. A. Moss, R. Hess, C. Swift, pp. 97–106. New York: Haworth. 122 pp.

Lau, K., Kane, R., Berry, S., Ware, J., Roy, D. 1980. Channeling health: A review of the evaluation of televised health campaigns. *Health Educ. Q.* 7:56–89

Lawler, E. E., Mohrman, A. M., Mohrman, S. A., Ledford, G. E., Cummings, T. C., and Assoc., eds. 1985. *Doing Research that is Useful for Theory and Practice.* San Francisco: Jossey-Bass. 371 pp.

Lazar, I., Darlington, R. 1982. Lasting effects of early education: A report from the consortium for longitudinal studies. *Monogr. Soc. Res. Child Dev.* 47(2–3):1–151

Lefley, H. P. 1984. Cross-cultural training for mental health professionals: Effects on the delivery of services. *Hosp. Community Psychol.* 3:1227–29

Leventhal, H., Cleary, P. D. 1980. The smoking problem: A review of the research and theory in behavioral risk modification. *Psychol. Bull.* 88:370–405

Leventhal, H., Prohaska, T. R., Hirschman, R. S. 1985. Preventive health behavior across the life span. See Rosen & Solomon 1985, pp. 191–235

Levine, M. 1981. *The History and Politics of Community Mental Health.* New York: Oxford Univ. Press

Levine, M. 1985. A comment on the debate on primary prevention. *J. Primary Prev.* 5: 276–83

Liebenstein, N. 1981. *Social Problem-solving competence building in elementary school classrooms: A follow-up evaluation of three program years.* Univ. Rochester. Unpublished

Loo, C. M., Fong, K. T., Iwamsa, G. 1986. Ethnicity and cultural diversity: An analysis of work published in community psychology journals, 1965–1985. *Community Psychol.* 19:4

Lorion, R. P. 1983. Evaluating preventive interventions: Guidelines for the serious social change-agent. See Felner et al 1983b, pp. 251–68

Lorion, R. P., Stenmark, D. E., eds. 1984. Special Issue: Training in community psychology. *Am. J. Community Psychol.* 12: 133–259

Lyons-Ruth, K., Botein, S., Grunebaum, H. U. 1984. Reaching the hard-to-reach: Serving isolated and depressed mothers with infants in the community. See Goodman 1984b, pp. 95–122

Mannarino, A. P., Christy, M., Durlak, J. A., Magnussen, M. G. 1982. Evaluation of social competence training in the schools. *J. Sch. Psychol.* 20:11–19

Markman, H. J., Floyd, F., Stanley, S., Jamieson, K. 1986. A cognitive behavioral program for the prevention of marital and family distress: Issues in program development and delivery. In *Marital Interaction: Analysis and Modification*, ed. N. Jacobson, K. Hahlweg. New York: Guilford

Marlowe, H. A., Weinberg, R. B., eds. 1985. Is mental illness preventable? Pros and cons. *J. Primary Prev.* 5:207–312

Maton, K. I., Rappaport, J. 1984. Empowerment in a religious setting: A multivariate investigation. See Rappaport et al 1984, pp. 37–72

Mechanic, D. 1985. Health and behavior: Perspectives on risk prevention. See Rosen & Solomon 1985, pp. 6–17

Medway, F. J., Updyke, J. F. 1985. Meta-analysis of consultation outcome studies. *Am. J. Community Psychol.* 13:489–505

Meissen, G. J., Cipriani, J. A. 1984. Community psychology and social impact assessment: An action model. *Am. J. Community Psychol.* 12:369–86

Miller, G. A. 1969. Psychology as a means of promoting human welfare. *Am. Psychol.* 24:1063–1075

Milsum, J. H. 1980. Lifestyle changes for the whole person: Stimulation through health hazard appraisal. In *Behavioral Medicine: Changing Health Lifestyles*, ed. P. A. Davidson, S. M. Davidson, pp. 116–50. New York: Brunner/Mazel. 474 pp.

Mitchell, R. E., Billings, A. G., Moos, R. H. 1982. Social support and well-being: Implications for prevention programs. *J. Primary Prev.* 3:77–98

Moos, R. H. 1984. Context and coping: Toward a unifying conceptual framework. *Am. J. Community Psychol.* 12:1–36

Muñoz, R. F., cd. 1987. *Depression Prevention: Research Directions*. New York: Hemisphere. In press

Muñoz, R. F., Glish, M., Soo-Hoo, T., Robertson, J. 1982. The San Francisco mood survey project: Preliminary work toward the prevention of depression. *Am. J. Community Psychol.* 10:317–29

National Center for Health Statistics. 1985. *Persons Injured and Disability Days Due to Injuries: United States, 1980–81. Vital and Health Statistics*. Ser. 10, No. 149. DHHS Publ. (PHS) 85–1577. Public Health Service, Washington, DC

National Mental Health Association. 1986. *The Prevention of Mental-Emotional Disabilities*. Report of the National Mental Health Association Commission on the Prevention of Mental-Emotional Disabilities. Alexandria: NMHA. 42 pp.

Olds, D. L. 1984. *Final report: Prenatal/early infancy project*. Maternal and Child Health Research, NIMH. Washington, DC

Oritt, E. J., Paul, S. C., Behrman, J. A. 1985. The perceived support network inventory. *Am. J. Community Psychol.* 13:565–82

Pavlovich, M., Greene, B. F. 1984. A self-instructional manual for installing low-cost/no-cost weatherization material: Experimental validation with scouts. *J. Appl. Behav. Anal.* 17:105–9

Pedro-Carroll, J. L., Cowen, E. L. 1985. The children of divorce intervention program: An investigation of the efficacy of a school-based prevention program. *J. Consult. Clin. Psychol.* 53:603–11

Pedro-Carroll, J. L., Cowen, E. L., Hightower, A. D., Guare, J. C. 1986. Preventive intervention with latency-aged children of divorce: A replication study. *Am. J. Community Psychol.* 14:277–90

Peterson, L., Mori, L. 1985. Prevention of child injury: An overview of targets, methods, and tactics for psychologists. *J. Consult. Clin. Psychol.* 53:586–95

Pierson, D. E., Walker, D. K., Tivnan, T. 1984. A school-based program from infancy to kindergarten for children and their parents. *Pers. Guid. J.* 62:448–54

Pilisuk, M., Minkler, M. 1985. Social support: Economic and political considerations. *Soc. Policy* 15:6–11

Powell, T. J. 1985. Improving the effectiveness of self-help. *Soc. Policy* 16:22–29

Price, R. H., Smith, S. S. 1985. *A Guide to Evaluating Prevention Programs in Mental Health*. DHHS Publ. (ADM) 85–1365. Washington, DC: GPO. 135 pp.

Procidano, M. E., Glenwick, D. S. 1985. *Unitas: Evaluating a Prevention Program for Hispanic and Black Youth*. Bronx, NY: Hispanic Res. Cent. 80 pp.

Procidano, M. E., Heller, K. 1983. Measures of perceived social support from friends and family: Three validation studies. *Am. J. Community Psychol.* 11:1–24

Rappaport, J. 1981. In praise of paradox: A social policy of empowerment over prevention. *Am. J. Community Psychol.* 9:1–25

Rappaport, J. 1985a. *The death and resurrection of community mental health*. Presented

at 93rd Ann. Meet. Am. Psychol. Assoc., Los Angeles

Rappaport, J. 1985b. The power of empowerment language. *Soc. Policy* 16:15–21

Rappaport, J., Davidson, W. S., Wilson, M. N., Mitchell, A. 1975. Alternatives to blaming the victim or the environment: Our places to stand have not moved the earth. *Am. Psychol.* 30:525–28

Rappaport, J., Seidman, E., Toro, P. A., McFadden, L. S., Reischl, T. M., et al. 1985. Collaborative research with a mutual help organization. *Soc. Policy* 15:12–24

Rappaport, J., Swift, C., Hess, R., eds. 1984. Studies in empowerment: Steps toward understanding and action. *Prev. Hum. Serv.* 3:1–230

Revenson, T. A. 1985. The alliance between community and health psychology: Through the looking glass, again. *Community Psychol.* 19:34–36

Richard, B. A., Dodge, K. A. 1982. Social maladjustment and problem-solving in school-aged children. *J. Consult. Clin. Psychol.* 50:226–33

Rickel, A. U., Gerrard, M., Iscoe, I., eds. 1984. *Social and Psychological Problems of Women: Prevention and Crisis Intervention.* Washington, DC: Hemisphere. 322 pp.

Riessman, F. 1965. The 'helper-therapy' principle. *Social Work* 10:27–32

Riessman, F. 1985. New dimensions in self-help. *Soc. Policy* 15:2–5

Rivara, F. P. 1985. Traumatic deaths of children in the United States: currently available prevention strategies. *Pediatrics* 75:456–62

Roberts, M. C., Peterson, L., eds. 1984. *Prevention of Problems in Childhood.* New York: Wiley. 450 pp.

Roberts, B. B., Thorsheim, H. I. 1986. A partnership approach to consultation: The process and results of a major primary prevention field experiment. See Kelly 1986b

Roberts, M. C., Turner, D. S. 1986. Rewarding parents for their children's use of safety seats. *J. Ped. Psychol.* 11:25–36

Rolf, J. E. 1985. Evolving adaptive theories and methods for prevention research with children. *J. Consult. Clin. Psychol.* 53:631–46

Rook, K. S. 1984a. *Loneliness, Social Support and Social Isolation.* Off. Prev., NIMH. Washington, DC: GPO

Rook, K. S. 1984b. The negative side of social interaction: Impact on psychological well-being. *J. Pers. Soc. Psychol.* 46:1097–1108

Rook, K. S., Dooley, D. 1985. Applying social support research: Theoretical problems and future directions. *J. Soc. Issues* 41:5–28

Rosen, J. C., Solomon, L. J., eds. 1985. *Prevention in Health Psychology.* Hanover, NH: Univ. Press New Engl. 441 pp.

Rosenbaum, M., Franks, C. M., Jaffe, Y., eds. 1983. *Perspective on Behavior Therapy in the Eighties.* New York: Springer. 464 pp.

Rosenberg, M. S., Reppucci, N. D. 1985. Primary prevention of child abuse. *J. Consult. Clin. Psychol.* 53:576–85

Roskin, M. 1982. Coping with life changes: A preventive social work approach. *Am. J. Community Psychol.* 10:331–40

Rubin, K. H., Daniels-Beirness, T., Bream, L. 1984. Social isolation and social problem-solving: A longitudinal study. *J. Consult. Clin. Psychol.* 52:17–25

Rudd, J. R., Geller, E. S. 1985. A university-based incentive program to increase safety belt use: Toward cost-effective institutionalization. *J. Appl. Behav. Anal.* 18: 215–26

Ryan, W. 1971. *Blaming the Victim.* New York: Random House

Sandler, I. N., Barrera, M. 1984. Toward a multimethod approach to assessing the effects of social support. *Am. J. Community Psychol.* 12:37–52

Sarason, S. B. 1983. Community psychology and public policy: Missed opportunity. See Felner et al 1983b, pp. 245–50

Sarason, I. G., Sarason, B. R., eds. 1985. *Social Support: Theory, Research, and Application.* Boston: Martinus Nijhoff

Shadish, W. R. 1984. Policy research. Lessons from the implementation of deinstitutionalization. *Am. Psychol.* 39:725–38

Sharp, K. C. 1981. Impact of interpersonal problem-solving training on preschoolers' social competency. *J. Appl. Dev. Psychol.* 2:129–43

Shinn, M. B. 1987. Expanding community psychology's domain. *Am. J. Community Psychol.* In press

Shinn, M., Lehmann, S., Wong, N. W. 1984. Social interaction and social support. *J. Soc. Issues* 40:55–76

Shippee, G., Gregory, W. L. 1982. Public commitment and energy conservation. *Am. J. Community Psychol.* 10:81–93

Shumaker, S. A., Brownell, A., eds. 1985. Social support: New perspectives in theory, research, and intervention. Part II: Intervention and policy. *J. Soc. Issues* 41:1–171

Shure, M. B. 1984. Enhancing child-rearing skills in lower income women. See Rickel et al 1984, pp. 121–38

Shure, M. B. 1985. *Mass-targeted competence building approach to intervention with preadolescents.* Presented at Soc. Res. Child Dev., Toronto

Shure, M. B., Spivack, G. 1982. Interper-

sonal problem-solving in young children: A cognitive approach to prevention. *Am. J. Community Psychol.* 10:341–56

Slaikeu, K. A., Culler, R. 1985. Process and outcome in divorce mediation. *Mediation Q.* In press

Slaughter, D. T. 1983. Early intervention and its effects on maternal and child development. *Monogr. Soc. Res. Child Dev.* 48(4):1–83

Smith, M. L., Glass, G. V., Miller, T. I. 1980. *The Benefits of Psychotherapy*. Baltimore: Johns Hopkins Press

Spivack, G., Shure, M. B. 1974. *Social Adjustment of Young Children*. San Francisco: Jossey-Bass

Stein, D. M., Polyson, J. 1984. The Primary Mental Health Project reconsidered. *J. Consult. Clin. Psychol.* 52:940–45

Steiner, D. D., Mark, M. M. 1985. The impact of a community action group: An illustration of the potential of time series analysis for the study of community groups. *Am. J. Community Psychol.* 13:13–30

Stokes, J. P., Wilson, D. G. 1984. The Inventory of Socially Supportive Behaviors: Dimensionality, prediction, and gender differences. *Am. J. Community Psychol.* 12:53–69

Stolberg, A. L., Garrison, K. M. 1985. Evaluating a primary prevention program for children of divorce: The divorce adjustment project. *Am. J. Community Psychol.* 13:111–24

Stunkard, A. J., Felix, M. R., Cohen, R. Y. 1985. Mobilizing a community to promote health. The Pennsylvania County Health Improvement Program. See Rosen & Solomon 1985, pp. 143–90

Sundberg, N. D. 1985. The use of future studies in training for prevention and promotion in mental health. *J. Primary Prev.* 6:98–114

Susskind, E. C., Klein, D. C., eds. 1985. *Community Research: Methods, Paradigms, and Applications*. New York: Praeger. 523 pp.

Swift, C. 1984. Empowerment: An antidote for folly. *Prev. Hum. Serv.* 3:xi–xv

Swift, C. 1987. Preventing family violence: Family focused programs. In *Families in Transition: Primary Prevention Programs that Work*, eds. L. Bond, B. Wagner. Beverly Hills: Sage. In press

Tardy, C. H. 1985. Social support measurement. *Am. J. Community Psychol.* 13:187–202

Taylor, R. L., Lam, D. J., Roppel, C. E., Barter, J. J. 1984. Friends can be good medicine: An excursion into mental health promotion. *Community Ment. Health J.* 20:294–303

Tertinger, D. A., Greene, B. F., Lutzker, J. R. 1984. Home safety: Development and validation of one component of an ecobehavioral treatment program for abused and neglected children. *J. Appl. Behav. Anal.* 7:159–74

Trickett, E. J. 1984. Toward a distinctive community psychology: An ecological metaphor for the conduct of community research and the nature of training. *Am. J. Community Psychol.* 12:261–80

Trickett, E. J., Kelly, J. G., Vincent, T. A. 1985. The spirit of ecological inquiry in community research. See Susskind & Klein 1985, pp. 283–333

Turkat, D. 1983. Cable television and psychology: Bringing peace to the planet. *Clin. Psychol.* 36:40–43

Unger, D. G., Wandersman, L. P. 1985a. Social support and adolescent mothers: Action research contributions to theory and application. *J. Soc. Issues.* 41:29–45

Unger, D. G., Wandersman, A. 1985b. The importance of neighbors: The social, cognitive, and affective components of neighboring. *Am. J. Community Psychol.* 13:139–69

Van Houten, R., Nau, P. A. 1983. Feedback interventions and driving speed: A parametric and comparative analysis. *J. Appl. Behav. Anal.* 16:253–81

Van Houten, R., Rolder, A., Nau, P. A., Friedman, R., Becker, M., et al. 1985. Large-scale reductions in speeding and accidents in Canada and Israel: A behavioral ecological perspective. *J. Appl. Behav. Anal.* 18:87–93

Vaux, A., Phillips, J., Holly, L., et al. 1986. The social support appraisals (SS-A) scale: Studies of reliability and validity. *Am. J. Community Psychol.* 14:195–220

Videka-Sherman, L. 1982a. Coping with the death of a child: A study over time. *Am. J. Orthopsychiatry* 52:688–98

Videka-Sherman, L. 1982b. Effects of participation in a self-help group for bereaved parents: Compassionate friends. *Prev. Hum. Serv.* 1:69–78

Wallerstein, J. S. 1983. Children of divorce: Stress and developmental tasks. In *Stress, Coping, and Development in Children*, ed. N. Garmezy, M. Rutter, pp. 265–302. New York: McGraw-Hill

Wallston, K. A., McMinn, M., Pleas, J., Katahn, M. 1983. The 'Helper-Therapy' principle applied to weight management specialists. *J. Community Psychol.* 11:58–66

Warner, K. E., Murt, H. A. 1985. Economic incentives and health behavior. See Rosen & Solomon 1985, pp. 236–74

Warren, N. J., Grew, R. S., Ilgen, E. R., Konanc, J. T., Van Bourgondien, M. E., et

al. 1984. *Parenting after divorce: Preventive measures for divorcing families.* Synopsis of research prepared for NIMH Conf., "Children and Divorce," Washington, DC

Weissberg, R. P. 1985. Developing effective social problem-solving programs for the classroom. In *Peer Relationships and Social Skills in Childhood,* ed. B. Schneider, K. H. Rubin, J. Ledingham, 2:225–42. New York: Springer-Verlag

Weissberg, R. P., Gesten, E. L., Carnrike, C. L., Toro, P. A., Rapkin, B. D. et al. 1981. Social problem-solving skills training: A competence building intervention with second to fourth grade children. *Am. J. Community Psychol.* 9:411–23

Wellman, B. 1981. Applying network analysis to the study of support. In *Social Networks and Social Support,* ed. B. Gottlieb, pp. 97–115. Beverly Hills: Sage

Willems, E. P., McIntire, J. D. 1982. A review of preserving the environment: New strategies for behavior change. *Behav. Anal.* 5:191–97

Winett, R. A., Leckliter, I. N., Chinn, D. E., Stahl, B., Love, S. Q. 1985. Effects of television modeling on residential energy conservation. *J. Appl. Behav. Anal.* 18:33–44

Winkler, R. C., Winett, R. A. 1982. Behavioral interventions in resource conservation: A systems approach based on behavioral economics. *Am. Psychol.* 37:421–35

Woolfolk, R. L., Richardson, F. C. 1984. Behavior therapy and the ideology of modernity. *Am. Psychol.* 39:777–86

Wright, S., Cowen, E. L. 1985. The effects of peer teaching on student perceptions of class environment, adjustment, and academic performance. *Am. J. Community Psychol.* 13:417–31

Yokley, J. M., Glenwick, D. S. 1984. Increasing the immunization of preschool children: An evaluation of applied community interventions. *J. Appl. Behav. Anal.* 17:313–25

Zigler, E., Finn, M. 1982. A vision of child care in the 1980s. In *Facilitating Infant and Early Childhood Development,* ed. L. A. Bond, J. M., Joffe, pp. 443–65. Hanover, NH: Univ. Press New Engl. 576 pp.