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The Present and Future of Prevention

In Honor of **GEORGE W. ALBEE**

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George Albee: An Appreciation

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In December 1991, George Albee reached the age of 70 and, in keeping with academic tradition, retired from his position as professor of psychology at the University of Vermont, where he taught for 20 years. This retirement will not close a brilliant and productive professional career—George will remain involved and active. The editors of this volume (all close friends, colleagues, and admirers of George Albee) felt that this milestone in his life and career deserved special recognition. Accordingly, in keeping with academic tradition, this Festschrift has been organized.

A number of noted psychologists have contributed to this volume. Many are psychologists in the field of prevention, a field with which Albee has been identified in one way or another throughout his career. In 1975 he won the American Psychological Association's Distinguished Professional Contribution Award, and in the citation for that award it was noted that George "has had an active role in plotting the direction and independence of professional psychology" and that "his study of the nation's manpower needs and resources in mental health was one of the major influences in developing the community mental health center movement." That study of manpower led most directly to his work on prevention.

George Albee was born in 1921 in Saint Mary's, Pennsylvania. He graduated from Bethany College in West Virginia in 1943, spent three years in the Air Force, and in 1946 entered graduate school at the University of Pittsburgh, where he became one of the first Veterans Administration trainees in clinical psychology. Following receipt of his Ph.D. in 1949, Albee joined the research staff at Western Psychiatric Institute in Pittsburgh. In 1951 he accepted a position as assistant executive secretary of the American Psychological Association (APA) in Washington, DC. At APA he was in charge of the placement office, public information, and public relations, and he had other administrative duties as well, because there were few staff in those days. He has been involved

with the APA in one way or another ever since, including a term as president of that organization in 1969-1970.

In 1953 he received a Fulbright Professorship at Helsinki University in Finland and returned to the United States the next year to become an associate professor at Western Reserve University in Cleveland. He rose through the ranks to professor, chaired the department three different times, and was named the George Trumbull Ladd Distinguished Professor of Psychology in 1958.

In 1958, Albee was director of the Task Force on Manpower of the Joint Commission on Mental Illness and Health, and the report of that task force and the work of the commission in general changed the face of the mental health landscape, led to the development of the community mental health centers, and changed the nature of service delivery in this field.

George's involvement in professional psychology has been extensive. At APA alone he has been program chair of the annual convention, was a member of the council numerous times, was a member of the Board of Directors for more than 10 years, served as president of Division 12, and, as mentioned above, was president of APA in 1969-1970. More recently he has been a member of the Policy and Planning Board, chair of the Committee on Human Resources, and a member of the Committee on Ethics. He has also been active in the American Psychological Foundation, the American Board of Professional Psychology, the American Association for Applied and Preventive Psychology (as president), and other organizations at the state, national, and international levels.

In 1971, Albee moved to the University of Vermont as professor of psychology. There, he established the Vermont Conference on Primary Prevention, which, through 1991, has held 16 conferences bringing together researchers, policymakers, and implementers of prevention programs throughout the world. Conference topics have included schools, children, sexuality, politics, the environment, AIDS just about the entire range of areas covered by prevention activities. The Vermont Conference has become one of the preeminent forums for dissemination of information on prevention in this country and in the world. In conjunction with the conferences themselves, the Vermont Conference on Primary Prevention, under Albee's leadership, created the Prevention Clearinghouse to collate and disseminate information about prevention research and programs. Given his interest in training and education, George made sure that a large part of the clearinghouse was devoted to information about the teaching of prevention, and he has run pre-conference programs for teachers to make sure that the gospel of prevention is widely disseminated.

George is no stranger to controversy-in fact, he is always in the center of one controversy or another. His debates with psychiatry over the appropriateness of the illness model for mental health, his fights within psychology about the direction clinical training should take, and his famous (some would say infamous) stand against inclusion of psychological services in medical insurance have made him the target of attacks from within and outside the field. Yet, what many of his

critics do not recognize is his consistent and strong support for psychology as an independent profession, but a profession that, as George Miller has said, gives psychology away.

The consistency in Albee's thinking can be appreciated by browsing through some of the hundreds of papers George has published over the last 40 years or more, which we have done and attempted to capture here. The changes over this period have to do with detail rather than principles, with the further unpacking of the implications of his arguments, and with increasing insights into two matters in particular:

- (1) What are the alternatives to conventional one-to-one treatment of people with mental disorders?
- (2) Given the logic of the arguments for prevention, what accounts for the longevity and strength of the opposition to it?

To illustrate the continuity and change in Albee's writings, we have chosen extracts from a couple dozen of his papers and grouped them under a number of headings:

- *Resources for treating "mental illness"*: Albee's work in the 1950s, especially his work as director of the Task Force on Manpower of the Joint Commission on Mental Illness and Health, clearly showed that there could never be a sufficient number of medically trained people to help all those with "mental illnesses." Those who, because of adverse social conditions, might have the most need of such help are least likely to be able to find it.
- *The medicalization of mental illness and its effects*: Continuing to conceptualize mental disorder in medical terms makes the problem of adequate resources insoluble, and in any case the evidence for regarding most forms of "mental illness" as "illnesses like any other" is indefensible. Furthermore, adherence to the medical model distracts attention from the social conditions that are far more important determinants of mental disturbance-and diverts resources from attempts to ameliorate these conditions.
- *The role of clinical psychology*: To train its professionals in a different tradition from psychiatry, clinical psychology needed its own training centers, separate from both academic departments of psychology and medical control. However, if the methods of intervention remained in the realm of conventional psychotherapy, the problem of numbers remained-those intervening needed a new approach, not just a new job title or professional training site. Psychologists need to become agents of social change.

- *Prevention-the answer*: The logic of the arguments points inexorably to a single conclusion: The only way to deal with a problem as massive as that of mental disorder is the way that other problems affecting vast numbers of people have been successfully resolved-that is, through prevention.
- *Society, social policy, and the "isms"*: In the discussions of the above issues emerges, over the years, a growing awareness of and concern with the question, Who benefits? Support for the medicalization of mental disorder and for the status quo was not a force of nature; there were people supporting it for reasons that were not necessarily intimately related to the logic of the position. There is an increasing realization that when good ideas threaten powerful vested interests they do not necessarily triumph through their own virtues. The issues become politicized, meaning that ideas becomes less important than the lobbyists defending them, and that programs that are manifestly beneficial can be trampled underfoot if they threaten those in power. This is particularly the case when the medical model of psychopathology is replaced by ideas about the role society can play as a pathogen-where unemployment, racism, sexism, and all the myriad forms of exploitation of people by people are far more important causes of psychopathology than "twisted molecules." And so one sees in Albee's more recent writing discussion of the ideological reasons people profess "scientific" positions, and arguments concerning the need for radical social change.

What we gleaned from looking at George Albee's writings from the 1950s to the 1990s was that his positions on issues were entirely consistent with an underlying commitment to the proposition that professional psychology has to play an effective role in bettering the lot of humankind - this is the continuity in his thinking - but that ideas about how it could best play such a role were shaped and changed by the accumulation of evidence about a multiplicity of relevant issues. A much fuller picture of how the ideas relate to each other can be obtained by reading the articles from which the extracts have been selected (and others).

Resources for Treating "Mental Illness"

We can only conclude ... with the prediction that our country will continue to be faced with personnel shortages in psychiatry, psychology, and social work for years to come. Barring the possibility of a massive national effort in all areas of education, or the possibility of a sharp breakthrough in mental health research, the prospects are pessimistic for improvements in the quantity or quality of service in the field of mental health. (Albee & Dickey, 1957)¹

There is, in the United States, approximately one psychiatrist to every 18,000 people. This does not mean, of course, that psychiatrists and people are evenly distributed within the country. In the northeastern section of the country there is one psychiatrist to 11,000 people but in the southern region, if we do not include the District of Columbia, there is one psychiatrist to every 34,000 people.... A Congressional Inquiry on Mental Illness ... (1953) concluded its hearings with the judgment that the country needed at least twice as many psychiatrists as are available. It does not seem likely that such an increase ... is in prospect for the foreseeable future.... It seems clear ... that the prospect for the future is a continuing decline in the number of psychiatrists available for public agencies and institutions. (1959c)

Nor need we dwell long on the 2,000 new comprehensive mental health centers that the National Institute of Mental Health promises will be built by 1980 with Federal, state, and local funds. The demand for professional medical and paramedical care in these centers is beyond all hope of realization. How can the 2,000 centers be staffed when two-thirds of our existing 2,000 psychiatric clinics are without a single full-time psychiatrist, and when little psychiatric care is available in at least one-third of our state hospitals? (1968a)

There is clearly a significant relationship between the affluence of a geographic area or city census tract and the presence of mental health services. At the present time there are few private practitioners in the central city. Even when there are public clinics in the central city, the clientele using them tends to come from the affluent suburbs. (1977a)

Twenty years ago there was a serious shortage of psychiatrists; the shortage continues. The geographic maldistribution of psychiatrists was evident 20 years ago; it is still evident. The shortage of psychiatrists to work with poor people, with children and adolescents, with the aged, with the organically impaired, and with the physically handicapped continues today. (1979c)

In the 20 years since I wrote the volume *Mental Health Manpower Trends* there has been a dramatic decline in the number of medical school graduates attracted to the field of psychiatry. Back in 1960, 9% or 10% of all medical school graduates opted for psychiatric training. Today the number is well under 4%. Then and now, a small proportion of those choosing psychiatry as a career actually decide to specialize in child psychiatry. All the brave proposals ... stressing the importance of having child psychiatrists consult with schools, social agencies, and welfare departments, for example, are words blowing in the wind because of the unavailability of these professionals. (1981b)

The more critical problem, after accepting the evidence that psychotherapy is often effective in reducing anxiety and developing more effective and mature personal social relationships, is the unbridgeable gap between the enormous number of people with serious emotional problems and the small number of therapists available. (1990c)

The Medicalization of Mental Illness and Its Effects

If we continue to use the illness model of mental disorder, we cannot produce a fraction of the medical and paramedical people the model demands. This would not be a sufficient reason for abandoning the illness model, if it were supported firmly by research evidence. But the evidence supporting it is thin indeed. What I am suggesting is that we are in a manpower cul-de-sac because of the conceptual model we use. (1968a)

The explanatory model which is used to account for disturbed and deviant human behavior determines the kind of institutions which society supports to provide intervention, and the nature of these institutions in turn determines the kind of manpower required for their staffing.

The explanatory model occupying the center of the stage today insists on the fiction that "mental illness is an illness like any other." It trims the stage with institutional trappings of sickness, beds, hospitals, and clinics. As a consequence, the manpower problems are defined as shortages of medical and paramedical professionals, which include the four major actors in the drama—the psychiatrist, the clinical psychologist, the psychiatric social worker, and the psychiatric nurse. The bit players include all of the ancillary paramedical professions normally found in "treatment institutions." . . . What is required in this field is a whole re-conceptualization of causation. Once the sickness model is replaced with a more valid social-learning explanation (which attributes most emotional disturbance to the dehumanized environment rather than to biological defect) there will follow a redefinition of intervention institutions as re-educational or rehabilitative centers which call for a very different sort of manpower. (1969e)

We cannot begin to develop our own theoretical explanations, nor our own practical approaches to the real and serious problems of our society, until we abandon the myth of mental illness and until we stop attributing the human consequences of our dehumanized society to bugs and poisons. (19691)

The illness explanation of psychopathology supports the forces of reaction and delays necessary social change that would prevent emotional distress and allow the use of less highly trained therapists. If mentally disturbed persons suffer from unknown and undiscovered illness, then the strategy for action is to discover the cause of the disease. But if they have been damaged by hostile and evil social environments, then we must change the dehumanizing forces of society. (1970d)

The sickness model, indeed, is the cornerstone which supports the edifice of denial of social responsibility for dehumanization and destruction of human beings in a mass-production, profit-seeking, competitive society. We have seen publicized the new Comprehensive Community Mental Health Centers as the shining hope for bringing care to the poor. But then the whole purpose of these centers is distorted, and they become a source of funds for the construction of beds for general hospitals which will exclude the poor because they do not have hospitalization insurance. (1971b)

The "sickness model" is extremely effective in supporting reactionary or status quo social policies. It justifies the elitist practices that limit intervention to the affluent and relegate the emotionally-disturbed poor to a drug-filled existence on the back wards of state hospitals. It justifies the enormously profitable drug industry, which sells drugs for several hundred million dollars a year for the relief of "mental diseases." (1971b)

I have been arguing that the sickness model, usually defended and justified with the hoary examples of paresis and pellagra, reduces the help available to large numbers of emotionally disturbed poor because of the professional manpower it demands for treatment. . . . The sickness model of disturbed behavior often seems to support reactionary policies. It demands that we pour tax money into building and staffing hospitals and clinics because only in such places can "sick" people be "treated." It justifies both the shameful degrading incarceration and often the neglect of the emotionally disturbed poor, because there are just not enough doctors and nurses to go around to staff "hospitals." It justifies the shameful practice whereby, each year, the National Institute of Mental Health spends more than 50% of its professional training budget to support the residency and specialty training of psychiatrists who, after years of such support with tax dollars, finally open offices for private practice with the affluent, leaving the public institutions without meaningful professional help.... Calling the mentally retarded "sick" and pretending to diagnose and "treat" them in medically operated clinics and hospitals has had the effect of denying meaningful educational habilitation to enormous numbers of normally retarded children and adults who might otherwise have benefited from educational intervention, habit training, and research aimed at developing techniques for maximizing their limited potential. (1971d)

Most psychologists (and most psychiatrists, as well) in private conversation readily admit that they are not treating conventional illnesses. A majority of clients seeking help from members of both groups are concerned with problems of bad marriages, career frustrations, role confusions, generational misunderstandings, and other emotional disturbances of an existential sort. They are not sick in any generally definable meaning of the term sickness. (1975c)

Explanations that attribute causation to disease and insist that "mental illness is an illness like any other" have failed to account for the striking association between the incidence of specific disorders and sociocultural conditions. (1977d)

The endless search goes on for the twisted molecule that will be identified as the "cause." The promise is that such efforts will lead to better mental health through chemistry! (1979a)

Few mental problems can be diagnosed with laboratory or other objective tests. We can tell with virtual certainty whether a person has a coronary occlusion or a strep throat, diabetes or spinal cord damage. But to say someone is depressed or schizophrenic is to pass judgment on a pattern of behavior or on reported subjective experience, a much more difficult matter.... Show a videotape of an interview with a "disturbed person" to therapists from different countries and cultures and you will receive different diagnoses. Even within our own society the diagnosis will vary depending on what the therapist is told about the subject's social class. The same people will be diagnosed differently if they are seen as poor than if they are believed to be affluent. Appendicitis, a brain tumor and chicken-pox are the same everywhere, regardless of culture or class; mental conditions, it seems, are not. (1985a)

Periodically the American Psychiatric Association publishes a Diagnostic and Statistical Manual of Mental Disorders (DSM). DSM I, published in 1952, listed 60 types and subtypes of mental illness. Sixteen years later, DSM II expanded the number to 145. The current guide, DSM III, has 230 separate conditions, including tobacco dependence, developmental disorders and sexual dysfunctions. Clearly the more human problems that we label mental illnesses, the more people that we can say suffer from them. And, a cynic might add, the more conditions the therapist can treat and collect health-insurance payments for. (1985a)

In the case of mental disorders, the key elements are not bacteria, viruses or other noxious agents but a high level of current or past stress that may be engendered by many things, including serious marital problems; involuntary unemployment; sexual confusion and guilt; or a childhood history of serious neglect, physical abuse, sexual exploitation and lack of affection. (1985a)

With a few obvious exceptions, most of the conditions defined as psychopathological are disorders of behavior for which no laboratory or other objective tests are available. The identification of a so-called mental illness

is usually a judgment based on an interview or other behavioral observation. Despite a major reorientation of American and Canadian psychiatry in recent years away from a concern with psychodynamics and the childhood origins of adult distress and toward a biological approach, with growing emphasis on the search for genetic and biochemical causation and drug treatment, the bedrock fact remains—most mental conditions are not identifiable by objective tests, and most have not been shown to be real organic diseases. Rather, epidemiological studies find clear correlations between most forms of psychopathology and one or more of the following: (a) emotionally damaging infant and childhood experiences; (b) poverty and degrading life experiences; (c) powerlessness and low self-esteem; and (d) loneliness, social isolation, and social marginality. (1986e)

In addition to reclassifying most problems of living as illnesses, American psychiatry has joined forces with ... reactionary citizens' groups ... to advance the position that "All mental illness is a medical illness." This conservative message serves the dual purpose of raising more public funds for coverage of psychiatric drug treatment and reduction or elimination of support for social change as prevention. If all mental conditions are caused by organic, biochemical defects in the brain, then bad parenting is not to blame, parents are guiltless, NIMH can support only organic research, and the Establishment is not threatened. (1990c)

The Role of Clinical Psychology

In this area [child psychiatry] . . . we find the usual shortages and lack of interest. . . Similar shortages exist for child workers in the other mental health professions.

What is left? One fairly radical proposal . . . [is] the creation of a new professional group, trained as psychotherapists, though not required to master all of the knowledge presently in the various professional curricula. These people, who could be trained much more rapidly than can a psychiatrist or a psychologist, would not take over completely the field of therapy but would augment present personnel and perhaps free more highly trained people for research. (Albee & Dickey, 1957)

Let me emphasize that I do not see psychology as the care-delivery field. We can never have the manpower to meet the demands. Rather, we must create the theory and show how it is applicable, to enable care to be given by bachelor's level people in habilitation centers that they themselves administer. Psychology can only be the developer of the conceptual models and of the research underpinning. The parallel with the field of education is evident. Intervention in the educational system is by bachelor's level teachers who are supported by more highly trained research workers from several fields. (1968a)

[In our own training settings], while participation in individual therapy may be necessary for students to learn the hopelessness of one-to-one approaches, their souls

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may be seared with sufficient guilt that they will be inoculated against the syndrome of private practice in suburbia! And when we learn what the real social problems are, we can set about figuring out how to train BA-level people to do the intervention with all those cases our "best places" do not care to handle. (1969i)

Clinical psychology is at a critical stage of development. We are dissatisfied with the old, and uncertain about where to turn for new directions. It is so comfortable to go on doing what we have been doing, and to listen to the counsel of the older and wiser heads who caution against rocking the boat. But how can clinical psychologists with hearts and consciences look on forever silent at the double standard of care that prevails in our society; how long can clinical psychologists' silence be bought? (1969j)

As a psychologist I had to grit my teeth as he rubbed my nose in the fact that clinical psychology's development was fostered by psychiatry and originated, along with a number of groups, for "technical assistants for psychiatrists." God help us all Tiny Tim, it is true. But clinical psychology has wandered out of Egypt's land and is now adrift in the trackless desert looking for a new home. (1971f)

The academic department is the wrong place to train professional psychologists, but the psychiatric setting is just as bad. In psychiatric settings the clinical psychologist learns to speak the language of psychiatry, to use the illness model and to aspire to the private practice of psychotherapy.... The sickness model requires highly trained medical and paramedical people not available to the poor. So long as the disease model prevails we will limp along with too few medical and paramedical professionals attempting with minimal effectiveness to treat sick human beings in hospitals and clinics. When the sickness model ultimately is laid to rest perhaps society can set about training new kinds of professionals, closer to schoolteachers than to psychiatrists, to work with disordered people in new kinds of institutions more like schools than hospitals.... So, at a time when the opportunities for clinical psychology appear practically boundless, the problems of identity and relevance threaten it with extinction. For my part, I find the role of scientist and the role of professional incompatible. Looking ahead 10 to 15 years, I predict that there may be an American Scientific Psychological Association and an American Professional Psychological Association, perhaps existing side by side. Separation or divorce may be inevitable, and both science and profession may benefit. (1970d)

It is not my secret plan to replace psychiatrists with psychologists. Psychologists are going to be in even shorter supply for the next 20 years. I urge, rather, that we turn the whole field over to social work, special education, and nursing, and unnamed new professional groups, all of whom would develop their own intervention centers, train their own people, and run their

own show. When this solution occurs, we can begin to develop meaningful and humane conditions of intervention. In the area of prevention, the abandonment of the sickness model as our operating myth and its replacement with a developmental-social educational model will lead to efforts at reducing the pollution of our human environment, which may be even worse than the pollution of our physical environment. I look forward to the day when behavioral scientists . . . join forces to build an alternative human-action oriented philosophy of social change. (1971d)

Professions exist to serve human needs. Surely if our purpose is to deliver helpful psychological services to the largest number, and to those with the most desperate need, we could find some other model than individual one-to-one therapy supported by third-party payments. (1975c)

The training of clinical psychologists is hardly any better in preparing them to work with the poor. As admission to clinical training programs becomes more and more selective and difficult, the lucky few who are admitted are obsessive high-achievers with outstanding academic records and high test scores. In short, they too are obsessives heavily indoctrinated about the importance of time, inner control, and research. Both groups are selected from the upper-middle class, and few of them speak the language, share the values, or understand the problems of the poor. (1977a)

Will psychology have the courage to face and challenge the religious and economic causes of sexism? The middle-class professional must continuously decide whether she or he is a defender of the established social-economic order or whether she or he must become an advocate for the victims of that order. Those who opt for the traditional definition of deviant behavior in terms of a sickness originating in weakness, a defective brain or endocrine system, or a chromosomal defect are clearly defenders of the status quo. Treating depression in women with psychoactive drugs and explaining the higher prevalence of depression in women as a sex-linked biological defect reflects a counterrevolutionary ideology: The poor are to blame for their poverty, the insane are to blame for their insanity, and women are to blame for their oppression.

On the other hand, professionals who see and describe sexism as an exploitative and dehumanizing system are in danger of being made visible and labeled as radicals or rebels with emotional problems. We need to support one another in these matters, or we will be picked off one by one! (1981 a)

What can psychologists do about these enormous human problems? Our first task is to make vocal what is now silent. It is to make conscious what is now unconscious. It is to resist being co-opted by an exploitative social system that pays us well with status, income, and upward social mobility in exchange for our remaining silent about injustice. (1990c)

Let us be clear that it is not sacrilegious, illegal or unconstitutional to choose a career as a psychotherapist in an affluent society. After facing the fact that

doctoral level therapists serve primarily well-educated clients, that psychotherapy is rarely available to the poor, and is not much sought after by blue collar workers, the choice of this "health profession" is no more blameworthy than the decision to become a dentist or a funeral director. Many people want or require the service and they or their insurance programs are willing to pay....

While psychotherapy uncovers the individual damage inflicted by all of these social problems, treating the victims does nothing to correct the basic causes. Only when the findings of psychotherapists are translated into wellformulated preventive actions to correct or change the social and economic structure will it have made a significant contribution to prevention. But most therapists, like most professionals in other fields, have a major stake in defending the social order, not in attacking it. (1990c)

Prevention-the Answer

Much is already known about mental disorder. Whether we agree about causes, at least we can agree that there probably are prophylactic and preventive measures which can be effective if used early enough. (Albee & Dickey, 1957)

We are torn between a humanitarian desire to do something to help present day neurotics and psychotics and the rational decision that only by research can we achieve our goal of reducing suffering. Attempts to solve the problem of mental disorder through approaches based on one-to-one, face-to-face relationships, however moral and admirable, are simply not sensible from a manpower point of view. (1963a)

Primary prevention, whether aimed at real illnesses or at emotional distress, has specific definable characteristics. It is proactive; and it deals with large groups of people not yet affected with the conditions to be prevented. While it may direct its efforts at high risk groups, these characteristics still hold. It sometimes does not deal directly with people who might be at risk-it may be concerned instead with mass media, with laws affecting children, with changing administrative policies. Persons involved in primary prevention efforts need not be traditional mental health professionals. Primary prevention is involved when Head Start programs teach children better adaptive skills; when slum dwellings are condemned because of the presence of lead paint; when sex education courses are taught in the schools; when sexist readers in the early grades are changed to non-sexist ones; when job skills are provided to unemployed teenagers; when mass media are enjoined from showing minorities and women in demeaning and stereotyped roles; when programs to reduce unemployment are introduced; or when tax rates are modified to alter massive inequalities in income. (1979a).

Successful prevention ... requires a series of steps: first, careful epidemiological study of the distribution of disturbance leading to (a) the identification of the noxious agents responsible, (b) the sources of effective resistance, and/or (c) the ways of preventing transmission. Prevention programs attempt to reduce stress, to strengthen competence, and to enhance support systems. (1984c)

Public health wisdom states that mass disorders afflicting humankind rarely or never have been brought under control or eliminated by attempts at treating each afflicted individual, nor by efforts at increasing the number of professional individual treatment providers. Rather, successes have come through public health methods that have stressed (a) finding the noxious agent and eliminating or neutralizing it, and/or, (b) strengthening the host's resistance to the noxious agent, and/or, (c) preventing transmission of the noxious agent to the host. (1988e)

The goal of primary prevention is to reduce the probability of future new cases and the social value of any intervention activity may arguably be related to its success in reducing (down the road) the rate of distress in the population. Both dentists and psychotherapists relieve individual pain and suffering. But fluoridation of the public water supply is preventing more caries than dentists repair. There is no comparable massive prevention program to ensure more consistent loving and caring parenting so as to prevent future psychopathology. (1990c)

Society, Social Policy, and the "Isms"

We must realize that the terrible suffering that exists in our society among the disenfranchised, the poor, the have-nots, can only be remedied by direct confrontation with the establishment, by the socialization of our care-delivery systems, by the development of adequate tax-supported public facilities, staffed by BA-level interventionists using social models, and with inventive solutions which can only be developed as creative people find out about the real problems. (19691)

There was discussion of the question of the relevance of much of the content of graduate education in psychology to critical human problems on which man's survival itself may depend-problems like war, overpopulation, racism, and the increasing pollution of our social and physical environment. APA cannot tell university departments what to teach, but we do know enough about reinforcement theory to suggest that both APA and NIMH (and other Federal funding agencies) should be prepared to reward programs as they begin to approximate scientific and professional concern with these problems. (1969a)

Why are the comprehensive community mental health centers not "treating" these poor people early and near their homes? Very simple: Poor people diagnosed as "sick" psychotics cannot afford to pay for treatment, and they do not have Blue Cross Insurance to pay for a bed in the general hospital psychiatric ward that has

been transmuted by grantsmanship magic into a Comprehensive Community Mental Health Center.... It may surprise those professionals who have not read President Kennedy's 1963 message to learn that he visualized tax-supported intensive intervention centers where salaried professionals would indeed intervene with the poor and would keep them out of the purgatory on our side of the Styx. But President Kennedy ... did not reckon with the power of the American Medical Association.... Williams ... pointed out how every congressman got a call from his family physician telling him that what he was about to do was wrong. The implication was that the centers as proposed by Kennedy and his friends in the Congress were another step down the road to socialized medicine, and perhaps ultimately, of course, to Godless Communism and worse. (1971f)

Kolb argues, nay asserts categorically, that there is no evidence that social change will "eradicate mental illness." He argues that countries that have achieved vast social reforms still have neuroses and psychoses. This, of course, is largely irrelevant. We do have good epidemiological evidence that the rate of psychoses has been very high for every immigrant group arriving on our shores and in our central cities and that their rate of psychoses has dropped precipitously as each has been assimilated and has moved up into middle-class respectability. As they become middle class and adopt the Protestant Ethic, it is true that their rate of neurosis increases, along with their sexual repression, and their newly-formed Puritanical internalized conscience. (1971f)

Let us divert some of the 80 million dollars a day we are spending in Vietnam and build research centers on every campus in both bio-medical and educational settings! Let us take one or two of the many billions of dollars we spend collecting moon dust to collect research information on retardation and to enrich the lives of the retarded.

Let us pray. (1970a)

Let me suggest to you ... that racism is a far more serious, pathological, and deep-seated emotional problem in our society than either the sexual neuroses of latter-day Victorians or the existential neuroses of the affluent.... Does this mental condition not merit our attention? Have we tried to do anything in the way of meaningful intervention with racists? . . . Similarly, clinical psychology has paid almost no attention to the damaging emotional consequences of discrimination based on sex, and yet sexism, like racism, is almost entirely a psychological process, especially a learning process....

Our society locks up overt paranoids. But it pays honor and respect to the industrialist who builds automobiles that are death traps, who sprays our fruit with coal tar poisons, and who shows utter disregard for public good in a simple-minded search for profits and power. (1970g)

The . . . best outcome, in my book, would be a decision by Congress to exclude

[from third-party payments] nearly all conditions presently considered under the general term mental or emotional illness. This would mean that the services of neither psychiatrists nor psychologists would be covered except in those very clearly specified (and clinically unpopular) cases involving psychosomatic, neurological, and organic conditions, and perhaps a few specified patterns requiring intensive emergency intervention. With neither psychology nor psychiatry covered for the wide variety of services now being offered in private offices, pressures would build up over time for the kind of efforts at primary prevention that offer the only long-range solution to the disturbances with which we are all concerned. Psychology would be free to compete in the marketplace without the handicap of third-party payments for psychiatric services. The situation would be consistent with the reality emotionally disturbed people are not sick. (1975c)

One might be tempted to suggest that American Psychiatry speaks with a forked tongue. When the circumstances call for a defense of psychiatric hegemony, their spokespersons testify before Congress about the importance of medical training in the preparation of the psychiatrist because of the high frequency of patients with organic, neurological, psychosomatic, and other organic conditions. When in the '60s there were large sums of federal money available for the construction of facilities to attack the problems of mental retardation, they testified that psychiatry should have major responsibility in this area because of their historic and major involvement in the field of retardation. When the Comprehensive Community Mental Health Centers were being funded, they testified in favor of regulations that ensured medical domination of the Centers. Yet the survey finds that most of their office practice is one-to-one therapy with affluent neurotics. (1976a)

The health industry has long resisted efforts at prevention. Our whole health delivery system emphasizes high technology medicine that focuses on treatments that are highly profitable for hospitals, physicians and the drug industry. Of the billions of dollars spent on cancer research, less than 1 % has been spent on efforts at prevention. Although it is generally acknowledged that most forms of cancer are due to environmental pollution and life styles, cigarette smoking, diet, industrial pollutants, etc.-research is still aimed at discovering a "cure" for cancer while 20 million Americans go without any health care, and another 50 million are seriously under-served. Medicine and surgery continue to prefer dramatic heart transplants, coronary bypass operations and research for curative drugs while preventive efforts are neglected. (1979a)

Sexism, like other forms of prejudice, can validly be regarded as a species of delusion-false beliefs rooted in emotional and personal needs. But like other forms of psychopathology we must look for causes beyond only individual psychodynamics-we must look to the dynamics of the larger societal context, especially as we attempt to formulate primary prevention programs. . . . Most categorically sexism involves perceiving and acting towards females as if they are categorically inferior. This places sexism in the pantheon of prejudices alongside

alongside racism, ageism, and other political pathologies as part of natural eternal cosmic truths supported by religion and science.... Traditionally, a major criterion of mental disorders is the judgment that the person is so irrational and emotionally out of control as to be dangerous to others. According to this definition, sexists (along with anti-Semites, anti-gays, racists, and bigots of all kinds) should be defined as emotionally disturbed. (1981a)

It is clear that in the United States most forms of psychopathology are more prevalent among the very poor and the powerless; among those subject to the stresses of prejudices like sexism, racism, and ageism; among the economically exploited like the migrant farm workers and the vast underclass; and among those involuntarily unemployed, underemployed, or exploited by an economic system oriented primarily to the maximization of profits. (1984c)

What stops the world's people from building a more just, more equitable world—a world in which preventable stress has been reduced for the majority of people—as is envisioned as a major goal by the World Health Organization? The forces that are barriers to a just world are some of the same forces that block significant efforts at reducing psychopathology in our own society: exploitation, imperialism, excessive concentration of economic power, nationalism, institutions that perpetuate powerlessness, hopelessness, poverty, discrimination, sexism, racism, and ageism. These forces control or influence the world's communication systems, especially mass media and educational systems, and they deliberately distribute rewards for conformity and for the support of injustice. (1986e)

There are compelling reasons, of course, for the failure of psychology to concern itself with social systems that are based on the exploitation of people in the interest of maximizing profit and power. Psychologists are imbedded in these systems and have been socialized in cultures that often paint laissez-faire capitalism as synonymous with democracy.... Any social criticism of unbridled capitalism, and its dominant power motive that emphasizes profiteering at all costs, is attacked as unpatriotic and subversive and while this may be an unjust accusation, it has succeeded in stilling voices of criticism; indeed, it has succeeded in papering over, with skilled and masterful propaganda, any awareness of the basic injustices of our economic system. (1990c)

Because George has, for many years, been identified with the thrust for prevention (his students, those from the last 20 years at least, walk around quoting George's quoting of "No major illness has ever been conquered by treating the individual case"), the essays in this honorary volume are about prevention. More

than that, in the main they are about active, vibrant programs of preventive work that outline the frontiers of this effort—to reduce the incidence of psychopathology by preventing its occurrence. Prevention, as found in these papers, embodies George's formulation that implies that fostering healthy environments, promoting good parenting and child development practices, and providing people with the resources they need to cope with life will go a long way toward the prevention of psychopathology.

Also included in these essays is more evidence for the importance of continuing efforts to promote important social changes that underlie the later development of psychopathology, such as David, Dytrych, Matejcek, and Roth's chapter on the effects of unwanted pregnancy, and Crissey's history of the Iowa child development station. David et al.'s chapter echoes Bond's concern for providing environments that develop thinking "voices," and Moos's continues to develop invaluable measuring instruments for evaluating planning and prevention efforts.

George's way of helping people to develop is to invite them to "come along." In the opening remarks to her chapter, Lynne Bond recalls George's taking her to a baseball game when she was an 8-year-old. The three editors of this volume have also been invited along with George—to write articles and books, to plan conferences, to kill and dress chickens that were no longer layers, and in myriad other ways to walk with him in his path and to see the world through his lenses: a world free from exploitation and domination of one group by another, a world in which each person has the freedom and the resources to develop her or his potential to the fullest, a world in which the highest goal would be one person's concern and regard for others.

As always, with George's invitation comes the unwritten command to fight the good fight, to smite the unrighteous, to educate the Philistines with energy, commitment, and enthusiasm. It is this energy and dedication, this relish for debate and the commitment to overcome, that suggest that George's life has been filled with unbounded enthusiasm, with joy.

We invite readers to come along now and sample the ideas that have been generated by others who share Albee's vision, who are creating a preventive psychology that will contribute to the development of the world that George Albee has envisioned.

Note

1. Citations in this section refer to the publications in the following list, "Publications of G. W. Albee, Ph.D."

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