Facts and Fallacies about Primary Prevention

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ABSTRACT: This paper clarifies eight common misconceptions about primary prevention.

We have been distressed over the past few years by a paradoxical situation in the clinical field. On the one hand, many of the insights of practicing clinicians have inspired the conception and design of primary prevention programs. But on the other hand, much of the most strenuous and vociferous opposition to prevention efforts has come from practicing clinicians. Clearly not only one's personal values but one's career commitments and shared perceptions of useful models of disturbance influence one's level of acceptance or rejection of new ideas, particularly when these imply the possibility of a redistribution of power and alternative modes of intervention.

Primary prevention has been called "An idea whose time has come" (Klein & Goldston, 1977) and has been referred to as the "fourth mental health revolution" (Albee, 1980). Yet we find misperceptions, misunderstandings, and active opposition in many quarters to efforts at primary prevention and to proposals for a modest reallocation of resources to support prevention programs.

It has been recognized for a long time that the political ideology of scientific and professional workers tends to influence their choice of models to explain human behavior and human deviance (Pastore, 1949). And the model chosen, of course, determines the kind of intervention action taken. We are under no illusion that any calm presentation of evidence is likely to change the ideology of those who are most fierce in their opposition to primary prevention efforts. But we are hopeful that a relatively factual and objective presentation of myths...
and realities, misunderstandings and facts, to counter them may be acceptable to those clinicians and others who may not be immersed in the literature of prevention but who have open minds.

**Misconception Number 1**

Almost anything we do as mental health professionals to help other human beings is a form of prevention. Indeed, the terms primary, secondary, and tertiary prevention cover nearly every activity and program that is part of the repertoire of mental health workers. So what is all the talk about?

**Clarification**

This is the fault of preventionists. It is a legitimate misunderstanding. Loyd Rowland, pioneering giant in the field of prevention, often railed against the use of the term prevention in such confusing ways. He suggested that we ought to talk about prevention, early treatment, treatment, and rehabilitation. Most persons seriously concerned with prevention today focus on primary prevention only. By this they mean proactive programs that affect groups of unaffected people—those not yet showing any signs of disturbance. In other words, prevention programs should be proactive, not reactive, should be planned for the purpose of reducing incidence down the road, should be evaluated carefully for effectiveness (Cowen, 1982) and should pay careful attention to the ethical questions involving work with groups under conditions where informed consent often is impossible.

**Misconception Number 2**

Prevention is impossible without a knowledge of specific causes. Because we do not know the specific cause of most mental illnesses, little or nothing can be done to prevent them.

**Clarification**

This objection is couched in the allopathic model of medicine, and for most conditions it does not apply to emotional disturbances. One of the