Book Review/Essay


A common theme of these two books is that we need to be more consistent and rigorous in measuring the outcomes of interventions and use these results to tailor interventions to meet the needs of target populations. Health promotion and disease prevention involve numerous disciplines and influences. Before there can be a “science” of health promotion and disease prevention, there is a need to focus and build upon theory as well as refine methodology. Furthermore, there is a need to turn attempts to “reinvent the wheel” into efforts which replicate, refine, and test past efforts in interventions, benefiting from what worked and didn’t work. Certainly we do not want to discourage new ideas and approaches to this broad field, but if it is to become a respected science, the ingredients of the scientific method need to be firmly in place and practiced.

Raczynski and DiClemente have assembled a distinguished group of authors to compile their state of the art handbook. The book’s 32 chapters address the history, theoretical models, and evaluation methods of health promotion and disease prevention and general issues such as symptom perception, health-care-seeking behaviors, and stress, coping, and social support, and illness. A large number of chapters are directed toward behavior change and intervention channels. Finally, there are chapters which discuss policy issues and the needs of special populations.

The messages conveyed in this volume can be summarized in 14 statements of findings and experience which describe the current status of the field of health promotion and disease prevention.
• The majority of health promotion and disease prevention programs have been developed based on the assumption that individuals are ready to change, when, in fact, research has shown that only 20 to 30% of individuals at risk are adequately prepared to change their behavior.
• Many researchers and practitioners are beginning to recognize that a “one size fits all” intervention approach may not be appropriate.
• Intervenors should be aware that even genuine treatment effects may wear off over time, e.g., 80% of people who quit smoking can be expected to start again within the year and the majority of smokers who quit do so in the absence of a formal cessation program.
• Once a unit of analysis has been chosen, intervenors must guard against making cross-level references, that is, drawing conclusions about individual behavior based on group-level data, and vice versa.
• Irrespective of the target, interventions are most successful when delivered in a variety of ways through diverse channels to the intended audience.
• Behavioral interventions designed for a single stage of life are not necessarily effective over the long term.
• Programs need to be tailored to meet the specific needs of different populations including assuring that the intervention was culturally sensitive, developmentally appropriate, gender relevant, and risk relevant.
• Use a theoretical model on which to base the intervention, one that addresses the interactions among social, psychological, physical, cultural, and environmental influences.
• Facilitate the dissemination of intervention programs that are known to change behavior.
• Interventions need to be presented so that practitioners can incorporate them with little effort, little time, and maximum effect.
• Peer involvement offers advantages over traditional, didactic prevention interventions.
• Simpler and less resource intensive interventions have a better chance for survival.
• The most successful interventions are those that include a plan for evaluating outcome.
• A good evaluation should include an assessment of what worked and didn’t work and why, and the cost, and this should be shared with others.

These statements of fact and experience collectively form a set of minimum standards for interventions. As knowledge and experience accu-