

New Directions. Interaction Contexts in Prevention Science and Community Mobilization*

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Many disciplines and stakeholders have an interest in social conditions, stress, resources, and health-- and in their implications for disease prevention and health promotion. The disciplines include sociology, psychology, economics, public health, and political science. The stakeholders include social scientists, federal funding agencies, politicians, prevention practitioners, and the general public. Assuming that the stakeholders are in fact concerned with improving the physical and mental health of our society , the research disciplines must be able to describe what they are learning about social conditions, stress, resources, and health and how that research is relevant to the millions of people in our national population. These premises serve as the basis of my comments on the papers addressed to the interactional contexts of stress.

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What We Are Doing (And not Doing) In the Mental Health Field on Social Conditions, Stress, Resources, and Mental Health

There are several conceptual frameworks in the stress and coping research literature that subsume concepts in Pearlin's "stress process" model but also create some interdisciplinary bridges to the psychology of social conditions, stress, resources and mental health (Baum, Singer, & Baum, 1981; Cowen, 1991; Kelly & Hess, 1987; Lazarus & Folkman, 1984; Pearlin, 1989; Wandersman, 1990; Wandersman, Andrews, Riddle & Fancett, 1983). Perhaps consideration of the expanded content of these frameworks can help us better understand the context in which this stocktaking of research on community and physical and mental health is taking place-- what we have learned and what is missing.

- *The distal and contextual factors in these frameworks extend the list of conditions that influence the prevalence of stressors beyond demographic categories to include conditions in the physical environment as well as non-demographic characteristics of social, economic, and community environments*. For example, environmental policies on building and highway codes (distal/contextual factors) in California reduced the loss of lives and property (stressors) caused by earthquakes; this in turn reduced personal stress and negative mental health outcomes. *Both policy interventions and individual interventions* are used when distal/contextual factors become the focus of prevention efforts (e.g., unemployment as an individual situation to be changed versus unemployment as a systemic problem to be resolved). *A major strength of this volume in general, as well as the papers by Aneshensel and Sucoff (1996) and Wellman and Gulia (1996), is the recognition and prominence given to distal/contextual factors.*
- *The stressors in these broadened frameworks also extend beyond social stressors such as negative life events or chronic role strains to include traumatic events (e.g., crime, child abuse, drug abuse) and excessive demands in the physical environment (e.g., natural and human-made disasters, noise, toxic contamination, and high density).* It is not unusual for preventive interventions to substitute the goal of reducing the occurrence of the risk factor or stressor for that of reducing a disorder.

- *Expanded protective factors or resources in these elaborated frameworks influence the social stress process at two points: (a) in the cognitive appraisal of a risk or stressor and (b) as cognitive-behavioral influences on coping strategies. As a result, not only are resources such as competencies, self-efficacy, social support, and special skills often the target of preventive interventions, so too are various cognitive-behavioral coping strategies. These can range from the elimination of exposure to a stressor to the provision of instrumental aid or redefinition of meaning of the stressor, from temporary reductions in exposure through hospitalization, vacations, or recreational activity, to support groups, psychotherapy or counseling, to biofeedback, stress inoculation training, desensitization, and reciprocal inhibition therapies.*
- *Expanded frameworks also present a broad set of outcomes that include positive mental and physical health as well as disorder outcomes. They are based on outcomes considered important in behavioral, psychodynamic, and humanistic interventions (Ricks, Wandersman, & Poppen, 1976; Wandersman & Moos, 1981). They recognize the possibility of reciprocal effects between outcomes as well as the possibility of a reciprocal effect between an outcome and resources, stress exposure, or environmental conditions.*

When broadened stress and coping frameworks are translated into preventive interventions, they are commonly conceptualized as dimensions that overlap with, but do not completely correspond to those of the social “stress process” model.

- *Timing* of the intervention refers to whether the intervention occurs before the individual becomes symptomatic (primary prevention), in the early stages of symptom development to avoid progression of the disease (secondary prevention), or after disease onset to reduce its duration and the level of impairment it brings.
- *Level* refers to the unit of analysis the intervention is attempting to change (e.g., individual, family, networks).
 - *The structure or mechanism* more specifically describes the medium of the intervention. For example, an intervention can aim to change individual outcomes (level) by working with family support strategies (structure).
- *Content* describes the substance of the intervention (e.g., social support, skill building).
- *The value system* describes values embedded in the intervention and how the intervention operates. For example, the medical model puts the intervention in the hands of an expert who will help alleviate suffering in the individual.

What Is Happening with our Interventions and Are They Reaching the Population at Large? A Role for Community Mobilization

Wandersman, et al. (1995) discuss analyses, reports, and commissions that have analyzed the status of children, youth, and families in the United States and report that we are “a nation at risk” or “a nation in jeopardy” in regard to many social indicators such as alcohol, tobacco, and other drug use; adolescent pregnancy; single-parent families; youth violence; and domestic violence (Bronfenbrenner, 1995; National Research Council, 1993; U.S. Advisory Board on Child Abuse and Neglect, 1995). In this area alone the need for effective prevention and health promotion programs and policies is enormous.

University-Directed Prevention Science Strategies

The science of prevention is being actively pursued in universities and institutes throughout the United States in projects funded by federal agencies (e.g., National Institute of Mental Health, National Cancer Institute, Centers for Disease Control and Prevention) and foundations (e.g., Grant Foundation). These research programs are attempting to build a prevention science-- explaining what works for what types of problems with which types of children, youth, and families. Many of these well-funded studies are multisite, experimental designs. The results show limited outcomes (e.g., Mrazek & Haggerty, 1994). Yet no matter how well developed and how efficacious/effective these prevention science programs are, they do not directly reach the 99% of the population that does not come into contact with “state of the science research” programs. If we want to see a positive change in the dire statistics, then we need to understand and improve the practice of prevention -- the prevention programming that is offered day in and day out in all the schools and communities of our society. We need to bring more of what prevention science does know into our communities. There are several paths that can be simultaneously pursued to improve prevention and health promotion efforts at the community level. (Wandersman, Morrissey, et al., submitted).

Bringing prevention science to scale. One strategy involves bringing university-driven prevention science programs to scale. The impact of successful prevention programs will be limited if they are not widely tested, disseminated, and adopted (e.g., Fishbein & Hornik, 1995). Multiple considerations are responsible for these limits. *One important consideration is the role of contextual factors* (Linney, 1991). A program that works in one part of the country with a certain target group (e.g., age, race, sex) or a certain provider system does not necessarily work the same way with another target group or operating system. *Research that empirically investigates the contextual factors that influence effectiveness in various community settings and adoption by community providers with a variety of target groups is essential.* Elias (1993) and his colleagues are conducting such a study; they are investigating the adoption of all preventive and social competency programs in all of the New Jersey school districts.

Technology transfer. *Technology transfer attempts to bring to practitioners the basic knowledge generated by research. Generally, it involves education, training, and dissemination of information through conferences, journal articles, and reports or brochures.* The literature on technology transfer is estimated to contain more than 10,000 citations (Backer, David, & Soucy, 1995). *The National Institute on Drug Abuse monograph edited by Backer, David, and Soucy offers an excellent set of articles on issues in technology transfer and suggestions for improving technology transfer.* An important example of a technology transfer approach is the prestigious Institute of Medicine report, Reducing Risks for Mental Disorders (Mrazek & Haggerty, 1994). The report describes a *preventive intervention science research cycle that progresses from research on defining disorders to risk and protective factor research to efficacy trials (rigorous pilot studies and confirmatory and replication trials) to effectiveness trials (extending the initial positive findings in large-scale field trials) to the researcher facilitating the dissemination, adoption, and ongoing evaluation of the program in community service settings (p. 517).* This approach grapples with the challenge of bringing prevention science to scale.

Outcome-oriented community research. Another important path involved in broadening prevention programs into our communities involves performing more research on understanding communities: how they are structured, how they function, and how community characteristics influence mental health outcomes. The works of Aneshensel and Sucoff (1996) and Wellman and Gulia (1996) provide excellent examples of the type of research that is being done but clearly needs to be built upon.

Community-Directed Prevention Strategies

A different, yet related, model of prevention and health promotion is strong and continues to evolve in the public health field. (The discussion below is largely based on Butterfoss, Goodman, & Wandersman, 1993). Health-promotion specialists have stressed the importance of multiple interventions aimed both at individuals who are at health risk and at risk-producing environments and policies (McLeroy, Bibeau, Steckler, & Glanz, 1988; Pentz et al., 1989; Stokols, 1992; Winett, 1995). The current emphasis on multiple interventions at multiple levels of the “social ecology” is a response to the severity and complexity of chronic health conditions that are rooted in a larger social, cultural, political, and economic fabric. *The current wisdom in health promotion holds that targeting the behavior of individuals without also intervening at these other social levels that shape behavior will not have as great an impact on health status. This view has led to the development of a community coalition model for prevention and health promotion. The coalitions and the programs and policies they foster are community-directed rather than university-directed.*

Two definitions capture an understanding of coalitions:

1. An organization of individuals representing diverse organizations, factions, or constituencies who agree to work together in order to achieve a common goal. (Feighery & Rogers, 1989, p. 1)
2. An organization of diverse interest groups that combine their human and material resources to effect a specific change the members are unable to bring about independently. (Brown, 1984, p. 4)

The development of coalitions of community agencies, institutions, and concerned citizens to combat chronic health conditions is gaining popularity as an intervention aimed at strengthening the social fabric. Currently, hundreds of millions of dollars are being invested in coalition development as a disease-prevention and health-promotion intervention. The following examples target neighborhoods and networks-- interaction contexts in the community:

- The *Center for Substance Abuse Prevention (CSAP)* has funded 250 *community partnerships* throughout the United States
- The “*Fighting Back*” *substance-abuse treatment and prevention program* was funded by the *Robert Wood Johnson Foundation*
- *SAFE KIDS-- local, state, and national coalitions to prevent childhood injuries*—was supported by *Johnson & Johnson*
- The *Kellogg Foundation’s Community Based Public Health Initiative* funds consortia of schools of public health, local health care agencies, and community-based organizations to promote community-based public health training and service.
- The *National Cancer Institute’s COMMIT and ASSIST community tobacco-control programs*, were funded by the *National Institutes of Health*
- The *PATCH cardiovascular health-promotion program* is supported by grants from the *U.S. Centers for Disease Control and Prevention*
- *Native American, tribal health-promotion efforts* have been sponsored by the *U.S. Office of Minority Health*
- The *Comprehensive Community Initiatives for Children and Families* was staffed by the *Aspen Roundtable* and funded by an *eight-foundation consortium*.

A discussion of coalition functioning should take into account its stages of development, which include formation, implementation, maintenance, and the accomplishment of goals or outcomes. (This principle underlies our evaluation of several local community partnerships that are funded by CSAP for preventing the abuse of alcohol, tobacco, and drugs.)

The formation stage occurs at the initiation of funding. The agency that is granted the funding (lead agency) convenes an ad hoc committee of local community leaders. The ad hoc committee nominates influential citizens to serve on committees representing health care, business, education, religion, criminal justice, neighborhood organizations, the media, and other sectors of the community. Training on prevention goals, issues, and tasks takes place. *The implementation stage occurs as each of the committees conducts a needs and resource assessment to determine the extent and nature of its constituents' concerns and resources in regard to alcohol, tobacco, and drug abuse.* The needs assessment consists of secondary data as well as written questionnaires, town meetings, and interviews that are developed and conducted by the committees with input from the staff and evaluation team. *Implementation continues, with committees using the results of the needs assessment to develop a community-wide intervention plan.* *The maintenance stage consists of the monitoring and upkeep of the committees and their planned activities.* *The outcome stage involves the impacts that result from the deployment of community-wide strategies.* *The series of activities is aimed at ameliorating risk factors and thereby facilitating positive outcomes.*

The generic community mobilization model can benefit greatly from contributions from multiple relevant disciplines (e.g., sociology, psychology, public health, and political science). Social stressors, negative life events, and hazardous physical environments subsume the problems that many communities are mobilizing to combat. *I would emphasize that the contextual/distal factors that influence stressors and interventions (Table 1) also influence the formation and maintenance of community mobilization efforts such as community coalitions (Wandersman, Valois, Ochs, de la Cruz, & Adkins, 1996).*

Table 1

Dimensions of Preventive Interventions

Timing

Primary (distal/contextual, risk factors, resources)
Secondary
Tertiary

Level

Individual
Family
Networks
Organization
Community
Society

Structure/Mechanism

Groups
Networks
Policy
Programs
Setting

Content

Social support
Behavior change
Skill building
Knowledge

Value System

Medical model
Expert
Self-help
Empowerment
Values about research (e.g., generative, executive)

Many of the coalition initiatives listed above, for instance, have a geographic (e.g., neighborhood) focus and aim to increase collaboration and networking among the sectors of the geographic community.

In sum, significant change in the mental and physical health of our population will require not only significant advances in university-directed prevention science programs but also research on contextual factors as they influence the adoption and adaptation of prevention programs, research on differentially salient community characteristics, and research on community mobilization for disease prevention and health promotion.

On the Scientific Base for Community Relevant, University-Conducted Research: Comments

Community is a term that is widely and ambiguously used in the social sciences. There are two major ways of discussing community: (a) *community as a place* and (b) *community as relationships and resources* (Heller, Price, Reinharz, Riger, & Wandersman, 1984). Aneshensel and Sucoff focus on the former, developing models and providing evidence for neighborhood effects. Wellman and Gulia provide an interesting counterbalance, focusing on the importance of personal communities and networks and reducing the importance of geographical location.

Aneshensel and Sucoff's, "Neighborhood and Adolescent Mental Health"

This chapter presents an excellent review of the research literature and develops a structure for examining the relationship of neighborhood characteristics to adolescent mental health outcomes. In the first section, the authors examine theories and research on neighborhoods and the relationship of neighborhood characteristics to behavioral and health outcomes. A major strength of this section is its description of the impact of neighborhood characteristics as a main effect on outcomes and as an interactive variable with individual characteristics that affect outcomes. In the second section, the authors discuss the significance of the neighborhood specifically for mental health. A major strength of this section is the presentation of models and data for two different types of neighborhood influence on adolescent mental health outcomes: (a) a main effect that "generalizes impact of neighborhood on the mental health of its typical adolescent inhabitants" and (b) a yet-to-be conducted study of "differential impact of neighborhood contingent upon attributes of the individual." The third section explores implications of these models for prevention. Given the size of the community mobilization effort already focusing on adolescent outcomes, the trivial size of the average effect of neighborhood characteristics on adolescent mental health combines with the absence of mental health studies of indirect and moderating effects of neighborhood to suggest an urgent need for further research.

Micro-neighborhoods and blocks.-- I would like to see an exploration of micro-neighborhoods and blocks included in this further research. I believe it could strengthen the evidence related to the influence of the main effects neighborhoods model on outcomes. "The micro-neighborhood is operationally defined as a next-door neighbor, the person in the next apartment, or the most immediate set of adjacent households" (Warren, 1981, p. 63). The block consists of the two sides of a street that face each other, with cross-streets serving as block boundaries. The block has been used as the unit of study in a number of studies, especially in looking at neighborhood crime and crime prevention (Perkins, Wandersman, Rich, & Taylor, 1993; Unger & Wandersman, 1982). *It would be useful to explore the models that Aneshensel and Sucoff propose using block-level characteristics in addition to neighborhood-level characteristics.*

Wellman, Potter, and Gulia's, "Where Does Social Support Come From?"

Wellman, Potter and Gulia present a thoughtful review of social networks that can provide comfort to those of us who are worried about the loss of community. They describe an approach to community based on personal networks. They relate personal networks to social support and review the literature on the effects of compositional characteristics of networks. My major comment on this piece relates not to what is said, but to broadening its relationship to other chapters in the book and to the theme of the book. Networks may be a contextual factor, but the social support they can produce, under conditions well described by the authors, is generally conceptualized as a resource or protective factor. A fuller understanding of the linked roles of personal networks and social support in moderating the effects of social conditions and social stressors on outcomes is in order. For example, in the material presented by Aneshensel and Sucoff, it is likely that networks, through social support, play an important role in moderating the differential effects of living in a particular neighborhood. In relation to health outcomes, it would be useful to explicate the research on social networks and social support with mortality, morbidity, and general well being. The field would benefit from additional reviews and research that would (a) expand an examination of relationships of networks and social support to include the mental health outcomes of network and support characteristics and (b) examine the potential of interventions with networks and social support to promote positive outcomes and prevent negative outcomes.

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