
Guidelines for Prevention in Psychology

American Psychological Association

The effectiveness of prevention to enhance human functioning and reduce psychological distress has been demonstrated (Catalano, Berglund, Ryan, Lonczak, & Hawkins, 2002; Greenberg, Domitrovich, & Bumbarger, 2001; National Research Council & Institute of Medicine, 2009). Successful preventive interventions are typically theory driven, culturally relevant, developmentally appropriate, and delivered across multiple contexts (Nation et al., 2003). Preventive services and interventions help to further the health and well-being of individuals, communities, and nations (Satcher, 2000; World Health Organization, 2008). Expanding preventive services reduces the costs of mental health care (Tolan & Dodge, 2005), while emerging technological innovations (e.g., telehealth) offer promise for preventive interventions (Bull, 2011; Chinman, Tremain, Imm, & Wandersman, 2009).

From infancy through adulthood, access to preventive services and interventions is important to improve the quality of life and human functioning and reduce illness and premature death (Grunberg & Klein, 2009; Konner, Gatz, & Hertzprung, 1999). Prevention has typically taken a developmental approach, focusing on children and adolescents, in order to facilitate trajectories leading to positive outcomes (National Research Council & Institute of Medicine, 2009). Children and adolescents are at significant risk for substance abuse, violence, and sexually transmitted infections, and their access to quality health services is limited (Centers for Disease Control and Prevention, 2007; Weissberg, Walberg, O'Brien, & Kuster, 2003). Thus, normal development may be impeded at large costs to society, and additional strains imposed on families. In any given year, 14%–20% of children and adolescents experience a mental, emotional, or behavioral disorder (National Research Council & Institute of Medicine, 2009). In addition, national surveys show that the majority of youth who could potentially benefit from mental health services do not receive services (Ringel & Sturm, 2001). Early and focused interventions can limit the length and severity of symptoms and enhance functioning (Cicchetti & Toth, 1992; Durlak, Weissberg, & Pachan, 2010). Prevention also includes the collaborative design and delivery of strengths-based health promotion and environmental improvement strategies (e.g., Cowen, 1985). Health promotion approaches equip people with life skills and coping competencies, such as problem-solving skills, contributing to their capacity to live more fully while being better able to withstand future stressful life events.

Preventive services and interventions also address issues of health, educational, and social inequities that reflect disparities across demographic groups such as those based on race, gender, and socioeconomic class. Environmental

improvement prevention strategies, such as consultation to improve community–family–school coordination or interventions to help communities create well-paying jobs, aim to inform social policy, which can minimize or eliminate factors contributing to unhealthy functioning.

The importance of prevention is consistent with the Patient Protection and Affordable Care Act (2010), which calls for expansion of preventive services to maximize positive health outcomes, as well as with the U.S. National Prevention Strategy (National Prevention Council, 2011), which “provides an unprecedented opportunity to shift the nation from a focus on sickness and disease to one based on wellness and prevention” (National Prevention, Health Promotion, and Public Health Council, 2011, p. 1) throughout the life span. Several disciplines other than psychology have been historically and currently active in prevention (e.g., public health, social work). However, beginning in the mid-20th century with the field of community psychology, psychology began to play an increasingly important role (e.g., Eby, Chin, Rollock, Schwartz, & Worell, 2011). Even with the increased focus on prevention, psychology training programs rarely require specific courses on prevention (O’Neil & Britner, 2009). In particular, conceptualizations about best practices in prevention, particularly at the environmental level, are lacking (Snyder & Elliott, 2005). In addition, the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association [APA], 2010) do not fully address unique ethical issues that may arise in prevention (e.g., Schwartz & Hage, 2009). Therefore, psychologists engaged in prevention can benefit from a set of guidelines that address and inform prevention practices.

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These guidelines were approved by the American Psychological Association (APA) Council of Representatives in February 2013. The guidelines were developed by APA’s Prevention Guidelines Work Group. The Work Group members, listed alphabetically after the chair, included John L. Romano (chair), G. Anne Bogat, Robert K. Conyne, Sally M. Hage, Arthur M. Horne, Maureen E. Kenny, Connie Matthews, Jonathan P. Schwartz, Anneliese Singh, Michael Waldo, and Y. Joel Wong.

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This document is scheduled to expire as APA policy in February 2020. After this date, users are encouraged to contact the APA Practice Directorate to confirm that this document remains in effect.

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Purpose

APA (2002, p. 1050) refers to guidelines as

statements that suggest or recommend specific professional behavior, endeavors, or conduct for psychologists. Guidelines differ from standards in that standards are mandatory and may be accompanied by an enforcement mechanism . . . guidelines are aspirational . . . intended to facilitate the continued systematic development of the profession and to help assure a high level of professional practice . . . Guidelines are not intended to be mandatory or exhaustive and may not be applicable to every professional and clinical situation. They are not definitive and they are not intended to take precedence over the judgment of psychologists.

Accordingly, the Guidelines for Prevention in Psychology (cited as Prevention Guidelines or Guidelines for the remainder of this document) are intended to “inform psychologists, the public, and other interested parties regarding desirable professional practices” (APA, 2002, p. 1049) in prevention.

The Prevention Guidelines are, in part, practice guidelines and different from treatment guidelines as defined by APA (2002). The Guidelines are recommended for the practice of psychology across areas that engage psychologists. The Guidelines are consistent with federal and state laws and regulations. In the event of a conflict between the Guidelines and any federal or state law or regulation, the law or regulation in question supersedes these Guidelines. Psychologists are encouraged to use their education and skills to resolve any conflicts in a way that best conforms to both law and ethical practice. The Guidelines are consistent with the Ethical Principles of Psychologists and Code of Conduct (APA, 2010), particularly Principles D (justice) and E (respect for people’s rights and dignity).

Background

APA convention symposia (Hage & Romano, 2006; Kenny, 2003; Romano, 2002) initiated the development of these Guidelines, followed by an article describing prevention best practices (Hage et al., 2007). These Guidelines were later introduced as new business for the APA Council of Representatives, whereupon they underwent significant review, including APA governance and public comment periods, in accordance with Association policy relevant to guidelines (APA, 2013, Association Rule 30-8). The Guidelines were approved by the APA Board of Directors in December 2012 and by the APA Council of Representatives in February 2013.

Definitions

Prevention has been conceptualized as including one or more of the following: (a) stopping a problem behavior from ever occurring; (b) delaying the onset of a problem behavior, especially for those at-risk for the problem; (c) reducing the impact of a problem behavior; (d) strengthening knowledge, attitudes, and behaviors that promote emotional and physical well-being; and (e) promoting institutional, community, and government policies that further physical, social, and emotional well-being of the larger

community (Romano & Hage, 2000). This conceptualization is consistent with Caplan’s (1964) definition that identified prevention interventions as primary, secondary, and tertiary prevention, and with the definition by Gordon (1987) that identified prevention interventions as universal, selected, and indicated for those not at risk, at risk, and experiencing early signs of problems, respectively. Gordon’s conceptualization was adopted by the Institute of Medicine (1994). A follow-up report from the Institute of Medicine broadened this universal, selective, and indicated framework to include “the promotion of mental health” (National Research Council & Institute of Medicine, 2009, p. 65).

Throughout this document, the terms *prevention*, *preventive intervention(s)*, *preventive program(s)*, and *preventive services* are used. Activities subsumed by these rubrics could focus on any of the five aspects of prevention included in the Romano and Hage (2000) conceptualization of prevention. Although space precludes a thorough exegesis of all types of programs, decisions about how and when to intervene might lead to different outcomes, different ancillary effects, and different ways of approaching issues within cultures and settings.

Documentation of Need

The Prevention Guidelines are recommended based on their potential benefits to the public and the professional practice of psychology. The Guidelines support prevention as an important area of practice, research, and training for psychologists. The Guidelines give increased attention to prevention within APA, encouraging psychologists to become involved with preventive activities relevant to their area of practice.

The National Research Council and Institute of Medicine’s (2009) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults: Research Advances and Promising Interventions stated, “Infusing a prevention focus into the public consciousness requires development of a shared public vision and attention at a higher national level than currently exists” (p. 5). The Guidelines provide added visibility to the importance of prevention across professional practice areas and among the public. The Guidelines also support the U.S. Department of Health and Human Services’ calls for health promotion and prevention in its *Healthy People* publications outlining national health goals (e.g., U.S. Department of Health and Human Services, 2000). *Healthy People 2020* (U.S. Department of Health and Human Services, 2010) continues the tradition of earlier publications by setting goals to eliminate preventable disease, achieve health equity, eliminate health disparities, create social and physical environments to promote good health, and promote healthy development and healthy behaviors across the life span. Other U.S. government bodies have also emphasized the importance of prevention to the overall health and well-being of the population (Mrazek, 2002).

The Patient Protection and Affordable Care Act (2010) includes preventive services as an important component of overall health care. The legislation strives to make wellness and preventive services affordable and accessible by requiring health plans to cover preventive services without copayments. These services include counseling to improve habits of lifestyle (e.g., proper nutrition, weight management), counseling to reduce depression, and preventive services to foster healthy birth outcomes.

The contributions and leadership of psychologists are critical in implementing a prevention focus in the health care system. Evidence increasingly suggests that mental illness, such as depression, is linked to chronic health issues such as heart disease and diabetes (Volgelzangs et al., 2008). Therefore, the Guidelines identify best practices for psychologists who engage in preventive activities relating to the interface between physical health and emotional well-being.

The Guidelines also respond to policies and legislation that aim to prevent and reduce problems such as chemical addictions, depression, suicide, school bullying, social violence, and obesity (Institute of Medicine, 1994). The Guidelines respond to social disparities, discrimination, and bias against people based on (but not limited to) their race, ethnicity, immigrant status, sexual orientation, age, gender identity, socioeconomic status, religion, HIV serostatus, physical and psychological health status, and gender (APA, 2003, 2007; Kenny, Horne, Orpinas, & Reese, 2009). The Guidelines offer recommendations to psychologists as they respond to public policy and legislative initiatives that promote positive health behaviors in the name of prevention and health promotion (National Research Council & Institute of Medicine, 2009). In addition, the Guidelines endeavor to apply the science and practice of psychology to address major social issues and real-world problems through education, training, and public policy positions (Anderson, 2011).

The Guidelines offer guidance to psychologists on several levels, including supporting the value of prevention as important work of psychologists and providing recommendations that give greater visibility to prevention among psychologists regardless of specialty area or work setting (Snyder & Elliott, 2005).

Expiration

Given the evolving nature of prevention, the Guidelines are scheduled to expire in the year 2020. After this date, users are encouraged to contact the APA Practice Directorate to determine if the document remains in effect. The year 2020 was selected because it coincides with the decennial *Healthy People* publications, which set national health goals for the United States every 10 years. In addition, it is expected that the Patient Protection and Affordable Care Act (2010) will be implemented fully by 2014, providing a reasonable time frame for these Guidelines, given the evolving nature of health care and psychology's place within the spectrum of health care services and research.

Guidelines

Guideline 1. Psychologists are encouraged to select and implement preventive interventions that are theory- and evidence-based.

Rationale. Preventive interventions that demonstrate sustained effectiveness can be considered as meeting the highest standard for efficacy and maximum benefits to the consumer (National Institute of Mental Health, 1998). Consistent with foundational principles in psychology, theory and research should be inseparably tied to prevention practice. Research suggests that programs developed from a sound theoretical framework are more effective than programs that are not theoretically based (Weissberg, Kumpfer, & Seligman, 2003). Also, preventive programs that are based on theory and regularly evaluated are more likely to consider risk and protective factors that operate across multiple contexts (Black & Krishnakumar, 1998), especially for groups who are historically marginalized (e.g., women, people of color). Accountability to client populations, funding agencies, and policymakers demands that prevention practices be grounded in theory and research (Vera & Reese, 2000).

Application. Psychologists are encouraged to conduct preventive programs that have been rigorously evaluated (Guterman, 2004; Weissberg, Kumpfer, & Seligman, 2003). While no single theoretical perspective is suggested, psychologists are encouraged to select theoretically based preventive approaches when considering their prevention goals. The theoretical frameworks and intervention strategies of positive psychology, positive youth development, applied developmental science, risk and resilience, health promotion, competence enhancement, and wellness, among others, can be selected and integrated when designing preventive interventions that will simultaneously prevent negative outcomes and enhance positive outcomes (Weissberg, Kumpfer, & Seligman, 2003). It is recommended that preventive programs be selected based on a careful review of empirical evidence in order to choose programs that are empirically supported for their specific contexts and specified goals, in addition to identifying how these relate to both multicultural issues and concerns generated by social inequities. Therefore, it is recommended that psychologists stay informed regarding current outcome research in prevention science to help ensure that the preventive programs they implement offer the most promise for the identified goals and population.

Guideline 2. Psychologists are encouraged to use socially and culturally relevant preventive practices adapted to the specific context in which they are implemented.

Rationale. Given the increasing diversity of the U.S. population, it is crucial that preventive programs be designed, selected, and implemented with consideration of cultural relevance and cultural competence. Historically, many preventive programs were developed by professionals working with urban and suburban middle-class com-

munities and reflect heterosexual European American values and methods; furthermore, many did not address the unique issues faced by persons with disabilities. Preventive programs that lack relevance to the lives of participants will often fail (Lerner, 1995). Even when a preventive program is effective in one setting, it may not be effective in another setting with different populations (e.g., rural vs. urban communities, individuals above and below the federal poverty guidelines). Research suggests that programs perceived as socially and culturally relevant by their constituents have a greater likelihood of being sustained (Vera & Reese, 2000). As Trickett et al. (2011) noted, "Culture is not seen as something to which interventions are tailored; rather, culture is a fundamental set of defining qualities of community life out of which interventions flow" (p. 1412).

Because risk and protective factors are found within individuals and in the multiple social contexts in which individuals are situated, prevention programs that attend to both individual and contextual factors are most advantageous. Focusing only on individuals and the more proximal context of the family may place undue responsibility and blame on the individual and the individual's milieu without recognizing the roles played by social institutions and culture in determining and sustaining positive human outcomes (Kenny & Hage, 2009). Therefore, psychologists strive to understand the cultural worldviews and community contexts of individuals in order to strengthen prevention interventions, especially interventions that have been developed for one cultural group and implemented in another (National Research Council & Institute of Medicine, 2009).

Application. Psychologists are encouraged to be aware of and to articulate the evidence that supports their selection of specific prevention programs for implementation in different cultural contexts (Reese & Vera, 2007). Along this line, existing programs may need significant adaptation, or new programs may need to be developed, to meet social, cultural, community, and developmental norms of program participants and to ensure access to all members. Technological advances, such as the use of web-based preventive interventions and social media to promote, deliver, and assess prevention interventions, can assist with this process. Psychologists are encouraged to recognize the diversity that exists within cultural groups as cultural values may differ by race, ethnicity, social class, family income, gender, gender identity, sexual orientation, geographic region, education, ability, and acculturation level (Kumpfer, Alvarado, Smith, & Bellamy, 2002). Psychologists are encouraged to examine cultural assumptions and biases of specific preventive programs and to consult the APA's (2003) "Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists" and its "Guidelines for Assessment of and Intervention With Persons With Disabilities" (APA, 2012a) in integrating considerations of culture in the design, implementation, and evaluation of prevention interventions. It is important for psychologists to acquire and demonstrate cultural competence across prevention activities and to strive to work sensitively with diverse popula-

tions. This typically means that the psychologist must immerse him- or herself in the community and culture in order to be a sensitive partner with the community.

Psychologists endeavor to include relevant stakeholders in all aspects of prevention planning and implementation to ensure program fit with the local culture and to build community investment in the program. In order to ensure that preventive programs meet local norms, it is recommended that psychologists engage in careful planning and ongoing monitoring and evaluation of programs (Nation et al., 2003). Dynamic trial designs have been proposed that avoid problems associated with randomized clinical trials and focus on whether significant information is lost as the intervention proceeds (Jason & Glenwick, 2012), whether there are unintended consequences (positive and negative) that result from the intervention, and how to consider issues of diversity when statistical power may be low (Rapkin & Trickett, 2005).

Guideline 3. Psychologists are encouraged to develop and implement interventions that reduce risks and promote human strengths.

Rationale. Early prevention interventions focused on reducing risks or causes of psychological dysfunction (Conyne, 2004). However, psychological research has identified personal and environmental protective factors that may also mitigate the probability of negative outcomes in the face of risk and that contribute to optimal health. Research indicates that prevention is most beneficial when attempts to reduce risk are direct and are combined with efforts to build strengths and protective factors (Eccles & Appleton, 2002; Vera & Reese, 2000). Focusing only on building competencies or only on preventing problems may not be as effective as addressing both competencies and problems (Catalano, Berglund, et al., 2002).

Application. Psychologists are encouraged to consider and ameliorate factors that contribute to risk and also to recognize and promote factors that enhance human strengths. Prevention programs can seek to reduce or eliminate factors, such as socioeconomic disparities, negative peer influences, family dysfunction, and school failure, or they can seek to increase social competencies and other protective factors (National Research Council & Institute of Medicine, 2009). Although psychologists may consider only the benefits of either a risk-reduction or a strength-promotion approach, an optimal approach is to address both. Protective factors, such as socioemotional skills, interpersonal connection, ethical decision making, graduating from high school, school-to-work transitions, civic engagement, and proper nutrition, might be selected as foci of interventions based upon their malleability and their relevance to daily life (Eccles & Appleton, 2002; Nation et al., 2003; Stone et al., 2003). For instance, a focus on expanding the resilience that historically marginalized groups have demonstrated despite obstacles might also serve to enhance strengths in other arenas of life (Singh, Hays, & Watson, 2011; Singh & McKleroy, 2011).

An emphasis on simultaneously reducing risks and developing competencies is consistent with research on

positive youth development, empowerment, advocacy, and participatory community research. Positive youth development posits that (a) protective factors reduce the likelihood of maladaptive outcomes under conditions of risk and (b) freedom from risk is not synonymous with preparation for life (Catalano, Hawkins, Berglund, Pollard, & Arthur, 2002; Pittman, Irby, Tolman, Yohalem, & Ferber, 2001). The APA Presidential Task Force on Prevention: Promoting Strength, Resilience, and Health in Young People recommended that prevention encompass the goals of reducing health problems and promoting health and social competence (Weissberg, Kumpfer, & Seligman, 2003).

Similarly, empowerment interventions focus on helping individuals master and maintain control over life situations. Inherently, empowerment is concerned with competencies and strengths (Zimmerman, 1995; Zimmerman, Israel, Schulz, & Checkoway, 1992). Advocacy interventions also have been implemented with populations such as adjudicated youth (e.g., E. P. Smith, Wolf, Cantillon, Thomas, & Davidson, 2004), and women experiencing intimate partner violence (Allen, Bybee, & Sullivan, 2004). Finally, participatory action research (PAR) interventions, which focus on researcher-participant collaborations and, thus, on utilizing strengths and competencies of the participants, have been successfully implemented with diverse groups of youth (e.g., Foster-Fishman, Law, Lichty, & Aoun, 2010; Jason, Keys, Suarez-Balcazar, Taylor, & Davis, 2003; L. Smith, Davis, & Bhowmik, 2010). It is recommended that PAR be a genuine community-researcher partnership (i.e., the development of shared goals, shared methods, and shared sense of the value of the project and the findings) to successfully implement the methodology (Trickett, 2011).

Guideline 4. Psychologists are encouraged to incorporate research and evaluation as integral to prevention program development and implementation, including consideration of environmental contexts that impact prevention.

Rationale. Prevention research encompasses “theory and practice related to the prevention of social, physical, and mental health problems, including etiology, methodology, epidemiology, and intervention” (National Research Council & Institute of Medicine, 2009, p. xxvii). At its best, prevention research addresses multifaceted contexts (biological, psychological, and sociocultural levels) and functions (preintervention epidemiology, preventive interventions, and preventive service delivery systems; National Institute of Mental Health, 1998). The contexts and functions of prevention research can inform each other. Problems and their prevention occur at interrelated biological, psychological and sociocultural levels. Epidemiological research can identify targets for preventive interventions; evaluation of interventions can identify preferred approaches that can be incorporated into service delivery systems; the effectiveness and efficiency of service delivery systems can be assessed by examining their impact on epidemiology. At all stages of the research process, the

dynamic interactions between biological, psychological, and sociocultural environments are important to consider (Albee, 1996). Research solely examining intrapersonal factors that affect behaviors might ignore the context in which the individuals’ behaviors occur and could result in incomplete or misleading conclusions (National Institute of Mental Health, 1998). It is important that prevention research examine the etiology of maladaptive behaviors and potential determinants, including biological, intrapersonal, interpersonal, community, and societal risk and protective factors. It is also recommended that evaluations of prevention interventions address how adaptive behavioral changes promoted by a specific program are valued within different environmental contexts.

Application. Psychologists conducting research on prevention are encouraged to take into account the interface between biological, psychological, and sociocultural variables and the best available evidence regarding epidemiology, intervention, and service delivery. Resources are available to identify evidence-based prevention interventions for different demographics, topical areas, and contexts. One such resource is the National Registry of Evidence-Based Programs and Practices (<http://www.nrepp.samhsa.gov/Index.aspx>), compiled by the U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Psychologists are encouraged to consider the social ecology of the community in which they work (Bronfenbrenner, 1979) and to collaborate with community stakeholders on research goals and methods (Caplan & Caplan, 2000; Foster-Fishman, Berkowitz, Lounsbury, Jacobson, & Allen, 2001; Sullivan et al., 2001). Researchers are encouraged to assess the differential impact of prevention programs on specific communities. Prevention researchers may unknowingly design and evaluate programs using criteria from their own cultural perspectives and worldviews and may miss important contextual factors that contribute to the success or failure of prevention interventions within specific communities and cultures (e.g., diverse social classes and socioeconomic groups; Trickett, 1998; Turner, 2000). Community collaboration is important in the interpretation and application of research findings and for the provision of oversight and monitoring of community-based research. PAR is one example of collaborative research that appreciates environmental contexts and recognizes that knowledge is coproduced through collaborative actions with those who have traditionally been left out of the research process and whose lives are most affected by the research problem (Prilleltensky & Nelson, 2002).

Guideline 5. Psychologists are encouraged to consider ethical issues in prevention research and practice.

Rationale. Psychologists are required to adhere to ethical standards of the profession and to be mindful of its highest ideals (APA, 2010). Prevention efforts may raise unique ethical issues (Bond & Albee, 1990; Waldo, Kaczmarek, & Romano, 2004). Prevention is typically conducted with numerous participants and has individual, sys-

temic, and societal implications. It is important to evaluate possible negative impacts that preventive interventions may have on individuals, the community, or the larger society (Bloom, 1993; Caplan & Caplan, 1994). For example, conducting preventive interventions that identify higher risk within a historically stigmatized group could be harmful to members of that group. Thus, it is important that confidentiality be adhered to during the prevention intervention process (Bloom, 1993). Additionally, targeted behavior may serve one or more purposes for the individual and community; eliminating the behavior without attention to its possible protective functions may lead to negative consequences for a segment of the community.

Application. Psychologists are encouraged to be knowledgeable regarding methods and designs in prevention research and practice within their boundaries of competence (APA, 2010, Ethical Standard 2.01). It is important that preventive interventions and research include considerations of the ethical implications of new or promoted behaviors before, during, and after a prevention intervention. Informed consent poses particular challenges with regard to ensuring that individuals and multiple stakeholders comprehend the implications of their participation. Other ethical issues to consider include equitable selection, confidentiality, cultural relevancy, socially and culturally competent research and practice (APA, 2010, Ethical Standards 8.02 and 2.01b), and researcher bias (Schwartz & Hage, 2009). It is important to evaluate the long-term effects of preventive interventions (Brown & Liao, 1999), especially as they relate to historically marginalized groups.

Guideline 6. Psychologists are encouraged to attend to contextual issues of social disparity that may inform prevention practice and research.

Rationale. Considerations of social disparities can provide a context for prevention work in which the causes and effects of oppression can be identified and considered. Reducing social disparities is essential for preventing the myriad of problems that they spawn (e.g., Vera, Buhin, & Isacco, 2009). For example, children living in disadvantaged neighborhoods are at risk for childhood behavioral difficulties, including conduct disorders, mental health problems, academic failure, and teen pregnancy (e.g., Goodnight et al., 2012; Harding, 2003; Leventhal & Brooks-Gunn, 2000; Nikulina, Widom, & Czaja, 2011). For adults, those living at or near poverty level have a greater incidence of major depressive disorder than those with higher incomes (e.g., Kessler et al., 2003). Furthermore, numerous health problems (e.g., diabetes, obesity, coronary heart disease) have been associated with living in poverty (e.g., Kittleson et al., 2006; Ludwig et al., 2011). Consistent with these considerations, the importance of creating contexts of fairness in order to improve the health and wellness of those served by prevention programs has been emphasized (Lawson, Noblett, & Rodwell, 2009; Prilleltensky, 2001, 2012; Tepper, 2001).

Application. Psychologists strive to be cognizant of the social implications of the preventive services they offer. For example, interventions that fail to consider those structural inequalities and contextual factors (e.g., social class, socioeconomic status) that influence behavior may inadvertently suggest that the problem lies within a particular group instead of acknowledging the influence of being marginalized in society (Walker, 2009). Prevention interventions may have maximum impact if societal inequalities related to social class, economic status, discrimination, and exploitation are considered (M. J. Perry & Albee, 1994). Dissemination of prevention findings grounded in the social ecology of the community may aid in acknowledging inequalities that may contribute to or exacerbate a particular behavior that is the target of intervention. For example, lesbian, gay, bisexual, transgender, and queer young people who are bullied in school may be experiencing not only homophobia reactions from peers but also bullying based on racial/ethnic, gender, and/or class identities (American Psychological Association, 2012b; Singh & McKleroy, 2011).

Guideline 7. Psychologists are encouraged to increase their awareness, knowledge, and skills essential to prevention through continuing education, training, supervision, and consultation.

Rationale. The *Guidelines and Principles for Accreditation of Programs in Professional Psychology* (APA, 2009) stress the importance of education and training that cover the breadth of psychology. Research suggests that prevention helps to reduce the need for remedial interventions (Schwartz & Hage, 2009; Vera et al., 2009). Therefore, remediation and prevention are best viewed as complementary to one another, not in conflict. However, despite psychology's history with prevention practice and research during the 20th century (Cowen, 1973; Elias, 1987), the education of psychologists continues to emphasize crisis interventions and remedial approaches, giving much less attention to prevention as a core component of training and education (Matthews, 2003; O'Byrne, Brammer, Davidson, & Poston, 2002; Snyder & Elliott, 2005). Although some psychologists learn about the development and implementation of prevention activities in graduate school (e.g., community psychologists), most new prevention interventionists do not have a high level of training in the established content areas of prevention, and more-established professionals report low levels of knowledge in newer areas of prevention (e.g., gender and culture issues, economic analysis of prevention; Eddy, Smith, Brown, & Reid, 2005). This research suggests that much of the education and training in prevention is learned through less formal methods than graduate education. In psychology graduate education, there is a need to expand opportunities to learn about prevention by developing prevention-based courses and/or infusing prevention-related content into existing courses (Conyne, Newmeyer, Kenny, Romano, & Matthews, 2008; Matthews & Skowron, 2004).

Application. The training and continuing education of psychologists in awareness, knowledge, and skills related to prevention provide psychologists with resources to be proactive in reducing human suffering and in promoting positive aspects of human functioning. Psychologists are encouraged to obtain education and training in preventive approaches through various pathways, including respecialization programs, postdoctoral fellowships, continuing education programs, self-study, conferences, professional societies that focus on prevention, and combinations of such alternatives. Other avenues include service learning and experiential work in community settings less typical for psychologists (DeLeon, Dubanoski, & Oliveira-Berry, 2005). Predoctoral psychology graduate students may also consider taking advantage of coursework, practicum experiences, and predoctoral internships that have a prevention focus. Psychology training programs can also encourage enrollment in prevention courses in other disciplines, such as public health, thus encouraging training in interdisciplinary perspectives important to prevention. Those already in practice and unable to participate in concentrated, formal training programs may be able to utilize continuing education programs. Psychologists may also gain supervised experience and consultation working with psychologists, or other professionals, skilled in prevention. Because public health has a strong focus on prevention, increased training and collaboration with professionals in the field of public health are encouraged. Through more formal education, psychology trainees and psychologists may consider earning dual degrees in public health (e.g., a master's in public health) and psychology. The collaborative training, which pairs psychologists' understanding of human behavior and public health professionals' knowledge of health and prevention at community or population levels, may be particularly effective at creating change at the societal level. Literature relevant to prevention is available through professional journals, including a growing number of applied journals in, for example, psychiatry, public health, and psychology. Prevention research and applications are also disseminated through professional organizations and their respective conferences.

Scholars have noted several knowledge and skill domains important to psychologists engaging in prevention (Conyne, 1997; Hage et al., 2007; O'Neil & Britner, 2009). The domains include (a) understanding distinctions between preventive and remedial approaches; (b) designing and implementing educational programs; (c) assessing community needs; (d) understanding systemic approaches that incorporate cultural and contextual factors into preventive interventions; (e) using group skills and approaches, when appropriate, in program design and implementation; (f) collaborating with interdisciplinary teams that include professionals and community leaders; (g) grant-writing and marketing skills to address sustainability of preventive efforts; (h) promoting positive development across the life span; (i) empowering individuals and communities to work on their own behalf; (j) developing strength-based approaches that reduce risk and enhance resilience in indi-

viduals and communities; (k) influencing policy decisions and their impact on preventive efforts; and (l) evaluating preventive interventions. Each of these domains of knowledge and skill in prevention ideally would include attending to the needs and concerns of historically marginalized groups and would consider power differentials as they relate to cultural differences and concerns of social inequalities. In addition, training in newer technologies, such as telepsychology and social media, is important as these technologies are emerging methods for preventive efforts.

Guideline 8. Psychologists are encouraged to engage in systemic and institutional change interventions that strengthen the health of individuals, families, and communities and prevent psychological and physical distress and disability.

Rationale. Applications of prevention through systemic interventions are important across many domains. Systemic preventive interventions include those that affect families, schools, communities, and work environments. Individuals may not be able to achieve maximum health or full social participation if systemic barriers, such as classism, racism, sexism, and poverty, prevail. Preventive programs that focus only on changing individuals are likely to be less effective than those that also address the contexts that support or inhibit development and optimal health. Systemic interventions can be delivered across the life cycle, but the earlier prevention occurs, the greater the likelihood of reducing risk and strengthening protective factors (E. J. Smith, 2006). Systemic preventive programs that focus on developing community norms that promote healthy lifestyle behaviors are effective in reducing societal problems (Orpinas, Horne, & the Multisite Violence Prevention Project, 2004).

Application. Psychologists are encouraged to engage in activities that produce positive systemic, institutional, and organizational change. Psychologists can contribute to systemic change that strengthens protective and resiliency factors of individuals, families, schools, workplaces, faith communities, community centers, and health care centers (Johnson & Millstein, 2003; Kumpfer & Alvarado, 2003; Morsillo & Prilleltensky, 2007; Wandersman & Florin, 2003). For example, organizational psychologists can assist in the development of corporate policies to reduce work stress and stress-related illnesses and to increase worker satisfaction and productivity (Murphy, Hurrell, & Quick, 1992). Other examples include school-based preventive programs that address the multiple needs of students across the school and community. Such programs have yielded positive results and enhanced students' emotional, social, and academic development (e.g., August, Hektner, Egan, Realmuto, & Bloomquist, 2002; Greenberg et al., 2003; Newman-Carlson & Horne, 2004). School-based interventions that incorporate health promotion, competence enhancement, and youth development as frameworks for prevention can reduce youth risk behaviors and enhance protective factors (e.g., C. L. Perry, 1999; Weissberg & Greenberg, 1998). A recent meta-analysis of

after-school programs indicated that programs that foster personal and social skills of youth provide the greatest benefit (Durlak et al., 2010). School-based systemic interventions may also inform policies that address inequities and discrimination among groups of students (Morsillo & Prilleltensky, 2007).

Psychologists can influence the structure, role relationships, premises, rules, and assumptions governing systems to empower communities and to promote justice and equity (Evan, Hanlin, & Prilleltensky, 2007). Psychologists in health care settings can promote employee programs that strengthen employee resiliency in order to inoculate employees against the physical and psychological demands of the work setting (Freeman & Carson, 2006). Another area of systemic application is advocating for healthy food choices in cafeterias, lunchrooms, and vending machines to promote healthy nutrition, which, when coupled with an active lifestyle, can reduce obesity and resulting health risks (Hawkes, 2007; Suarez-Balcazar et al., 2007).

Parent- and family-based interventions can help parents and other caregivers learn effective child-rearing skills to strengthen adult and child relationships, which, in turn, reduce child and adolescent behavior problems and enhance learning (Thornton, Craft, Dahlberg, Lynch, & Baer, 2002). Applications of systemic prevention interventions at later stages of life include community-based programs that support older adults living in their homes. Elders with sufficient physical and emotional capacity will benefit from community preventive programs that involve them in community volunteer opportunities, public policymaking, neighborhood networking, and social support groups (Konert et al., 1999).

Guideline 9. Psychologists are encouraged to inform the deliberation of public policies that promote health and well-being when relevant prevention science findings are available.

Rationale. Psychologists are well positioned to educate and inform policymakers about the importance of prevention to enhance health and well-being (Kiselica, 2004). For example, public policy-based prevention programs such as Project Head Start have been an integral part of preventive initiatives that promote human functioning and reduce negative health outcomes (Ripple & Zigler, 2003). Psychologists are encouraged to apply their expertise by informing policymakers about the value of evidence-based preventive initiatives and to communicate their research findings clearly and concisely to policymakers (Coates & Szekeres, 2004; Hage et al., 2007; Ripple & Zigler, 2003).

Application. Psychologists are encouraged to become informed about public policy debates in which prevention research and programs may have relevant information to contribute to the discourse. Psychologists strive to enter such discussion and inform policymakers at local, state, and national levels by using their expertise and scholarship in prevention science as appropriate. For example, at the Surgeon General's Conference on Children's Mental

Health in 2000, psychologists provided recommendations to help formulate a national policy on children's mental health (Levant, Tolan, & Dodgen, 2002). It is suggested that psychologists become familiar with APA resources that are relevant to health care policy and health promotion. They are also encouraged to consider strengthening their efforts by forming multidisciplinary partnerships that include government, legal, and policymaking experts, as well as professionals from the health, social, and educational sciences. For example, Jason (2012) described a 20-year collaborative effort between psychologists and patient advocacy organizations to effect change in multiple areas regarding the problem of chronic fatigue syndrome, including epidemiological evidence, criteria for diagnosis, and leadership at the Centers for Disease Control and Prevention. As another example of collaboration, in 1965, Head Start began as a White House initiative that included the collaboration of psychologists, sociologists, and pediatricians focused on the goal of reducing the deleterious effects of poverty on young children (Styfco & Zigler, 2003). Furthermore, it is recommended that graduate programs teach students about the relationship between research and its relevancy to informing policy (Ripple & Zigler, 2003).

Conclusion

The Prevention Guidelines encourage psychologists, including those within the policymaking process, to strive to engage in prevention practice, research, and education to enhance human functioning. Prevention has numerous benefits, including the potential to strengthen the integration of science and practice in psychology (Biglan, Mrazek, Carnine, & Flay, 2003). Moreover, as discussed throughout the Guidelines, the benefits of prevention have been demonstrated through the reduction of illness and problem behaviors, the enhancement of human functioning, and the potential to reduce health care costs (Durlak et al., 2010; Institute of Medicine, 1994; Naton et al., 2003; National Research Council & Institute of Medicine, 2009). An increased focus on prevention has the potential to mobilize psychologists to respond more effectively and sensitively to conditions that place individuals, communities, and institutions at risk for various problems and to promote strengths that contribute to human functioning.

The Guidelines provide a framework for best practices in prevention and the promotion of health and well-being, regardless of an individual psychologist's specialty area, employment setting, or professional interests. Infusing prevention across the profession will help to orient psychologists to a broader application of psychological research and practice, with the goal of more effectively and sensitively responding to major societal needs for all individuals, especially those with the fewest resources and groups historically underserved by the profession.

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Appendix

Guidelines for Prevention in Psychology

Guideline 1. Psychologists are encouraged to select and implement preventive interventions that are theory- and evidence-based.

Guideline 2. Psychologists are encouraged to use socially and culturally relevant preventive practices adapted to the specific context in which they are implemented.

Guideline 3. Psychologists are encouraged to develop and implement interventions that reduce risks and promote human strengths.

Guideline 4. Psychologists are encouraged to incorporate research and evaluation as integral to prevention program development and implementation, including consideration of environmental contexts that impact prevention.

Guideline 5. Psychologists are encouraged to consider ethical issues in prevention research and practice.

Guideline 6. Psychologists are encouraged to attend to contextual issues of social disparity that may inform prevention practice and research.

Guideline 7. Psychologists are encouraged to increase their awareness, knowledge, and skills essential to prevention through continuing education, training, supervision, and consultation.

Guideline 8. Psychologists are encouraged to engage in systemic and institutional change interventions that strengthen the health of individuals, families, and communities and prevent psychological and physical distress and disability.

Guideline 9. Psychologists are encouraged to inform the deliberation of public policies that promote health and well-being when relevant prevention science findings are available.