• **Rejoinder**

Walking the Talk:
Implementing the Prevention Guidelines and Transforming the Profession of Psychology

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The Major Contribution aimed at strengthening a prevention focus in psychology, so as to more effectively and equitably promote the well-being of all members of psychology communities. The 3 reactions (L. A. Bond & A. Carmola Hauf, 2007 [this issue]; L. Reese, 2007 [this issue]; E. Rivera-Mosquera, E. T. Dowd, & M. Mitchell-Blanks 2007 [this issue]) give strong support for the best practice prevention guidelines, while providing new insights for their implementation in the field of psychology. In this rejoinder, the authors make an effort to build upon their colleagues' ideas, by addressing the topics of community-based collaboration, prevention across the life span, and implementation of the best practice guidelines. The authors urge further interdisciplinary collaboration by members of the American Psychological Association, and others interested in prevention, and invite genuine action to expand prevention efforts.

Undoubtedly, the expression—"You can talk the talk, but can you walk the walk?"—is familiar to many people. A shortened variation of the original phrase, "Walk the talk," may be less well known but can be found in the *Encarta World English Online Dictionary* (2006), and is defined as "to act on what you profess to believe in or value." The words suggest that real

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change happens when leaders not only say they want change and advancement but also match their words with actions. We are grateful to the authors who provided reactions to our article (Bond & Carmola Hauf, 2007 [this issue]; Reese, 2007 [this issue]; Rivera-Mosquera, Dowd, & Mitchell-Blanks, 2007 [this issue]). Their thoughtful commentary and suggestions highlight the importance of moving these Prevention Guidelines (Hage et al., 2007 [this issue]) from a publication in a scholarly journal to genuine actions for change in the field of psychology. We are also grateful to *The Counseling Psychologist* (*TCP*) Editor Robert T. Carter who gave us the opportunity to develop the article into a Major Contribution manuscript, and to receive reactions to these guidelines by eminent scholars in the field.

The reaction articles in this Major Contribution include authors from specialties in social work, clinical psychology, and counseling psychology. In addition, they represent work settings as diverse as university psychology departments, a government mental health department, a community advocacy agency, and a medical school. The work of prevention is multidisciplinary, and it is critically important that researchers, practitioners, and policy makers from across the professional landscape collaborate and form partnerships to advance a prevention agenda. We are extremely pleased and honored that these scholars, from different specialties and professional work environments, have given their reactions to the guidelines. In the limited space in this rejoinder, we will address several of the issues presented by the reaction articles.

COMMUNITY-BASED COLLABORATION

Bond and Carmola Hauf (2007), Reese (2007), and Rivera-Mosquera et al. (2007) all identified the importance of collaboration as a central component of best practices in prevention. Although our guidelines did not explicitly address collaboration, our third practice guideline emphasizes the importance of including "clients and other relevant stakeholders in all aspects of prevention planning and programming" and thus recognizes the necessity of forming community partnerships in prevention work (p. 508). That being said, the reactants did a service by further emphasizing the importance of collaboration as an integral component of best practices at several levels. All three reaction articles note that the perspectives and knowledge base of any single profession are limited in informing and guiding the practice of prevention. Indeed, these authors collectively describe why collaboration should occur at the local community level, with other helping professionals, and with scholars and researchers from other disciplines.

Bond and Carmola Hauf (2007) maintain that interdisciplinary scholarship should provide the theory and research base for effective prevention. They effectively explain how community collaboration is critical to the development of comprehensive and multisystemic interventions. In addition, Rivera-Mosquera et al. (2007) advocate for collaboration across the health and mental health professions, including counseling and clinical psychologists, social workers, nurses, and public health workers. Reese (2007) similarly notes that the knowledge base of multiple disciplines, such as epidemiology, health, economics, and sociology, are integral to public health practice and prevention. By insulating ourselves from other disciplines and professions, we are likely to miss important research knowledge. Similarly, by cutting ourselves off from the communities we serve, we may miss an understanding of local needs and knowledge. Furthermore, from a training perspective, learning the art of collaboration represents an example of an area where even more "how to" guidance is needed. Some authors (e.g., Kenny, Sparks, & Jackson, in press) are documenting their work in collaboration in efforts to identify lessons to further guide training and practice in interprofessional collaboration. Developing and sustaining effective collaborations with multiple stakeholders and then negotiating and reconciling the competing needs represented by varied perspectives are challenging tasks.

Similarly, as Bond and Carmola Hauf (2007) suggest, community-based collaboration enables more accurate and relevant prevention research. One potential function of Waldo and Schwartz's (2003) prevention research matrix presented in this issue is to point out how diverse sources of expertise available through community and interdisciplinary collaboration can be integrated to conduct comprehensive prevention research. For example, community members can provide unique information on the epidemiology of problems within their community; they can inform the design of preventive interventions, ensuring they are targeted on the most salient variables and are sensitive to community norms; and they can identify the systems and resources within a community that will allow wide and sustained delivery of prevention services.

The expertise of different disciplines may also make unique contributions in each of these service areas. For example, the field of public health is especially suited to clarifying epidemiology, clinical psychology is strong in the design and evaluation of interventions, and the social work profession is adept at creation and assessment of service delivery systems. Rivera-Moquera et al. (2007) eloquently state that "each of us brings a unique experience and set of skills that are needed to begin to address the serious societal problems facing our country and our world" (p. 590). Hence, the diverse communities and professional disciplines must work

together in "sharing our skill sets, lessons learned, and methodology to bring about real social change" (Rivera-Mosquera et al., 2007, p. 590).

Nevertheless, in spite of our strong agreement with all three of the reactants that collaborative community partnerships are critically important to the work of prevention specialists, we are reluctant to identify the forming of such partnerships as the "overarching best practice" of prevention. The major reason for our hesitation to adopt this perspective, as argued by Bond and Carmola Hauf (2007), is that "community" is too often interpreted narrowly. A framework of "community" may not give sufficient visibility to educational training of psychologists or political advocacy for prevention. As Rivera-Mosquera et al. (2007) comment, the four conceptual areas of the guidelines, which include practice, research, training, and social advocacy, provide a necessary conceptual framework. In addition, a community is not a single voice and may, for example, include parents, teachers, businesses, workers, social services agency leaders, clergy, and youths. In addition to a divergence in voices emanating from the field, these voices may not be congruent with those from multiple professions and scholarly disciplines. Thus, although better practice may eventually emerge, the processes through which this happens are not always clear. Indeed, Bond and Carmola Hauf (2007) recognize the tensions that often exist when preventionists attempt to apply prevention interventions across diverse groups of people.

One method to address specific needs across divergent groups or to assess in-group differences is through a process called "elicitation research" (Flores, Tschann, & Marin, 2002). This research process collects information during the development phase of a prevention intervention to better understand relevant personal cognitions and social norms important to a group or population receiving the intervention, thus strengthening the relevancy of the intervention for those receiving it. Conducting elicitation research prior to finalizing a prevention intervention increases the chances of a successful outcome for behavior change by addressing variables important to the group being served. Romano and Netland (in press) demonstrated how elicitation research and the theory of reasoned action (Ajzen & Fishbein, 1980; Albarracin, Fishbein, Johnson, & Muellerleile, 2001) can address within-group differences in the development and implementation of prevention interventions.

PREVENTION ACROSS THE LIFE SPAN

Reese (2007) notes that many of the examples of prevention interventions provided in our set of Prevention Guidelines were drawn from practice with

young people, despite the fact that prevention theory and practice cut across the life span. We concur with Reese on his point and hope that our examples of effective interventions with youths do not lead readers to think of prevention as an activity only for the early years. Prevention is not only for children and adolescents but also must be applied throughout the life cycle, including the development of preventative interventions for diverse groups of women and men at midlife and communities of older adults. Indeed, developmental challenges, risks, and opportunities for positive development occur across the life span, and these many stages of life represent significant opportunities for prevention-minded psychologists to engage in active collaborative efforts across the disciplines. It is possible that many of our examples emerge from youth work because schools and colleges have been available settings for prevention interventions, and they also offer opportunities for funding of prevention research. As we move to increase the reality of prevention across the life span, we will need to find mechanisms to fund and house prevention activities for all phases of life.

There are indications that the field of psychology is increasing its attention to the unique needs of older adults. For example, interventions have addressed the prevention of suicide and depression in older adults (Heisel & Duberstein, 2005; Whyte & Rovner, 2006). In addition, the American Psychological Association (APA) Public Interest Directorate has established an Office on Aging, which coordinates APA activities pertaining to aging and geropsychology. The Office on Aging also supports the work of the APA Committee on Aging, which has published a handbook on psychology and aging (American Psychological Association Committee on Aging, 2006). This work recognizes that not only are people 65 years of age and older the fastest growing segment of the U.S. population, with an increasing number of these older adults of immigrant status or members of ethnic or racial minority groups, but that more than 5 million older adults have incomes below the poverty level or are classified as poor. Adulthood is also a period of life where adults confront a variety of changes related to families, interpersonal relationships, careers, health, and end-of-life issues. Prevention has a role to play in helping adults manage and prevent the adverse effects of these changes.

Hence, we welcome Reese's (2007) reminder to "cast a broad net" in the goal of expanding our prevention efforts. He insightfully challenges psychologists to more effectively address the interface of physical and mental health, and reminds us of the imperative to decrease health disparities and improve the quality of life of communities in the United States and abroad. His remarks reflect the social justice orientation out of which the Prevention Guidelines emerge. This perspective demands that we become aware of how the numerous systems that are part of U.S. society, including economic, governmental,

and educational structures, define truth for the entire community (Dounce, 2004; Dworkin & Yi, 2003). Prevention work can and should begin within the local context (e.g., to apply the social justice model in our own communities) but also needs to be thoughtfully concerned with systemic practices and the state of power and oppression around the globe. Our efforts must aim to enhance personal and collective well-being and to create social and political change aimed at improving environments where people live, learn, and work (Hage, 2005).

Similarly, we endorse Bond and Carmola Hauf's (2007) recognition of the importance of moving beyond a focus on strengths and protective factors at the individual level, to also address such strengths at multiple systemic levels (e.g., microsystem, organizations and institutions, community, sociopolitical, cultural–environmental). While strength-based models related to individuals have received attention in the literature, there is much less focus on strengths and protective factors of communities, organizations, and institutions. Hence, it is important to consider the strengths, as well as the limitations, of institutions, such as schools, cultural centers, faith communities, and community organizations, when planning and implementing prevention interventions.

IMPLEMENTATION OF THE PREVENTION GUIDELINES

In their reaction articles, Rivera-Mosquera et al. (2007) and Reese (2007) recognize the significance of moving beyond the "ivory tower" and the level of "rhetoric" to make the Best Practices Prevention Guidelines a reality. Similarly, Bond and Carmola Hauf (2007) remind us that prevention review articles of this nature have been presented in other professional journals, with remarkably similar conclusions. We would like to recognize the validity of these concerns, while also providing further explanation of the process of development of these guidelines. Members of the Prevention Section of Division 17 developed these Prevention Guidelines with the goal of eventually bringing them forth for adoption by APA and other professional organizations and government entities, as suggested by Reese (2007). Therefore, the Prevention Guidelines were formulated in accordance with Criteria for Practice Guideline Development and Evaluation, developed by APA in 1995 and later revised and approved by the APA Council of Representatives (American Psychological Association, 2002). The APA criteria specify that proposed guidelines, such as those presented in our article, need to focus on educating and informing the practice of psychologists, as well as stimulating debate and research. As such, the APA document specifies that guidelines "must be reasonable, well researched, aspirational in language, and appropriate in goals" (Section 1.1). Hence, the specificity of these requirements meant

that content related to the implementation of the Prevention Guidelines was mostly left out of our article. However, despite this limitation, the Prevention Guidelines are the first set of comprehensive prevention guidelines that encompass the major areas of prevention work (i.e., practice, research, training, and social advocacy) that have been prepared for eventual adoption by APA. Finally, as noted in our article, these guidelines are an "initial step" in what we hope will be a broader collaboration of psychologists working together to enhance and implement these recommendations for prevention within the Society of Counseling Psychology, other appropriate APA divisions, as well as APA and other professional organizations.

We share the concern voiced by Rivera-Mosquera et al. (2007): If further efforts beyond the publishing of these guidelines are not made, this work may likely "fail to provide forceful guidance for significant change" (p. 587). Hence, while the guidelines may be recognized, as Reese (2007) notes, as a "next step" in stimulating counseling psychologists to engage in prevention, they represent just one step, and further discourse on implementation and process is essential to move prevention more visibly from the fringes of the field to center stage in the profession. Similar comments were made by two past presidents of Division 17, Rosie Bingham and Derald Wing Sue, at the 2006 APA Symposium addressing the implications of these guidelines (Hage & Romano, 2006). In their presentations, Bingham and Sue drew comparisons between the Prevention Guidelines and the *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (American Psychological Association, 2003) in terms of their movement from an academic article to implementation and action. In summary, the challenge for prevention specialists as well as the larger community of scholars and practitioners is to develop creative ways to advance a prevention agenda, and we hope that these Guidelines provide guidance.

We appreciate the specific recommendations put forth by the reactants for how best to advance the dissemination of the Prevention Guidelines, and would like to highlight some of their suggestions. Education and training, both at the pre- and the postdoctoral levels, was cited as one essential area for implementation. We strongly concur with Rivera-Mosquera et al. (2007) and with Reese (2007) in their recommendation that prevention theory, research, and practice need to be included within counseling psychology curricula at all levels. The challenge that demands further attention is how we move forward to infuse prevention practice and research not only in counseling psychology training but also throughout psychology education.

Reese's (2007) suggestion that the Prevention Guidelines become part of "any reading packet for courses on prevention" is well taken, as is the recommendation to include implementation of the Prevention Guidelines on the

agenda for discussion at the annual meeting of the Council of Counseling Psychology Training Programs. We would also suggest that the guidelines be included in the training of doctoral students and be discussed by other psychology training groups (e.g., Council of School Psychology Training Programs). Reese also suggests partnerships with professional organizations outside of psychology (e.g., public health), government entities (e.g., U.S. Department of Health and Human Services), and stakeholders in the community. We would add other academic disciplines (e.g., social work, counseling) as well as accreditation bodies such as the APA's Committee on Accreditation, the Council for Accreditation of Counseling and Related Educational Programs, and psychology as well as other mental health licensing boards to the list of disciplines and partnering organizations. Moreover, Rivera-Mosquera et al. (2007) note the importance of addressing the ethics of prevention. This need has begun to be addressed, although not as broadly as we would like (e.g., Hage & Schwartz, 2006; Schwartz & Hage, in press). Prevention practica are also urgently needed, as Reese (2007) suggests. Finally, developing the equivalents of "preventive medical residency programs" for counseling psychologists, as well as pre- and postdoctoral internships in prevention research and practice, are excellent suggestions that deserve careful consideration.

In addition, one of the most innovative ideas for dissemination of these guidelines comes from Rivera-Mosquera et al. (2007), who point out that the economics of prevention has been a major obstacle in furthering prevention efforts. Their unique contribution is the suggestion that preventive services be viewed as a type of therapeutic program. They argue that by conceptualizing prevention as a "therapeutic intervention," new avenues to support the work of prevention (e.g., third-party reimbursement) may emerge. By extension, if third-party reimbursement were to become possible for prevention, then the place of prevention in psychology education and training programs will be more fully secured. This perspective is an interesting one to consider and merits close attention and further discussion among scholars, practitioners, and policy makers. However, it may be more effective to develop financial models that can prove the cost-effectiveness of prevention, rather than compromising the conceptualization of prevention. For example, several recent studies have found that teaching clients interventions based on cognitive–behavioral therapy is cost-effective in preventing the onset of a full-blown depressive disorder (Churchill et al., 2001; McCrone et al., 2004; Schulberg, Raue, & Rollman, 2002; Smit et al., 2006). The dissemination of more findings like these studies on depression is critical in convincing policy makers and funding organizations that prevention is cost-effective.

Reese (2007) issues a similar call for prevention research that is relevant, disseminated, and utilized. We agree that too much good prevention research

remains academic, and thus fails to realize its potential to improve lives, particularly in communities disadvantaged by disparities in resources. We believe that including a focus on service delivery systems as an integral component of programmatic prevention research has significant potential for correcting this deficit. For example, we recommend that investigators examine the practical utility and economic feasibility of their research by utilizing the prevention research matrix presented in this issue, and by examining how a research project relates to the third category—Prevention Service Delivery Systems. The prevention research matrix provides a tool to understand the need for research and how the outcome of this research can inform the field. Understanding this process will often lead to more open and informed communication with participating communities about the meaning and scope of the prevention program at each step of the intervention.

CONCLUDING OBSERVATION

A final observation we would like to make is to underline the significance of the reaction articles being intentionally authored by a clinical psychologist, a counseling psychologist, and a social worker. This effort by *TCP* represents an excellent attempt at reflecting an important reality about prevention: It is an interdisciplinary science and practice that requires interdependent collaboration in order to be effective. We need more efforts like this one, including applications to education and training in prevention. In addition, Reese (2007) provides a valuable perspective as a counseling psychologist who previously was employed by the Centers for Disease Control and Prevention, and currently is in the Department of Community Health and Preventive Medicine, Morehouse School of Medicine. He observes that psychology must move prevention more forcefully from the margins of the field to the heart of the profession, and that the Society of Counseling Psychology ought to take the lead for all of psychology in making this transformation happen. We whole-heartedly agree with this perspective, and we invite psychologists and others interested in prevention to join this effort by becoming involved in the Prevention Section (http://www.div17.org/preventionsection).

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