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1 THE PAST, PRESENT, AND FUTURE OF PREVENTION

The rise of prevention in psychology has been a welcome development. Prevention promises to alleviate the societal burden of violence and other ills more than intervention alone ever can, by stopping adversities and suffering from happening in the first place. Most social problems are addressed through a response or intervention—we put a Band-Aid on a cut after a fall; we provide medication to reduce symptoms of depression or to cure an infection. *Prevention*, as we use the term in this book, is about trying to do something sooner—to keep the toddler from an injury by moving the scissors out of reach, to vaccinate against polio to keep the invasive virus from getting a foothold in a person's body, or to educate students about healthy conflict management strategies before an argument escalates to an afterschool fight. In some domains, such as childhood vaccinations, prevention has been wildly successful, saving countless lives and millions of dollars (Whitney et al., 2014). Efforts to promote seatbelt use, reduce smoking, and decrease drunk driving have also met with success (Hemenway, 2009; Potter, 2016). Even in more challenging areas, such as child maltreatment prevention, data suggest that modestly effective efforts can nonetheless meaningfully improve quality of life and reduce costs (e.g., Olds et al., 1998).

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Strengths-Based Prevention: Reducing Violence and Other Public Health Problems,
by V. Banyard and S. Hamby
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However, the array of problems that create barriers to well-being across the lifespan are numerous: More than eight in 10 people experience adverse childhood experiences such as family substance use, maltreatment, and peer victimization (Hamby et al., 2021), one in four women experiences intimate partner violence in her lifetime (Smith et al., 2018), and rates of opioid and other substance use and death by suicide have increased in recent years (e.g., Hedegaard, Minino, & Warner, 2020). Prevention has not been successful at reducing many significant public health problems (we use the broad umbrella term of "public health" given their prevalence and wide impact, but these problems are studied and addressed by disciplines including but not limited to psychology, social work, criminology, and education). Furthermore, although researchers and preventionists often document, study, and respond to these issues separately, the issues rarely occur in isolation. Whether we are counting *adverse childhood experiences* (e.g., exposure to divorce, a parent with substance abuse or mental health problems) or the number of types of victimization a person experienced (*poly-victimization*), problems compound and interact to create many physical and mental health problems that can stifle the potential and well-being of an individual or a community.

Prevention is a key part of the solution. The *Guidelines for Prevention in Psychology* (American Psychological Association [APA], 2014) define prevention as processes that keep a problem from happening, interrupt the development of a problem in those who are at risk, and promote strengths and well-being. Prevention in psychology is grounded in work by Albee (1986) and is often classified based on the audience or levels for prevention: *Universal* or *primary* prevention targets everyone in a community, *selective* or *secondary* prevention focuses on at-risk groups, and *indicated* or *tertiary* prevention targets individuals showing early symptoms of a problem (Institute of Medicine, 1994). Practitioners across fields including clinical, community, and counseling psychology; public health; social work; criminology; and education have been heeding the call to action described in the set of guidelines for prevention outlined by the APA and others (APA, 2014; Nation et al., 2003). Preventionists use a variety of methods ranging across social marketing campaigns, skill- and knowledge-focused workshops, online games, and hot-spot mapping. Recent preventionists remind us that prevention also needs to be global and to move beyond individual levels of analysis (Israelashvili & Romano, 2017; Vera, 2020). Table 1.1 includes details of basic prevention concepts.

Most people are exposed to prevention messages. In one of the few national studies of prevention exposure, Finkelhor and colleagues (2014) found that 65% of a national sample of children ages 7 to 17 reported exposure to some kind of antiviolence or antibullying prevention program.

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TABLE 1.1. The Prevention Landscape

Category	Concept	Definition
Levels of prevention (CDC, 2020)	Primary prevention	Strategies to keep a problem behavior or risk exposure from happening at all (e.g., childhood vaccinations).
	Secondary prevention	Strategies that focus on groups identified as high risk (often they have one problem or vulnerability, and prevention is used to keep others from developing; e.g., home visitation programs for adolescent mothers).
	Tertiary prevention	Strategies to treat a problem after it has already emerged and to keep it from reccurring in the future. This form of prevention is usually thought of as intervention or treatment (e.g., trauma-focused cognitive behavior therapy) and is not a focus of this book.
Prevention classifications (Institute of Medicine, 1994)	Universal	Addresses an entire population to prevent a problem behavior from ever showing up (e.g., informational materials for all parents who give birth in city hospitals).
	Selected	Addresses an audience that, because of some characteristic, is already seen as at risk for a particular behavior. Individuals are not assessed; rather, a whole subgroup of a population is targeted based on being part of an at-risk group (e.g., parenting classes for all teen parents).
	Indicated	Addresses a full-blown problem behavior in individuals who already show low levels of the problem to keep the problem from getting worse or to reduce its effects (e.g., programs for college students who have gotten in trouble for underage drinking but who may not yet meet the criteria for an alcohol abuse disorder).
Common prevention frameworks and strategies	Social marketing campaigns	The use of business marketing principles to design information and health communications that persuade individuals to make changes to health behaviors.

(*continues*)

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TABLE 1.1. The Prevention Landscape (*Continued*)

Category	Concept	Definition
	Social norms approaches	Prevention based on the premise that individuals are driven to behave in ways that they perceive are consistent with other people in a social group they want to be part of. Prevention involves signaling more positive behavior norms or correcting misperceptions of behaviors that usually result from individuals thinking that peers engage in risky or problem behaviors to a greater extent than they do. Social norms campaigns are a specific use of social marketing and health communication strategies that focus on messages to convey what others in one's community are doing or should be doing.
	Hot spot mapping	A technique that engages community members (e.g., students in a school) to use a map of a particular location (e.g., school, neighborhood) and to mark places where they feel safe and where they feel unsafe (see, e.g., https://www.colorado.gov/pacific/cdphe/news/hot-spot-mapping). Maps are then used to divert resources and supervision to unsafe spaces.
	Built environment	Prevention efforts that focus on physical spaces (e.g., parks, buildings, streetlights) in a community. Such programs are truly environmental rather than focused on changing individual attitudes.
	Policy	State or federal laws, institutional regulations, or governing documents that affect human behavior by outlining actions that are disallowed or by supporting positive actions. Laws and policies can also be used to provide resources (especially funding allocations) to offer services and opportunities to selected communities.
	Workshops	Presentations of information and at times discussion and skill practicing with groups of participants (usually small, in-person groups or classrooms of students, although could be online).
	Gamification	Using principles of gaming to achieve prevention goals. Includes cooperative and competitive formats. This term also refers to the use of gaming platforms, in which health messages are delivered through a game.

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TABLE 1.1. The Prevention Landscape (*Continued*)

Category	Concept	Definition
	Nudges	A notion that comes from behavioral economics (Thaler, 2018) and describes strategies designed to change behaviors or the choices people make by intentionally working around errors in how people make decisions. Changes can be made to the physical space of decision making (e.g., where foods are placed in a cafeteria) or how programs are designed.
	Network diagnostics/ social network analysis	Techniques that use data collection methods to identify key community influencers who are embedded within and across different social groups. These individuals are usually nominated by social network members. These leaders are the focus of prevention training and then, because of their position as network influencers, they spread prevention messages (including modeling new social norms and healthy behaviors) to others in their social groups.
	Gender transformative and social justice approaches	Methods that engage men and boys in work to reduce gender-inequitable and stereotyped attitudes and behaviors and embrace more gender-equitable views. This work connects with a broad social justice framework for prevention that attempts to reduce a variety of inequalities, including antiracism training.

Note. Specific citations and examples of these approaches and strategies are provided throughout the chapters in this book.

A regional study found that nearly 90% of high school students in three northern New England communities reported prevention exposure in the past year (Edwards et al., 2021), and 62% of a sample of college students reported that they received child sexual abuse prevention training in school (Kenny et al., 2020). Yet violence and many other public health problems persist. Clearly, lack of exposure to prevention is not the problem. The issue is the effectiveness and utility of what participants get—does it actually make any difference in their lives? Finkelhor and colleagues (2014), for example, found that only 16% of their sample of children reported that the prevention they received was high quality (defined as including more than one day of programming, opportunities to practice new information and skills, and materials that were sent home to parents). A main point of this book is that prevention innovations and resources are needed more than

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ever. Realizing the potential of prevention, however, requires us first to look closely at the limitations of where we are, including taking a hard look at the theories we draw from and what failed examples can teach us.

We also believe that advancing prevention requires incorporating insights from other fields. In this book, we draw from a variety of disciplines (psychology, public health, social work, sociology, criminology, resilience science, critical race theory, and even urban planning). Our aim is to contribute to the de-siloing of prevention; in our view, sticking to our own disciplinary "lane" results in too many unnecessary reinventions of prevention strategies and remaking mistakes that reduce prevention effectiveness. The purpose of this book is to create next steps for prevention that are grounded in a broad review of the scientific evidence regarding what works and what does not.

We address prevention for many types of public health problems, especially those with typical onset during adolescence and those in which behavior dysregulation plays a key role. Violence preventionists need to be in conversation with substance abuse researchers and suicide prevention researchers; more connections are needed even within the broad umbrella of violence (Decker et al., 2018). We also draw from other areas of health behavior change, such as diet and exercise. Furthermore, preventionists in all fields need to know the individuals and groups working to dismantle broad systemic injustices that promote social disparities that underpin many of the behavior problems we seek to prevent. A key objective of this book is to present innovations in prevention by integrating research on similar prevention challenges and connecting that literature to other relevant literatures on behavior change, sociocultural forces, and related topics.

Each chapter examines a different facet of research and practice that builds toward our framework, the prevention portfolio model. We invite the reader, however, to approach the book in whichever way is most helpful to your work. You might start with a chapter in the middle or sample a set of chapters without reading from beginning to end.

THE NEED FOR PSYCHOLOGY IN PREVENTION

Despite the achievements of some prevention initiatives, the full promise of prevention has proven difficult to realize. Some of this failure is due to unexpected backlash, such as the rejection of vaccinations by some parents (Kata, 2010). However, many challenges are scientific in nature. Today, nearly 20 years after Nation et al.'s (2003) seminal review of key prevention principles (e.g., the importance of sufficient dose and varied teaching

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methods, grounding in theory and built on strong positive relationships, staff who are well-trained and attention to cultural relevance), many prevention programs have shown modest success, at best. Evaluations of programs that focus on problems such as violence and substance abuse have been especially disappointing, with several reviews and meta-analyses finding modest or even null effects, especially when the outcome is changing behaviors rather than attitudes or knowledge (Anderson & Whiston, 2005; Ennett et al., 1994; Fox et al., 2020; Hahn et al., 2007; Lee & Wong, 2020; Lynam et al., 1999; McEwan, 2015; Merrell et al., 2008; Park-Higgerson et al., 2008). For some popular programs, such as the Drug Abuse and Resistance Education (D.A.R.E.) prevention program, efforts to find "sleeper" (i.e., delayed) effects have also failed (Lynam et al., 1999). Furthermore, and even more regrettably, program evaluations are rarely replicated (repeated to see if the same result is obtained), a concern not limited to prevention (cf. Maxwell et al., 2015). For example, a recent review of violence programs for boys and men of color did not find a single program with a published replication (Hamby, Blount, et al., 2017; see Chapter 3, this volume, for more discussion).

Lack of replication hints at still bigger problems because existing replications, even those overseen by the original curriculum designers, often report more mixed findings than those obtained in the original setting (e.g., Cares et al., 2015; Moynihan et al., 2015). Independent replications are even scarcer, but a meta-analysis (i.e., a project that statistically summarizes results across many studies of a topic) of independently replicated substance abuse programs yielded null effects for the six programs for which an independent replication could be found (Flynn et al., 2015). It seems likely that there are unrecognized elements of the setting that are not captured in prevention curricula, an issue that has been identified by implementation scientists (e.g., Durlak & DuPre, 2008).

Even these grim results are not the worst possible outcome. Several studies have found evidence of *backlash*, defined as significant change in the undesired direction (Jaffe et al., 1992; Kerner & Goodyear, 2017; Lewis et al., 2016; Lynam et al., 1999). Backlash remains, somewhat remarkably, understudied in psychology. The scarcity of knowledge on unwanted "side effects" of psychological interventions stands in stark contrast to the approach to this issue in medicine, where side effects are much better documented. Prevention professionals need to understand that not everyone perceives prevention content the way that psychologists, social workers, educators, and other providers do. One study found adolescents who described themselves as particularly oppositional to authority from others were less affected by smoking prevention campaigns (Henriksen et al., 2006); another study

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suggested that messages with shaming content reduced adults' intentions to quit smoking (Kim et al., 2018). Several studies have found that some subgroups of participants may be particularly irritated by or resistant to prevention program content in ways that make them worse, not better (Darnell & Cook, 2009; Stephens & George, 2009; Tinkler, 2013). For example, efforts to modify social or gender norms to improve risk factors for perpetration have had reverse, boomerang effects for some groups of participants, with the participants at highest risk most likely to have adverse responses to messaging (Bosson et al., 2015; Kearney et al., 2004; Tinkler, 2013). This negative effect has also been found for other topics such as lab studies of antibias interventions on ratings of job candidates. Popular programs such as D.A.R.E. not only are ineffective but may even promote substance abuse or low self-esteem (Ennett et al., 1994; Lynam et al., 1999; West & O'Neal, 2004; Wilson, 2011). Incentives to increase physical activity may meet with short-term success but lead to negative outcomes when the incentives are discontinued, and efforts to influence other health outcomes in health promotion remain even more elusive (Finkelstein et al., 2016).

In one of the largest and most famous examples, the Cambridge–Somerville Study, McCord (1978) showed that participants in a comprehensive summer camp program for at-risk youth actually got worse compared to participants who did not participate in the program—and that outcomes worsened for those who attended a greater number of summer camps, a dose effect contrary to the expectation that more prevention exposure is better. It is increasingly well-recognized that many of these types of programs are instead better described as *deviancy training* than prevention (Dishion et al., 1999, 2015; O'Donnell & Williams, 2013). Unfortunately, many studies focus only on overall averages of outcome measures, rather than the ways in which a program might work differently for different groups of participants (e.g., one mentoring program found overall reductions in adult arrests among participants with prior arrest records but increased arrests for females who entered the program with no arrest record). Studies like these suggest that participants at highest risk may respond to prevention messages in a different way than their more advantaged peers would respond (Gidycz et al., 2011). Psychology needs to pay much more attention to the safety of prevention efforts (Hamby, Blount, et al., 2017). For some youth, discussions about drugs, risky sexual behavior, violence, or other problems may be more titillating than inhibiting. Ideally, we should not only know how many participants may experience unwanted side effects of prevention programming; we should also have some method of identifying high-risk people and offering guidance about what sorts of alternative programming would be preferable.

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OUR BACKGROUND AND EARLY EXPERIENCES WITH PREVENTION

Our own histories illustrate the need for a psychology- and strengths-informed approach to prevention and also provide *reflexivity* statements, which are opportunities to reflect on the strengths and limits of the viewpoints each of us brings to this work. We share a little about our backgrounds and our early experiences with prevention as a way not only to help readers better understand the viewpoints we bring to the book but also to encourage readers to reflect on their own understandings and experiences with prevention (see Exhibits 1.1 and 1.2). To assist readers with their own reflections, each chapter of the book concludes with a set of narrative exercises that can help readers engage with the ideas in the book and apply them specifically to their own work.

EXHIBIT 1.1. Dr. Hamby's Early Prevention Experiences and Other Background Information

I went to high school in the *Scared Straight* era. *Scared Straight* is a film that debuted in 1978, showing a group of teens who were brought into a prison, where they met inmates who tried to scare them into avoiding a life of crime. My school, in the Washington DC suburbs, liked to fancy itself on the cutting edge and, like many schools of the era, embraced the *Scared Straight* philosophy. It is a good example of a problem that we will revisit many times in this book—that a compelling anecdote all too often outweighs lack of evidence or even clear evidence that a program does not work.

My school copied the *Scared Straight* approach, and one day we all trooped down to an assembly where we listened to a talk by a former gang member who had turned his life around. In driver education class, we watched films of horrifying car crashes; one afternoon, a police officer and my teacher took a group of us to view the aftermath of several car accidents. That day ended with a tour of the jail where, without any warning, they locked us in the cells (they had tricked us into entering as part of the tour) and left us there for 30 minutes or so. At the end, we were informed that we now realized it was no fun to be locked up and would thus henceforth avoid a life of crime. I suppose they might consider me a success story, because in fact I did avoid a life of crime. This is the kind of flawed analysis that I still hear all the time, even from trained scientists. I was not particularly at risk of following a life of crime anyway; the fact that I didn't is no credit to that cruel police officer who seemed thrilled with his little trick. We return to these issues when we discuss the need for control groups and other elements of careful scientific design.

I also recall the day that the police came to my high school for a session on drug prevention. They brought in a large batch of drug paraphernalia and explained each piece to us. (Well, I guess they must have said something like, "Don't do drugs" along the way, but the only part I remember is the show-and-tell.) They brought a range of marijuana bongs and pipes and showed the proper use for each one—but they didn't stop there. They also brought a coke spoon, a heroin kit, and a whole table full of other stuff, pausing over each tool to explain how it was used. They seemed quite pleased with all their personal knowledge on the topic as well as delighted to be holding our rapt attention. As indeed they were.

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EXHIBIT 1.1. Dr. Hamby's Early Prevention Experiences and Other Background Information (*Continued*)

We now know that such approaches are wrongheaded, and later in this volume we discuss why in more detail. Briefly, what I like to tell people about this experience is that one of the biggest inhibiting forces for adolescents is wanting to avoid looking ignorant in front of their peers. A youth who does not know how to use a bong may say "No thanks" when offered, simply to keep from looking foolish. As we now know from numerous evaluations of similar approaches (see Chapter 3), giving people information about how to do drugs can increase, rather than decrease, the likelihood they will use illegal drugs. It gives them information that ensures that they won't look foolish for not knowing how drug paraphernalia works. This insight—that not all knowledge improves behavior—is still resisted by many preventionists.

In addition to my early experiences with prevention, I'd like to share a little more of my background. Recognizing and acknowledging the perspective you bring to prevention (or any work) is important, as we discuss in more detail in Chapter 4. I have multigenerational roots in southern Appalachia and the rural southern United States more broadly. My paternal grandparents were tenant farmers and later orange pickers. My maternal grandfather was a coal miner until he got black lung disease, and then he and my grandmother became teachers. My father was the first person in his family to go to college, thanks to the GI bill. My mother did not go to college and worked in retail before her retirement. My father moved his family from the deep south to Washington, DC, to work as an aerospace engineer for NASA. Thus, I grew up learning to navigate the professional classes of the DC suburbs as well as the southern working-class norms of my extended family. I believe this code-switching ability is an advantage in my work. I was the first person in my extended family to get a graduate degree. My clinical psychology training helped me develop empathy and skills for interacting with people in distress. However, clinical psychology (like mainstream American culture) is limited in its focus on individuals, seldom asking whether there is a good reason that someone is, for example, depressed or considering the broad social forces that affect everyone. I had to seek out that broad perspective later.

As a White, straight, cisgender woman, I benefit from many kinds of privilege, which I did not really understand until I moved to the San Carlos Apache Reservation in the 1990s to work as a clinician and researcher. It was the first time I lived in a community that wasn't majority White and, more important, the first time I started to appreciate that Whiteness was not some sort of neutral default but that middle-class American White culture was a specific culture and way of being in the world. In addition to my time in San Carlos, I have spent most of my adult life living in rural and low-income communities. In these communities, I began to understand that the solutions typically offered by psychologists were not very helpful and that community members had answers to their own problems, which were hardly ever discussed in psychology. Now, I focus my research on documenting the untapped wisdom of marginalized communities and identifying the most helpful strategies for overcoming trauma.

As a psychological scientist, I am inclined to take a skeptical approach to most issues. My early, rather unimpressive experiences contributed to my current lens on prevention, as did the sociocultural setting I grew up in. Although I embrace the enthusiasm and creativity behind the diversity of prevention approaches and the urgency of addressing these social problems, I also recognize that not all well-intentioned ideas are good ones. For a variety of institutional reasons, it can be hard to let go of bad ideas, even after everyone knows they are bad. Yet it is essential for scientists and prevention practitioners to find a way to let go of bad ideas and move on to testing new ones. We hope to contribute to that effort with this book.

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EXHIBIT 1.2. Dr. Banyard's Prevention Narrative

I grew up in northern New Jersey during the late 1970s and early 1980s. Ironically, it is hard for me to remember my first exposure to a prevention program, given that I have spent the better part of my career studying violence prevention. We certainly learned about substance use in our annual health class throughout middle and high school. And we took a required sex education course in high school as well. Those courses mostly focused on knowledge and awareness, with little to no discussion of skills. We did not talk about relationship or conflict management. Our textbook dictated what we talked about, and classes were long on lecture and short on discussion. Skill building? That was not part of the curriculum as far as I can recall. We spent a lot of time looking down at our desks, trying not to appear as mortified and embarrassed in front of our peers as we felt when our teachers talked about things like sex. I definitely do not remember any connection between what happened in class and what we did in the "real world" of Friday night parties at the homes of classmates whose parents made the mistake of leaving town for the weekend.

I find it interesting that I cannot remember any prevention-oriented programming from my 4 years in college. My first encounter with what I would consider "real prevention" was in graduate school, and even then, it was not part of the curriculum in my clinical psychology doctoral program. It was a side project that I found on my own because I was training to be a child and family therapist. I was spending afternoons and evenings in our clinic with families whose teens were getting into trouble. Although there were things that I could help these young people work on, fundamentally many of their problems were bigger—they were being exposed to trauma and living in communities with few afterschool programs or job opportunities. Many had lots of unsupervised time after school while their parents worked several jobs to try to pay the bills. Although I am a cisgender, straight, White woman who was raised in a college-educated family (i.e., a lens that was in many ways different from those of the families I worked with), I had experience living in a divorced family. I lived for a time in an apartment complex and was part of groups of kids who played together after school with common ideas of adventure, although many of them came from families with many other challenges. These friends helped me see that these families, children, and teens—like the ones I met in graduate school—had many strengths. They were resourceful, took care of one another, and defended me when I was bullied on the playground. As a beginning clinician, though, I couldn't help feeling that I was arriving later than I should to help the young clients I was working with. I made time outside of classes and internship hours to help with a school-based curriculum for children whose families were coping with divorce and to spend time in a local early childhood intervention classroom. I wanted to understand how to keep problems from happening in the first place—the province of primary and secondary prevention (see Table 1.1), although at that point I didn't know that is what they were called. I was also still largely focused on seeing problems, even if I was trying to paddle upstream to solve them earlier. Fortunately, some of my mentors connected me with community-based advocates who challenged me to listen to the strengths and wisdom that clients brought in the door, not just their difficulties. These lessons triggered memories of narratives from my own family history and a desire to reflect on how my own history and position affected my work.

My background is part of what led me to violence prevention in my career and presents strengths and challenges to the work I seek to do. My family has multigenerational roots in the northeast United States. My maternal and paternal grandfathers had the benefit of higher education and used that privilege to enter community service professions—the law and the ministry. My father followed suit as a medical doctor. Women in my family filled roles traditional for White middle-class families, working as nurses, teachers, or secretaries while devoting significant labor to tending to family at home.

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EXHIBIT 1.2. Dr. Banyard's Prevention Narrative (*Continued*)

As a White, straight, cisgender woman whose family did not struggle to pay bills, I grew up knowing that I had privilege. I also grew up in a family that set clear expectations that my privilege carried responsibility with it, a responsibility to work for community change. My parents told stories of my grandparents, who refused to follow White flight out of their Trenton neighborhood in the 1950s and who refused to allow segregationist practices in their church congregation. I have early memories of playing games with other kids in the 1970s while our mothers attended a feminist consciousness-raising group in the next room.

So, in many ways a social justice orientation was part of the context in which I grew up. But like many White girls in the northeastern suburbs, that lens was still pretty limited. It still had elements of charity rather than a true transformative justice framework. But my relative comfort and safety growing up instilled in me a sense of optimism, a sense that change is possible and necessary, and I learned about the importance of strengths. My own race and class privileges also made it difficult to see beyond individual victims and incidents of violence to their connections to broader structural problems that needed to be the focus of prevention. I was still more likely to try to fix individual people or situations than to create collaborative partnerships for community change.

My journey to better understand prevention began from seeing its absence more than its presence. It has not always been easy to hold onto that early insight. A good deal of my early career used more of an intervention model and focused much more on symptoms and risk factors than strengths. As I acquired more professional resources and reflection, I was able to shift back to center strengths-based prevention. And so, to this book, which we hope will support creativity and innovation that leads to more effective prevention. We also hope it will help an array of readers, from many different disciplines, see a role they can play in making effective prevention more present in all our lives throughout our lifespans.

WHAT PREVENTIONISTS NEED TO KNOW ABOUT HUMAN IRRATIONALITY AND DYSREGULATION

One aspect of psychology is particularly important when it comes to prevention: human irrationality. Most people already know that they shouldn't perpetrate violence, abuse drugs, eat junk food, lead sedentary lifestyles, or engage in risky sexual behaviors, but many do so anyway. A lot of prevention is based on the idea that people simply need more information about these problems, but emerging scientific evidence suggests that information is not enough, in large part because humans are not fully rational creatures. Although program evaluators have historically been reluctant to examine side effects and other unintended consequences of their programming, social psychologists and behavioral economists have found extensive evidence of confirmation biases and other cognitive shortcuts that can keep participants from hearing and internalizing program messages and researchers from recognizing problems with their work (Kahneman & Tversky, 1984; Skurnik et al., 2005). The next generation of prevention programs must incorporate research showing that humans are not fully rational in many situations.

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As we outline in more detail throughout this book, the good news is that this body of work has led to the development of programs that focus on environmental cues and framing to "nudge" people to more desired behavior (Sunstein, 2014; Thaler, 2018; Thaler & Sunstein, 2009). Nudges need careful crafting and evaluation (Sunstein, 2014), and some nudges that sound good in principle have limited benefits in practice (e.g., fitness trackers; Finkelstein et al., 2016; Jakicic et al., 2016; Kerner & Goodyear, 2017). Nonetheless, they are one important piece of the puzzle of prevention, and some researchers think the challenge is figuring out how to best tailor nudges to make them more appealing and impactful (Sullivan & Lachman, 2017). Nudges are especially important because the best nudge strategies forego relying on willpower and other unrealistic strategies that result in shaming more often than in change.

Another important development is shifting to strengths-based prevention by focusing on developing protective factors that are more than the inverse of risks and supporting skills for living better lives. Because a range of different strengths (e.g., individual, family, community) are needed to maximize prevention, we call our strengths-based framework the *prevention portfolio model* (PPM). We describe this model in more detail in the second section of this book. People's life goals are not to avoid clinically significant levels of depression or addiction or to stay out of jail. People seek joy, meaning, and love (Grych et al., 2015). Yet most prevention efforts to date focus a great deal more on reducing risk than promoting the presence of strengths.

Challenges of human irrationality are particularly pronounced for problems that are, in part, caused by dysregulation, ranging from violence (both interpersonal and self-harm) to substance abuse to diet and exercise (Willoughby et al., 2013). Thinking about how to promote regulation is a key focus of the PPM. We use the term *regulation* broadly. Regulation involves moderating behavior in the service of long-term fitness and developmental potential, and, in parallel, resisting short-term temptations that have adverse consequences (Hagler et al., 2016). We want to emphasize strongly that behavior regulation never occurs in an environmental vacuum. It is not just a matter of individual willpower or personal choice; rather, it incorporates forces at all levels of the social ecology (Bronfenbrenner, 2009) that either promote or reduce regulation. For example, at the community level, factors such as the density of alcohol outlets in a neighborhood have been shown to affect not only the level of alcohol consumption but also related problems such as violence (Lippy & DeGue, 2016).

Effective prevention of regulatory challenges requires environmental supports. In the nudge model, for example, *choice architects* create subtle environmental cues to promote healthier choices. Simple environmental changes, such as placing healthier items at eye level in supermarket checkouts,

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can be as powerful as prevention efforts that target attitudes, knowledge, or behaviors more directly (Thaler & Sunstein, 2009).

TECHNICAL VERSUS WICKED PROBLEMS

Regulatory challenges are not entirely environmental. They involve sustained and intentional human behavior to a degree that differs from some other problems that society seeks to prevent. In other words, regulation problems are *wicked*, not technical. Prevention efforts that require minimum involvement of the targeted population are solutions to technical problems (Kania & Kramer, 2013). Technical problems are relatively discrete and often can be largely addressed with a specific infrastructure element or other physical product. Hemenway (2009) provided several examples, such as installing grooves on the side of the road to alert sleepy drivers that they are drifting out of their lane. The noise of the grooves cues preventive action with little effort on the driver's part. A single vaccination at the doctor's office (or even more accessibly, the pharmacy) can confer years of prevention just by rolling up your sleeve. Prevention scientists often strive for technologies that are as passive as possible, reducing the effortful behavior that is required, such as air bags that supplement seat belts. However, even seatbelts are relatively simple tools that do not require a lot of time, skill, or effort to use, especially relative to their effectiveness in preventing serious motor vehicle injuries (Hemenway, 2009). Although it is less often noted in the prevention science literature, another important characteristic of such problems is that they are often unintentional and accidental. Few, if any, people purposefully seek to acquire measles or fall asleep behind the wheel of their car. Many of these same tools are less effective when a negative outcome is intended. For example, seatbelts and air bags are sometimes disabled by suicidal drivers.

On the other hand, wicked (also called adaptive) problems are complex and require active rather than passive prevention strategies (Haddon, 1970; Kania & Kramer, 2013). Active strategies require people to make different choices and do different things, often after undoing previous patterns of behavior and habits, whereas passive strategies often unfold without effort from those who benefit (e.g., if fluoride is put into the water supply or vitamin D into orange juice, you receive the benefit just by using the water to brush your teeth or drinking a glass of juice). Full solutions may not be available and often require more than one strategy and involve choices. For example, people are likely to be conflicted about giving up alcohol or sugar. Obesity may serve as a self-protective strategy for people with trauma histories (Felitti, 1993). Behaviors such as bullying and violence are often

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instrumental acts that are intentionally chosen to meet the needs of the perpetrator in a given moment.

One might assume that if a problem negatively affects someone, that person would surely be willing to make active behavioral changes to address the problem. For example, it might seem obvious that people with chronic medical conditions would want to follow their treatment regimens. However, negative side effects or other barriers can make adherence a major challenge, with data again indicating that psychoeducational and many other approaches are largely ineffective (Costa et al., 2015; Dean et al., 2010). Even John Snow, the physician usually credited with the first public health intervention, met resistance when he removed a handle from a town water pump that drew from a cholera-infected source. Disabling that pump made accessing water more inconvenient, so the townspeople reinstalled the pump handle before the risk of cholera had passed (Hemenway, 2009). More recently, during the coronavirus pandemic, we note many people were similarly reluctant to endure minor inconveniences like mask-wearing for the sake of preventing many deaths due to infection.

Many prevention challenges require behavior changes, sometimes in the face of strong impulses to gain power or gratification in illicit, illegal, and unhealthy ways or to enjoy immediate gains at the expense of more distant potential consequences. Extensive evidence suggests that it is harder to make good choices under emotional circumstances than under calm ones, especially for young adults (Steinberg et al., 2018). Environmental features, social norms, and other sociocultural elements are important targets for programming. Behavioral economists and public health professionals have been especially vocal in pointing out the importance of these “upstream” changes and their too-common neglect in public discussion of these problems (Hemenway, 2009; Thaler & Sunstein, 2009). Nonetheless, at some point, regulatory challenges require individuals to engage in a healthy behavior in a particular moment. They are quintessentially human, not technical, problems, and thus quintessentially psychological ones. While we strongly reject the idea that more willpower or better individual choices will solve these problems, we recognize that effective solutions must consider their behavioral elements.

THE PREVENTION PORTFOLIO MODEL

The current state of affairs calls for a substantial reconsideration of the prevention model. We need an approach to prevention that addresses the limited success of past efforts and the unique challenges of wicked regulatory

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problems. Existing prevention success stories, such as a decrease in drunk driving, can be used to inform future prevention efforts (Potter, 2016).

As mentioned, we also incorporate research from many disciplines in this book. Unfortunately, the insights from this multidisciplinary work have not reduced the use of less effective prevention strategies. Thus, we offer a new model, the PPM. The PPM incorporates strategies from many fields, including behavioral economics and public health, to create an environmental "architecture" that promotes healthy choices. Our strengths-based approach focuses not only on decreasing unwanted behaviors (e.g., eating too much junk food) but also on strengthening individual, family, and community capacities to thrive. The portfolio concept introduces the idea of dose and the advantages of building up a range of strengths.

The name of the PPM has its roots in earlier work we did with our colleague John Grych (Banyard, Hamby, & Grych, 2017; Grych et al., 2015; Hamby, Grych, & Banyard, 2018), entitled the *resilience portfolio model* (RPM). This model integrated research findings related to coping and recovering from adversity and primarily focused on organizing protective factors within and outside of individuals for intervention and healing. Internal assets include regulatory strengths (e.g., emotion regulation), interpersonal strengths (e.g., social support), and meaning-making strengths (e.g., a sense of purpose or spirituality). A key contribution of the RPM is the notion of *poly-strengths*. Although many studies of trauma recovery focus on one or two factors that may promote healing and well-being (i.e., the density of a protective factor), the RPM tallied the number (i.e., diversity) of high levels of strengths, finding that this composite indicator, which captures the totality (i.e., dose) of a person's strengths portfolio, helped us explain differences among people in their well-being over and above measures of individual strengths (see also Schnell, 2011). The PPM incorporates the RPM's idea of poly-strengths, but its emphasis is slightly different. Rather than focusing on how key strengths help people recover from adversity, the PPM focuses on how key strengths may insulate individuals and communities from experiencing public health problems such as substance misuse or violence in the first place (see Chapter 6). The two models share an emphasis on looking at a range of strengths together rather than focusing only on single specific protective factors, although the specifics for prevention can be different from those for recovering after adversity. A main message is that strength matters and makes a distinct contribution to prevention, separate from exposure to risk or adversity.

The PPM organizes these prevention methods into the Three Ts for practice: *tailoring*, *ties*, and *toward* (see Chapter 11). We describe specific,

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actionable, tailored ways for the future of prevention work to embrace flexible designs to be more culturally and developmentally responsive. We make the case that prevention strategies that create ties across topics (e.g., substance misuse and dating violence prevention) will be more successful (Decker et al., 2018; Estefan et al., 2021). The model centers a move toward strengths (rather than away from problems), making the case that some of our most powerful tools for reducing public health problems may come from activities that do not even talk about the problem specifically. It highlights using each prevention touchpoint to intentionally build doses of strengths.

THE STRUCTURE OF THIS BOOK

The book is divided into three broad parts. In Part I (Chapters 2–5), we review, synthesize, and critique the current state of prevention science as it is applied to regulatory and public health problems. We focus on violence, the issue that we know best, but we also discuss other regulatory challenges and public health problems, including substance abuse, suicide, risky sexual behavior, diet, and exercise. Chapter 2 covers theoretical models for prevention. Chapter 3 summarizes the state of the research and identifies several issues that have impeded progress. Chapter 4 addresses our current scientific knowledge—or lack thereof—about tailoring prevention for different sociodemographic groups. Chapter 5 explores the benefits of a social justice lens and also reviews the role of broad social and economic forces, including how our own work as preventionists is shaped—and sometimes limited—by norms of what "counts" as expert knowledge and how larger social trends can serve or work against prevention goals. The chapters in this section offer frameworks for considering the PPM described in more specific detail in Part II.

Part II (Chapters 6–9) introduces the basics for strengths-based approaches, what we call the prevention portfolio model. This strengths-based framework focuses on the potential of prevention measures to insulate people and communities from adversity and its effects rather than just put the pieces back together afterwards. Its goal is thriving and well-being; it pulls insights from across disciplines and topics to see what we can learn from successes in research and practice. Each chapter in Part II explores elements of the PPM. Chapter 6 explains what it means to put strengths at the center of prevention and highlights the importance of a diverse portfolio of protective factors. Chapter 7 discusses developmental issues in prevention and makes the case for a lifespan prevention view within the PPM. Regulatory strengths

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are an important component of a prevention portfolio, especially for the problems that we are targeting; thus Chapter 8 synthesizes and describes key issues in behavior regulation. Chapter 9 focuses on relational strengths and the ways in which we can better insert prevention strategies into aspects of ties between people, within groups and organizations, and to places. Chapter 9 also considers both the social (i.e., building and leveraging interpersonal strengths and connecting to things outside oneself to build meaning) and physical elements of the environment that support behavior regulation and promote good lives. This chapter rounds out our discussion of the elements of strong prevention portfolios and puts these concepts in conversation with earlier chapter discussions.

The final section (Part III; Chapters 10 and 11) focuses on the future of prevention. We outline several directions for future scientific work in Chapter 10. In Chapter 11, we focus on developing a practice and policy agenda. We recognize that many preventionists, psychologists, teachers, social workers, and other professionals must go out every day and try to prevent these problems, despite the incomplete science. Thus, we offer our best recommendations for those who are in the field today. We close Chapter 11 with a reminder of our recommendation at the beginning—to engage with this book as it is most helpful to your learning (which may not be a sequential read from Chapter 1 through Chapter 11). We wrote chapters that make connections to others in the book and bring forward and foreshadow future key ideas that allow for a tailored approach.

Our work has primarily focused on violence, and thus readers will notice that many examples focus on violence prevention and the developmental stages of adolescence and young adulthood, which is the peak risk period for most forms of violence perpetration. However, violence is closely related to many other public health problems, including substance use, risky sexual behaviors, and suicide. We cannot prevent violence without considering the role of these other, connected issues. A careful reader may also note that we used the term "reducing" and not "eliminating" violence and other public health problems in the title. Although of course we would like to see these problems eliminated, we think it is unlikely that we will ever reach a point at which we see zero worldwide incidents of violence, substance abuse, and similar problems. Given that, as we've said, existing prevention efforts have had minimal impact in many areas, we think that reducing these problems is the appropriate goal. In the chapters that follow, we shift between presenting broad ideas for the field of prevention and using specific examples and recommendations within the field of interpersonal violence (e.g., child maltreatment, bullying, sexual and relationship violence) prevention.

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The scientific literature on prevention has exploded in recent decades and now expands on a daily basis. It is not possible to include every possible relevant reference, even in a book. We believe that the biggest challenge with the literature is hyperspecialization, as experts focus on narrower and narrower topics, in part to try to keep up in their area of expertise. The unfortunate downside is that scientists are often unaware of important work in related fields, leading to a lot of reinventing the wheel and slower scientific progress than might otherwise be possible.

We have had the good fortune to be able to work in a wide range of areas ourselves, including prevention, the basic epidemiology of violence, polyvictimization (i.e., the cumulative exposure to all different types of violence), other adversities, and resilience. We have also collaborated with a wide range of communities and with researchers, providers, and advocates from many disciplines. We gained further breadth during our work as editors. Dr. Hamby served as founding editor of the APA journal *Psychology of Violence*, and Dr. Banyard served as an associate editor of *Child Abuse and Neglect*. Still, there is no question that we have not cited every study that might help shed light on our topics. Even at double the length, it would not be possible to do that. What we hope to offer is a curated guide to a wide range of literatures that we believe can lead to more effective and more impactful prevention of violence and other public health problems. The articles cited here have helped shape our own thinking and our own research. We hope that readers of this book will similarly benefit.

NARRATIVE EXERCISES

1. What were your first prevention experiences, especially with violence or other problems in behavior regulation? Take 15 or 20 minutes and write about your early prevention experiences (it may be most helpful to start with prevention that you received as a participant, although you could also reflect on early prevention programs you facilitated). What did you like about these experiences? What didn't you like? Looking back, how did these prevention programs affect you? How do these early experiences shape your current ideas about prevention?

2. Identify a problem that you are confronting in your work or community and that you would label as a wicked problem. Compare it to a problem you would identify as technical. What solutions (active and/or passive) have been tried, how did they differ for each, and with what impact?