What Is the Upstream Parable and Why Is It Relevant for Our Well-Being? Part I

Robert Brooks, Ph.D.

Many of you may have heard or read about the lessons embedded in the Upstream Parable (sometimes called the River Story) without knowing the title it has been given. Sometimes there are different variations of the parable's narrative, although the primary message remains the same. Some have attributed the story to Saul Alinsky, a political activist, or Irving Zola, a medical sociologist at Brandeis University. Others have asserted that it received its greatest audience through a publication authored in 1975 by John McKinlay, a medical sociologist at Massachusetts General Hospital and Harvard Medical School and a friend of Zola. McKinlay applied the lessons of the parable to the healthcare system. His article was reprinted in 2019 and has been recognized as a classic.

One popular version of the story is that several people in a village were walking along the river's edge when they heard a child scream for help. The child was caught in the current. They rescued the child and soon they heard the cries of another child, also caught in the current. Within several minutes they saved other children. The next day they rescued more children who were in the same predicament. As another child was screaming for help, one of the villagers started to walk upstream. Another said to him, "Where are you going? We're helping drowning children here!"

The villager replied, "I'm going upstream to see why so many children are falling in the river in the first place!"

As is probably evident, a main lesson to be learned from the story is that more is to be gained by identifying and preventing what is generating a problem than frantically attempting to cope with the exhausting consequences of that problem. McKinlay wrote that the parable illustrated two important points related to the healthcare system. One was that the system is focused on "downstream behaviors" that represent "short-term" solutions that illustrate the "ultimate futility of downstream endeavors."

The second point emphasized by McKinlay was, “We should somehow cease our preoccupation with this short-term, problem-specific tinkering and begin focusing our attention upstream, where the real problems lie.”

While McKinlay’s explanation of the misdirected focus of care may seem apparent, many people, whether in their personal and/or professional lives, fall prey to expending much of their time and energy managing ongoing crises while spending little, if any, effort to address the cause of the problem. I have often described this situation as adopting a crisis intervention rather than a crisis prevention approach. The former is necessary at times, but if it becomes the dominant approach, it is highly likely that the problem will continue to persist.

A Personal Story of Being Dominated by a Downstream Perspective

It is easier than we may realize to become trapped in a downstream mindset, especially if we are so frantic putting out fires that we don’t have time to consider how to stop the fires from starting. I can vividly recall when I fell into such a trap at the beginning of my career, at first not even being aware that I was actually ensared in such a trap or that a more effective approach existed. In my writings and presentations I have often referred to this experience, which I believe was the most nerve-racking and difficult position I ever held. I was head of the school in a newly-developed inpatient child and adolescent program at McLean Hospital, a private psychiatric hospital in the Boston area.

My first few months at McLean proved to be very humbling and stressful, leading me to question whether I was the right person for the position. All staff were hired at the same time, including nurses, childcare workers, teachers, and therapists. We had few, if any, “seasoned” clinicians who had actually worked in such an inpatient setting, senior staff who would be able to share their insights and wisdom about collaborating in a multidisciplinary program in a psychiatric hospital. Although we didn’t anticipate it when the program was launched, the situation became a breeding ground for anxiety, frustration, and anger in both the patients and the staff.

In this climate, as the patients failed to adhere to the rules we established, our default position was to create harsher rules, which, not surprisingly, inflamed the situation. I learned that when adults, especially in their role as parents and educators, feel they are losing control of the children in their care, they often resort to exerting greater control, which only serves to exacerbate the problem. I also learned that when children are displaying ongoing challenging behaviors in a multidisciplinary sitting (e.g., clinicians, nursing and childcare staff, and teachers), it contributes to staff from one program or professional discipline to blame staff from another program or discipline.

Looking back, it's clear that I and my staff were fixated on the downstream, consumed by a crisis intervention mentality. Staff attempted to address problems by grabbing each other in the hallway for a few minutes. Sometimes we didn't even have a few minutes as another crisis involving another student's behavior erupted. The only scheduled staff meeting we held each week was filled with administrative details and forms to be completed. Little, if any, time was afforded to examining our clinical and educational approach.

At some point, perhaps borne of desperation, we began to shift our perspective from downstream to upstream and we began to ask the following questions: "What is it that *we can do differently* as a staff to minimize the lack of trust and aggressive behaviors displayed by many of our patients?" or, worded more positively, "What is it that *we can do differently* to gain the trust and cooperation of our patients?"

The words that are italicized are to highlight a key epiphany I had at that time, namely, the patients will not change their attitudes and behaviors unless we changed ours. My asking about what we could do differently should not be interpreted as "blaming" ourselves. We should avoid the "blame" game and instead understand the question of *what we can do differently?* as encouraging a sense of responsibility and empowerment. As I've often stated, especially when citing the concept of "personal control," it is advantageous to recognize that we have control over only one person in our lives and that is, ourselves (and sometimes it's a struggle to maintain personal control over our own emotions and behaviors).

Once my staff and I began to examine what we might do differently, it led not only to a shift in mindsets but in the structure and approach of our program. Four days a week we introduced a half hour Rounds before the school day began. Rounds were devoted to discussing either a certain patient and/or issue that we faced at the school. We invited clinical and nursing staff to attend, especially when the discussion centered on a particular patient or issue that was relevant to different members of the multidisciplinary team. Rather than catching each other in the hallway when crises were occurring, the Rounds permitted a thoughtful exchange of ideas with a focus on minimizing or preventing problems from emerging.

It is beyond the scope of this article to detail what I have described in previous writings, namely, the strength-based strategies we began to apply at the school, including identifying and reinforcing the children's strengths ("islands of competence"), promoting more positive relationships between patients and staff, inviting patients to help other patients and staff (what I was to refer to years later as "contributory activities"), and inviting patients to offer input about the rules of the school; this latter strategy reinforced self-discipline.

Please know that this shift in my and the staff's mindset and behaviors didn't erase all challenging behaviors in the students. We must remember that most of the students were inpatients at McLean because of their impulsive, aggressive behaviors that required their being in a locked door program. However, our evolving into an upstream approach lessened the frequency and intensity of such behaviors, enriched the relationships between the patients and staff, helped patients to develop more effective coping skills, and promoted a climate of hope rather than one of anger, mistrust, and despair.

Why Continue Counterproductive Strategies?

In describing my early experiences at McLean, I have frequently been asked why we persisted in using a truly ineffective downstream perspective? I believe there were at least a couple of reasons. First, while I was aware that what we were doing was not working, a more productive solution was not readily in our view, obscured by the crises of the moment.

Second, and perhaps more important, was a variable my colleague Sam Goldstein and I highlighted in our book *The Power of Resilience,* namely, “negative scripts” to which we adhere are not easily modified. Many of us engage in the same behaviors repeatedly even if these scripts/behaviors have consistently proven counterproductive and ineffective. A force supporting these negative scripts is the assumption that other people in our lives (e.g., children, students, spouse, employees) should change first since what we are doing is the “correct” path to take. If we believe we are “right,” a change on our part may be interpreted as “giving in.” In light of this kind of mindset, it is difficult to alter what one has been doing. Fortunately, as I noted earlier, it eventually dawned on me that the patients at the McLean school were not going to change their mindset and behaviors until the staff and I changed.

It’s important to note that there was something positive that emerged from this difficult phase in my career. Little did I know at that time that a shift from a downstream to an upstream perspective, an appreciation of the impact of personal control, and a movement from a crisis intervention to a crisis prevention framework would serve as catalysts for my adoption of a strength-based approach and my interest in resilience across the lifespan.

A Parable and Its Application to Our Health

The importance of subscribing to the message embedded in the upstream parable can be witnessed in many areas of our lives. Of special significance are the intentional steps we take to bolster our physical and emotional well-being and lessen the notable health issues that can emerge downstream. Although intellectually most of us are aware that there are behaviors we can incorporate into our daily activities that will enrich our lives, doing so is often more challenging than we might realize.

For at least the past 25 years many of my writings and presentations have focused on our lifestyle choices and the ways in which these choices impact on our lives. For example, in 2011 I posted articles in November and December about lifestyle behaviors. These writings were prompted by an article in the *American Psychologist* by Dr. Roger Walsh, a member of the faculty of the Department of Human Behavior at the University of California College of Medicine in Irvine. The article was titled “Lifestyle and Mental Health.” As I wrote in the November, 2011 article, Walsh articulated his primary position in the first paragraph of his article, expressing:

Robert Brooks, Ph.D.

> The main thesis of this article is very simple: Health officials have significantly underestimated the importance of lifestyle for mental health. More specifically, mental health professionals have underestimated the importance of unhealthy lifestyle factors in contributing to multiple psychopathologies, as well as the importance of healthy lifestyles for treating multiple psychopathologies, for fostering psychological and social well-being, and for preserving and optimizing cognitive capacities and neural functions. . . . Lifestyle factors can be potent in determining both physical and mental health. In modern affluent societies, the diseases exacting the greatest mortality and morbidity—such as cardiovascular disorders, obesity, diabetes, and cancer—are now strongly determined by lifestyle.

Walsh spotlighted the concept of therapeutic lifestyle changes (TLCs), asserting that in many instances TLCs can be as effective as psychotherapy or medication in treating different medical and mental health disorders. He recommended that clinicians pay increasing attention to assisting patients to engage in TLCs, both to prevent the occurrence of disorders and to minimize their potency should they appear. Walsh identified eight activities that represent TLCs—activities that he viewed as being within our power to control (please see my November, 2011 article for a description of the eight).

The "Six Pillars" of Lifestyle Medicine

In 2011, while reading Walsh's article and similar writings, I was unaware that in 2004 the American College of Lifestyle Medicine (ACLM) was founded. I have learned much more about lifestyle medicine (LM), especially based on the work of a friend and colleague, Dr. Beth Frates who is on the faculty of Harvard Medical School and the staff of Massachusetts General Hospital. Beth is President of the American College of Lifestyle Medicine and a prominent voice in the LM field. I have had the privilege of presenting in several of Beth's classes and becoming more knowledgeable about the "six pillars" of LM. Similar to Walsh's TLCs, the application of the six pillars has been found to "prevent, treat, and often reverse chronic disease."

In next month's article I will describe the six pillars of LM in greater detail. I believe that the more we understand the impact of TLCs and the six pillars, the better equipped we will be to navigate life's challenges guided by an upstream view, rather being caught in a constant crisis downstream.

https://www.drrobertbrooks.com/