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ORIGINAL PAPER

Child Wellness and Social Inclusion: Values for Action

Isaac Prilleltensky

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Abstract Participatory Action Research (PAR) with children and youth is at the intersection of child wellness and social inclusion. Exclusion and marginalization detract from personal and collective health. Inclusion, on the contrary, contributes to wellness. Hence, we should study inclusion and exclusion in the overall context of child wellness. This special issue offers a wealth of methodologies and lessons for fostering inclusion of young people through PAR. In an effort to synthesize my concerns with child wellness, inclusion, and the scholarly work of this special issue, this paper will (a) articulate the values underpinning the philosophy of social inclusion and child wellness, (b) suggest roles and responsibilities for putting these values into action, and (c) integrate the contributions of this special issue into the emerging framework for social inclusion and child wellness.

Keywords Values · Social inclusion · Participatory action research · Child wellness

Introduction

Unlike other groups claiming their legitimate rights, such as seniors, labour, women, and ethnic minorities, children are mostly political orphans. Until adults seriously embrace their plight, children will continue to suffer from blatant as well as from subtle forms of exclusion (Imig 2006; Minow and Weissbourd 1993; Wagner et al. 2009).

I. Prilleltensky (✉)
School of Education, University of Miami, POB 248065, Coral Gables, FL 33124-2040, USA
e-mail: isaac@miami.edu

Most of us regard ourselves as caring and compassionate people, and most of us would take offence at the thought that we do not care about children. Caring, in my view, is more than showing empathy to our own children. Caring can be reactive or proactive. Moreover, caring can be shown towards those near to us and those far from us. Most of us limit our caring to those children who are close to us. If and when we do care about children beyond our families, schools, and communities, we do so mostly in a reactive form; typically in response to a crisis or a dramatic event like a famine. The child welfare system, society's designated champion for children, captures the reactive nature of our collective caring.

Acting compassionately toward our own children is not good enough. What about the needs of other children who suffer from hunger, abuse, exploitation, shame, and exclusion? Helping victims of disease, poverty or abuse is not good enough either. We need to *extend* our compassion beyond our immediate circle of care, and we need to *prevent* poverty, illness and abuse, not just respond to them after the fact.

Consider for a moment the predicament of children whose rights are violated, who are abused by parents, and who go hungry because of social policies of neglect and exclusion. If we truly care about their rights, then we need to invest resources to prevent these tragedies from occurring, in the present, and in the future. Adults invest in pension plans to avert poverty in old age. Employees pay unemployment insurance to guard against harsh economic times. Even governments contribute to these funds because they recognize that citizens need protection. But this protection is afforded only to those who vote: adults and seniors. Children have no vote and no comparable social fund either.

Children's lack of political voice accounts not only for their exclusion in societal affairs, but also for their neglect.

Exclusion and marginalization detract from personal and collective health (Klasen 1998). Inclusion, on the contrary, contributes to wellness. Hence, we should study inclusion and exclusion in the overall context of child wellness. This special issue offers a wealth of methodologies and lessons for fostering inclusion of young people through participatory action research. In an effort to synthesize my concerns with child wellness, inclusion, and the scholarly work of this special issue, the objectives of this paper are threefold: (a) to articulate the values underpinning the philosophy of social inclusion and child wellness, (b) to suggest roles and responsibilities for putting these values into action, and (c) to integrate the contributions of this special issue into the emerging framework.

Much of the uncertainty surrounding social inclusion stems from two sources. First, there is confusion with respect to the values underpinning the concept; and second, it is not clear how it relates to child wellness in general. Unless we are clear about the moral and ethical foundations of social inclusion, our actions will lack direction, and our roles will lack a vision. In a similar vein, unless we know how social inclusion interfaces with child wellness, we are at risk of promoting the former in isolation of the latter, or of replacing the latter with the former. Social inclusion is a component of child wellness and not a substitute for it. Using the preceding contributions to the special issue, this essay will clarify the relationship between inclusion and wellness in children and youth. In my view, PAR is at the intersection of inclusion and child wellness, which is why I frame the issues in these terms.

The literature on inclusion is fragmented. Definitions and discussions of social inclusion fall generally within four categories: (a) domains, (b) sources, (c) consequences, and (d) recommendations for action. Within each of these categories authors concentrate on different dimensions of inclusion and exclusion. In my view, we require a comprehensive conceptualization of inclusion that encompasses diverse domains, sources and consequences, and that generates effective actions to reduce exclusion of children and youth in societal affairs and in matters affecting their own wellness. To date, we lack an integrative approach to inclusion. I will suggest in this essay a value-based definition of inclusion that integrates its multiple faces.

As demonstrated in the special issue, domains of inclusion that have remained somewhat disconnected pertain to children with mental health problems (Liegghio et al. 2010), economic disadvantage (Porter et al. 2010), educational opportunities for minorities (Ozer et al. 2010; Van Sluys 2010) and school climate (Ren and Langhout 2010; Duckett et al. 2010). At the individual level, consequences of exclusion include marginality and alienation (Kellett 2010). At the social level, exclusion diminishes social cohesion and opportunities for civic engagement (Chen et al. 2010; Holicek 2010). As can be seen, the sources and manifestations of exclusion span the range of psychological and political factors and domains. What we need now is a framework that can integrate the various domains of inclusion/exclusion in order to formulate coherent and consistent social policies. Otherwise, it is entirely possible to promote economic inclusion without corresponding attention to psychological inclusion, or vice versa. Children require fulfillment of material and emotional needs, not one or the other. In the absence of a comprehensive philosophy of wellness and inclusion we are at risk of focusing on some needs at the expense of others. The vision I will present in this paper is based on a set of values that correspond to basic needs. Once we have established the parameters of child wellness we will be in a position to define social inclusion and explore the roles that psychological and political power play in it. Following an understanding of the vision, values, sources and consequences of social inclusion, I will recommend changes for enhancing children's wellness and social inclusion. Papers from this special issue illustrate the connections among wellness and inclusion.

Child Wellness

Child wellness is achieved by the satisfaction of personal, collective, and relational needs of children and youth. These needs, in turn, are satisfied by the presence of cogent values, adequate psychological and material resources, and effective programs and policies (O'Connell et al. 2009). Wellness is a hierarchical concept in that the needs of the child are predicated on the satisfaction of needs of the family. The needs of the family, in turn, depend on community welfare, which is based largely on the level of social wellness. As an example, the needs of a child depend on parenting skills and on the economic situation of the family in general. The wellness of the family as a whole is closely related to the level of community safety, to the availability of recreational facilities, and to access to health and human services. The quality of education, transportation and housing has a lot to do with community welfare. These factors, in turn, are closely related to social policies dealing with allocation of resources, employment opportunities, fiscal policies, and the like. Wellness at one level is closely tied to wellness at other levels of analysis (Prilleltensky and Nelson 2000).

Wellness at each level of analysis depends on the satisfaction of personal, relational, and collective needs. Individual members of the community require the satisfaction of personal needs such as affection and educational opportunities, relational needs such as a sense of belonging, and collective needs such as access to societal

resources. Within the model of wellness, there are actions that need to be taken at all levels to procure the satisfaction of needs. The person bears responsibility to self and others to obtain satisfaction; the family as a whole has to look after the needs of its children; whereas communities need to protect their citizens by providing services.

The needs of community members depend on a set of four wellness components: values, psychological and material resources, programs and policies. Values such as caring, compassion and justice attend to diverse personal and collective needs, as do psychological and material resources. Programs and policies, in turn, target the needs of individuals and communities by offering educational, health, recreational, and social services. The presence of these services increases the life opportunities of community members. Wellness, then, is a multilevel concept that attends to the needs of individuals, families and communities. Social and community wellness require the satisfaction of the personal needs of their members. For social cohesion to emerge, individuals have to feel satisfied at a personal level. Otherwise, people turn inwards and do not have the psychological energy and resources to contribute to the well being of the collective. The wellness of children, in turn, depends not only on the satisfaction of personal and relational needs, but also on the fulfillment of collective needs such as overall prosperity.

To understand how child wellness is achieved we have to articulate the specific needs that must be met; needs that will inform values for the formulation of programs and policies. Table 1 describes the types of needs required for child wellness and their corresponding values (Prilleltensky and Nelson 2000).

How do needs and values for personal, relational, and collective wellness relate to inclusion and exclusion? In order to promote social inclusion, both as an outcome and as a process, we need to attend to three sets of values and needs. Values for personal wellness include self-determination, caring and protection of health, and opportunities for educational and personal growth. These values are essential in promoting feelings of self-efficacy, mastery and control, and in promoting affective bonds and attachment. Values for relational wellness include respect for human diversity and collaboration and democratic participation of children and families in decisions affecting their well-being. These principles should guide interactions among people in society in general, and between children and parents, professionals and parents, service recipients and child welfare workers. Without relational wellness, there is no mechanism for including people in decisions affecting their personal wellness, and this is precisely the great contribution of PAR with children and youth. Given that participatory action research is both a means and an end in itself, it fosters relational wellness and processes that are conducive to greater personal and collective wellness.

But values for personal and relational wellness are not enough. Unless we care about the fate of the collective, the necessary structures to promote personal and relational wellness will not be in place. Values for collective wellness include social justice and support for strong community structures. Without these structures there are not supports for the promotion of inclusion. The contributions by Duckett et al. and by Newman Phillips in this special issue demonstrate the need for enabling structures that support PAR with children and its emerging actions; actions that can often threaten the status quo, as these two papers demonstrate.

Based on the working definition of wellness, the achievement of inclusion requires personal and relational wellness, neither of which can be attained in the absence of collective wellness. At the surface, inclusion may seem analogous to relational wellness. After all, relational wellness is about participation and acceptance; pillars of inclusion (Gergen 2009). But upon careful examination, we realize that relational wellness must be accompanied by personal and collective wellness to facilitate inclusion. Personal wellness is almost a requisite for wishing to be included, as it undergirds the sense of self (Gergen 2009). The needs for protection, growth, and control, and their corresponding values of caring, creation of opportunities and self-determination contribute to inclusion. They do so by equipping the child with adequate skills to participate meaningfully in society. Several papers in this issue emphasize the need to create competent young researchers who have the critical analytical tools to understand personal (Foster-Fishman et al. 2010), school (Duckett et al. 2010; Ren and Langhout 2010; Ozer et al. 2010), and community contexts (Chen et al. 2010; Porter et al. 2010) and make a difference in them. Using photovoice and other innovative ethnographic techniques (e.g., Clark 2010; Foster-Fishman et al. 2010; Kellett 2010) several authors taught youth how to get to the root causes of problems, how to become competent researchers, and how to demand action from local government (Holicek 2010).

Personal and relational wellness are necessary but insufficient conditions for inclusion. Collective wellness is also required. Material and financial resources, as well as community structures enable participation in social affairs. These are the conduits for the expression of voice and choice. Economic security and adequate social resources, the basics of collective wellness, facilitate the satisfaction of basic needs and free psychological energy for participation in the community. The three dimensions of wellness are fully interdependent. One dimension cannot exist fully without the others. Using the three dimensions of wellness we can depict an ideal state of social inclusion whereby

Table 1 Needs and values for the promotion of child wellness

Needs for personal wellness	Values for personal wellness
Protection	*Caring and protection of health*
Empathy, affection, attachment, emotional and physical well-being	Expressing care, empathy, and concern for the physical and emotional health of children
Growth	*Education and personal development*
Cognitive, emotional, physical, and spiritual growth; autonomy	Providing children opportunities for education and personal growth
Control	*Self-determination*
Mastery, control, self-efficacy, voice, choice	Promoting the rights and ability of children and adults to pursue chosen goals without undue frustration and in consideration of other people's needs
Needs for relational wellness	**Values for relational wellness**
Acceptance	*Respect for human diversity*
Identity, dignity, self-respect, self-esteem, tolerance	Promoting respect and appreciation for diverse social identities and for people's ability to define themselves
Participation	*Collaboration and democratic participation*
Solidarity, mutuality, peace, involvement, participation, belonging	Fostering partnerships whereby children and adults can have meaningful input into decisions affecting their lives
Needs for Collective Wellness	Values for Collective Wellness
Community	*Collectivism*
Formal and informal support, health and social services	Promoting vital community structures that facilitate the pursuit of personal and communal goals
Resources	*Social justice*
Economic security, shelter, clothing, nutrition, access to vital health and social services	Promoting the fair and equitable allocation of bargaining powers, obligations, and resources in society

strong youth are enabled to participate in societal affairs through the presence of adequate societal resources. Hitherto, most of the literature on social inclusion relates to one aspect of participation. The present conceptualization integrates the various domains usually covered in isolation. Based on the values for personal, relational and collective wellness, in the next section I formulate a value-based definition of inclusion.

The Role of Social Inclusion in Child Wellness

Social inclusion is simultaneously an outcome and a precursor of wellness (Andresen and Siim 2004; Lord and Hutchison 2007). Child wellness consists of a set of interacting mechanisms; one of which is inclusion. If the goal of inclusion is reached, overall wellness is advanced; if other mechanisms promote wellness, inclusion is promoted as well. Although inclusion feeds directly into relational wellness, it also contributes to personal and collective wellness. Children's self-esteem is enhanced by recognition of personal achievement, whereas collective welfare is promoted by acceptance and inclusion of diversity. As Kellett noted in this issue: "The experience of participating as active researchers is an empowering process that leads to a virtuous circle of increased confidence and raised self esteem, resulting in more active participation by children in other aspects affecting their lives" (this issue, p. 9). In summary, there is a reciprocal relationship between inclusion and wellness.

Social inclusion of children addresses a set of needs and instigates a set of values. Furthermore, it can be considered an outcome and a process. As an outcome, it fulfills a need; as a process, it reflects a value; both of which are fostered by PAR with children and youth. Processes either facilitate or inhibit outcomes; whereas values or the lack thereof facilitate or inhibit the fulfilment of needs. Values are the principles supposed to meet needs. Social inclusion, then, entails a series of processes and outcomes that, respectively, reflect certain values and fulfil specific needs. In this issue, Ren and Langhout as well as Liegghio et al. deal with this carefully when they emphasize the need to start the whole conversation around PAR with the shared values underpinning the enterprise.

Just like the concept of empowerment, social inclusion implies both a personal experience and a principle for action. Inclusion refers to a personal state of affairs and to a value for practice. As a personal experience, or as an outcome, it refers to a satisfactory state of affairs brought about by the fulfilment of certain psychological and

material needs. As a principle for action, or as a process, social inclusion rests on the presence of values for personal, relational, and collective wellness; values which respond to basic human needs.

The values presented in Table 1 can be used to formulate a comprehensive definition of social inclusion. Such definition is provided in Table 2, where values point to specific processes and outcomes of inclusion; the essential pursuits of PAR. In essence, the table shows that social inclusion depends on our ability to (a) promote in children a sense of identity, competency and dignity, (b) facilitate the participation of children and families in decisions affecting their lives, and (c) improve institutions delivering health, educational, welfare, and social services. The social inclusion of children will be upheld to the extent that we are successful in promoting the processes and outcomes outlined in Table 2.

The Role of Power in Social Inclusion

There are several references in Table 2 to power. The main corollary of these comments is that inclusion cannot be attained in the absence of power. This was an all too vivid experience for some of the researchers describing their work in this issue (Duckett et al. 2010; Newman Phillips et al. 2010; Van Sluys 2010). Enabling and inclusive processes and outcomes require energy, resources, time and effort; they involve an action plan. To carry out these plans, agents of change need to exert power over the environment. Power is a bridge between understanding inclusion and bringing it about; without it, inclusive outcomes are unlikely to materialize. As suspected, the problem is that children have little organized power in society. This is why they require lobbyists and advocates. Wong, Zimmerman and Parker conceptualize in this special issue the relationship between children and adults and the need to share power in the pursuit of child and youth wellness.

In this section I explore sources and manifestations of power in children's lives. But before that we need to be precise in our definition of power. It is often the case that power is defined as a psychological entity or ability that individuals either possess or lack. Such definitions gloss over the role of external factors in our individual abilities to perform a task or achieve a goal, thereby reducing power to a psychological quality devoid of social origins. To avoid such a limiting account, I conceptualize power as having the opportunity to: (a) access valued resources that satisfy basic human needs, (b) exercise self-determination and democratic participation, and (c) experience self-efficacy and develop skills that are conducive to social inclusion. Power entails *having the right and opportunity* to experience positive circumstances because power and control do not derive exclusively from either internal or external sources, but from both (Prilleltensky 2008; Prilleltensky et al. 2007). The convergence of internal

Table 2 A value-based definition of social inclusion

Values	Social inclusion entails	
	Processes that promote	Outcomes that meet needs for
Caring and Protection of Health	Loving and safe environments, nurturance and interest in children's lives, adequate and timely care for physical and psychological development through proper preparation and training in parenting.	Physical and psychological development and well-being.
Education and Personal Development	Support and expectations for growth in cognitive, physical, emotional, spiritual and life skills through encouragement and involvement in children's education.	Life skills, cognitive mastery, self-efficacy, social and emotional learning, spiritual development and meaningful pursuits in life.
Self-Determination	Respect for children's rights, voice and choice through an appreciation of their relative powerlessness and need for advocacy.	Control, choice, autonomy, independence.
Respect for Human Diversity	Opportunities for disadvantaged children to participate in societythrough special initiatives that take into account their doublyprecarious state—as children, and as persons with disabilities ormarginalised status.	Personal identity, dignity, self-respect, pride, integrity, belonging, tolerance, sense of community.
Collaboration and Democratic Participation	Possibilities for children to express needs and wishes in decisions affecting their lives through respectful dialogue.	Legitimate expression of children's voice in matters affecting their well-being.
Collectivism	Support for vital community structures through social action with,and on behalf of children.	Accessing and supporting social institutions like health, housing, welfare and education.
Social Justice	Fair and equitable distribution of resources in society throughpolitical activities with, and on behalf of children.	Basic resources in life such as housing and economic security.

Fig. 1 Interactive sources and manifestations of power in children's lives

Interactive Sources and Manifestations of Power in Children's Lives

Power	Sources	Manifestations
Psychological	Perceived power acquired through experiences and opportunities for mastery, control and self-efficacy. ↕	Feeling of empowerment or disempowerment expressed in personal, interpersonal, and social domains. ↕
Political	Actual power acquired through advocacy on behalf of children. ↔	Degree of effectiveness and involvement in social decision-making processes.

capacities and external conditions creates opportunities for healthy control of life's circumstances for children and adults. Although for some individuals mastering the environment is easier than for others, power and control are not just abilities people are born with; these are gifts that are developed in constant interaction with the social environment. By the same token, I object to definitions that reduce power and control to favorable external circumstances because it is conceivable that individuals may not take advantage of positive conditions. As a result, I regard power and control as *rights and opportunities* that are born through a successful fit between the person and the environment.

It follows from this definition that power is not an inner quality possessed in various degrees by different children. Rather, power is the confluence of personal qualities with opportunities presented in, and by, the environment. In simple terms, we may say that power is the combination of political and psychological forces with rights and responsibilities.

As noted above, the value of self-determination entails the right to autonomy and control and subsumes the satisfaction of needs. Without the satisfaction of basic needs, wellness and inclusion are hampered. Without the right to claim your needs and express your voice, you are at the mercy of benevolence. In my view, self determination is the pillar of individual rights. But just as rights are crucial for wellness, so are obligations. In moral philosophy there has been a tension between self determination, which advocates for individual rights, and social justice, which promotes a fair and equitable allocation of resources, rights *and obligations*. Children are entitled to claim their rights, but are not entitled to omit their obligations to each other, other generations, or the environment. A discussion of rights without a concomitant discussion of obligations is risky. Today's petitioners of rights can become tomorrow's evaders of obligations.

Figure 1 shows the sources and manifestations of political and psychological power and their role in social inclusion and participation. In the psychological domain, power acquired through positive experiences of mastery is important but not enough to foster social inclusion. At best, this psychological experience will lead to feelings of empowerment, which are important but insufficient to propagate social inclusion. This is because the psychological sphere needs to be complemented by the political realm. As noted in Fig. 1, political power requires the support of adults, as noted by Wong et al. (2010), and Porter et al. (2010). This is crucial in enhancing children's rights. Once a measure of political power is secured, chances are greater that there will be substantive changes in policies and programs that promote the inclusion of children.

But just as psychological power is insufficient without political power, so is political power incomplete without psychological power. It is conceivable to have policies that are supposed to promote child inclusion but that have no effect on children's experience of power. This is the case when adults decide matters without consulting children and youth. On the surface, it may look as if adults are doing things on behalf of children, but children and youth are excluded from the decision making process, resulting in feelings of disempowerment.

The first corollary of this argument is that psychological power and political power are reciprocal and interactive. The second corollary is that children cannot enact on their own either type of power. Given their developmental stage, some children cannot engage in political or psychological processes to promote their own inclusion in society. As a result, concerted efforts are required to advance child wellness and inclusion in several fronts.

In the section that follows I recommend shifting priorities in cultural practices affecting children. I submit that inclusion will be advanced by the synergistic effect of changing priorities in several domains at the same time. I start with a global view about priorities in society in general and progressively narrow the focus on specific institutions.

Interventions to Promote Child Wellness and Inclusion

Consistent with the model of wellness presented earlier, interventions to promote inclusion have to take place at

several levels (O'Connell et al. 2009). Although governments fragment mandates for functionalist and bureaucratic reasons, the well-being of children cannot possibly depend on the welfare, health, or education system only. If we are to deal with the root causes of the problem, we need to minimize conditions of risk. Such minimization cannot occur unless serious transformations in the way we deal with social problems take place. Consequently, I proceed to outline desired changes in the form of an inverted pyramid. I start with global social changes and end with reforms that are necessary in the child welfare system.

Table 3 outlines six areas of intervention for the promotion of child wellness and inclusion. Within each area there is a continuum of options for policies, programs, interventions and cultural practices. I discuss the various options and their potential impact for child wellness and inclusion.

Social change. We can divide social interventions along a continuum of social change. Ameliorative interventions try to help victims of injustice, illness, or abuse without challenging the societal status quo. This type of help alleviates problems but does not strive to eliminate the social antecedents that contribute to the problem in the first place. Reformist initiatives adopt a more active role in perfecting existing institutions. Although a radical transformation of oppressive institutions and damaging norms is not called for, an effort is made to make them work better for people. Transformative agents are not content to tinker with existing sources of social ills; the goal is to envision more humane forms of co-operation and re-build public structures so that they will conform with the new ideal (Nelson and Prilleltensky 2010).

Judging from the focus of most social and preventive interventions, our social imagination is blunted. Most programs are ameliorative in nature, they tend to the wounded but refrain from social critique or social change. The latter are delegitimized as "too political." Some preventive interventions opt for a reformist focus and promote organizational changes to better serve the needs of children and youth. It is worth noting that most projects described in the special issue fall somewhat between the ameliorative and reformist end of the continuum. While valuable on their own accord as means of fostering civic engagement in youth, it would be important in the future to imagine PAR ventures with youth that attend to the other end of the continuum. Child advocates, practitioners, PAR researchers and policy-makers can use the social change continuum to evaluate the scope of their interventions and question whether their current focus is the best. Examples of lasting social changes include changes in taxation, in discriminating policies, and in labor laws that prevent child exploitation. Social justice movements, like the feminist and human rights movements, have done much to advance transformative as opposed to merely ameliorative changes in society. Although some efforts are underway to make children a global priority, we are still very far from consolidating a children's movement that will fight for inclusion and wellness of all children around the world. The contributions to this special issue are somewhat shy of promoting social change with the participation of children. While they pay considerable attention to the education of children as active participants in projects, they do not, in my view, train children in the critique of social structures that contribute to the oppression of children and poor people in society. Granted, this is a difficult developmental proposition, but worth exploring nonetheless. Work by Watts and colleagues on socio-political development is very much in line with the aspiration to make PAR a tool for social change for groups of various ages (Watts et al. 2003). Similarly, work by Wagner et al. (2009) demonstrates that relatively young children are capable to ascertaining their rights and connecting their personal well-being to salubrious or deleterious contexts.

Value orientation. Values can be plotted along a continuum that ranges from individualist to collectivist principles. Individualist values are those concerned primarily with the well-being of the person. As Liegghio et al. (2010) illustrate, autonomy and self-determination are examples of values that seek to achieve what the person desires. These two are highly valued tenets in North American society. Collectivist values, on the other hand, are those that strive to enhance the well-being of the community at large. They are premised on the notion that a strong community benefits everyone. Social justice is a collectivist value because it seeks a fair allocation of resources in the community. Distributing the wealth more equally among members of

Table 3 Areas of Action for Child Wellness and Inclusion

Areas of action	Continua of options		
Social change	Ameliorative	Reformist	Transformative
Value orientation	Individualist		Collectivist
Generational focus	Unigenerational	Bigenerational	Multigenerational
Scope of intervention	Indicated	Selective	Universal
Level of intervention	Micro	Meso	Macro
Health orientation	Risk reduction	Health maintenance	Wellness promotion

various classes and groups is a collectivist measure. It makes some people less rich, but it makes the enjoyment of social resources more even and it makes for greater social health (Wilkinson and Pickett 2009).

Some values may be conceptualized as belonging in the middle of the range. Human diversity, for instance, is a value that preserves the identity of individuals and groups in order to respect their integrity and in order for people to co-exist peacefully (see for example Chen et al. 2010; Ozer et al. 2010; Van Sluys 2010). Collaboration can also be placed somewhere in the middle of the continuum, for it seeks to attend to diverse voices in the hope that personal and collective interests will be met. We co-operate and negotiate with groups so that our needs and the needs of the collective will be advanced at the same time. This requires a give and take that is characteristic of values in the middle range between individualism and collectivism.

Today, most interventions to help children and youth cater to individual goals. We seek to promote autonomy and to enhance personal wellness. We endeavour to foster healthy life styles. These are worthy and moral causes indeed. The problem, however, is not investing in individual children, but neglecting the social dimension of caring. Balancing individualist with collectivist values is crucial because of two fundamental reasons. The first is that strong communities are vital in supporting private citizens to achieve their goals. A poor medical system blocks the attainment of health, a prerequisite for autonomous functioning. A stagnant educational system prevents us from reaching scholastic excellence. Hence, forming and supporting high quality public institutions is an instrumental step in helping children to pursue the good life (Prilleltensky and Prilleltensky 2006).

Collectivist values support the equalization of access to valued societal resources and foster a sense of community that is missing from today's society. The pursuit of private goals and fierce competition erode social bonds (Wilkinson and Pickett 2009). Communitarian values strive to restore meaning by living in connection with others, not by achieving at our neighbours' expense. The communitarian ideal is solidarity among people, a solidarity conducive to a sense of community and to pride in belonging to a group or nation that looks after everyone, not just the privileged ones (Bell 1993; Etzioni 1993; Sandel 1996).

North American society has been rightly described as highly individualist (Adams 2005; Baker 2008). The value of self-determination reigns supreme. This unidimensional preoccupation with the self has not come without a price though. Alienation, isolation, competition, and violence are some of consequences of the current adoration of the self (Gil 1996). Indeed, our current priorities in social interventions are skewed toward individualism. We define, analyze, research, and treat human problems as if they were all within the individual or the microsystem. At best we think also about the mesosystem, but we rarely think about the macrosystem (Prilleltensky 1994). Future priorities should reflect a more balanced approach. When such balance is achieved, there will be higher chances of promoting child wellness and inclusion. For inclusion depends on collectivist thinking to facilitate access to societal structures of wellness. In this special issue, various contributions sensitized young people to the need to foster collectivist values through participatory research and through the creation of safe places to discuss such loaded issues (e.g., Duckett et al. 2010; Foster-Fishman et al. 2010; Ozer et al. 2010; and others).

Generational focus. Interventions have the potential to address one or more generations. Just like environmentalists worry about the future of the planet and its natural beauty and resources, child advocates should concern themselves with the wellness of present and future generations. Enhancing the welfare of only one or two generations is a narrow vision of the good society. Our efforts should be aimed at improving the human condition in the long-term, the same way the environmental movement strives to preserve nature for generations to come. Resolving immediate crises is of great practical and humane importance, but the drive to cure today's predicaments should be accompanied by the will to bequeath a decent legacy for our children, and for the children of our children. It is a matter of generational justice (Kitchen 1995). As Chen and colleagues point out in their description of Girls Inc., their project rejects "age-based hierarchy" and strives to engage in a youth-adult partnership model. Similarly, Wong et al. (2010) foster a model of egalitarian relationships across generations. They observe that children and adolescents "cannot be expected to carry the full burden of empowering themselves and their communities. Adults ought to share in this responsibility" (2010, p. 11).

If we believe that teaching the values of social responsibility will make children and youth more aware of their duties to their family of origin and eventually to their own children, then it behoves us to impart communitarian values that will prevent inflicting needless suffering on others (Damon 1995). Fighting the culture of individualism is a job for more than one generation, but the eventual benefits will also last more than one generation. Another example of a multigenerational focus is eliminating child poverty. The sequel of poverty can be felt for a long time; its deleterious effects can cause enduring damage (Wilkinson and Pickett 2009).

Because of a unigenerational or bigenerational view, many of our programs are too narrowly focused. Programs help mothers bond with their children and access needed services, but how do they contribute to a more caring

society? How do they meet the requirement to build a better society for tomorrow's children? (Febbraro 1994).

Very few social interventions adopt a long range perspective (Institute of Medicine 1994). Thinking about the generational dimension of priorities would be a first step in balancing our investments between the present and the future. The goal of inclusion should not be a priority for 5 years, but for 5 generations.

Scope of intervention. There are compelling reasons to engage in promotion and prevention activities with children and youth (Belfield and Levin 2007; O'Connell et al. 2009), but, unfortunately, most resources in human and medical services go toward treatment, not prevention (Nelson et al. 1996). Most community psychologists are familiar with definitions of universal, selective and indicated levels of prevention. Universal preventive interventions are addressed at the public at large. Selective, in turn, target groups of people whose risk of developing psychosocial problems is higher than average. Indicated interventions, in turn, address people at high risk of developing problems or further complications stemming from a particular condition (O'Connell et al. 2009; NIMH Committee on Prevention Research 1995, pp. 6–7). This terminology, widely promoted by the Institute of Medicine (O'Connell et al. 2009), is helpful in clarifying what we mean when we talk about various preventive interventions.

Applied to the field of child wellness and inclusion, *universal* interventions are available to the entire population and are designed to strengthen families and prepare them for coping with life stressors and challenges. As part of the universal approach, we can envision educational and support services that, throughout the life cycle, would help people cope and would reinforce family life. Some of these programs include parenting courses, toy lending libraries, support groups for mothers, play groups for parents and children; whereas others work on more comprehensive community development initiatives driven by a philosophy of empowerment (Alsop et al. 2006; Orr 2007; Taylor-Ide and Taylor 2002). Schools, public health services, and child care are some of the routes to deliver universal programs (Commission on Social Determinants of Health 2008). Holicek's report (2010) in this issue is the project that gets closer to some universal approaches to improve the life of kids in the community by improving the physical environment.

Selective programs are designed for populations at risk for a number of negative psychosocial outcomes. Antecedents that place children at risk for abuse or neglect include teen pregnancy, domestic violence, parental or child isolation, drug abuse, and others. Selective interventions address these high risk groups with the intention of averting deteriorations in their life conditions. In this special issue Van Sluys addressed school drop outs among a high risk population.

Indicated preventive measures should take place when familial and ecological risk factors endanger the welfare of children. Liegghio et al. (2010) dealt with the problems of children already diagnosed with mental health problems. Such is an example of PAR at the service of an indicated intervention.

A paradigmatic change from treatment to prevention will not occur without changes in values and in society in general. Prevention requires transformative and collectivist thinking. This is why it is essential to promulgate changes in several fronts at the same time. Child wellness and inclusion will be advanced to the extent that we are successful in shifting the paradigm in more than one area. Systemic and holistic thinking will carry the day, not fragmentary approaches that divide children into separate ministries.

Level of intervention. An ecological and contextual approach considers multiple levels of analysis. Thus, mental health problems are viewed in the context of characteristics of the individual (e.g., coping skills, personality traits); the microsystem (e.g., the family and social network); the exosystem, which mediates between the individual and his/her family and the larger society (e.g., work settings, schools, religious settings, neighbourhoods); and the macrosystem (e.g., economic policies, social safety net, social norms, social class). Each of the smaller levels is nested within the larger levels (e.g., person in the family in the community in society). Thus, for example, the problem of child maltreatment is viewed as being influenced by characteristics of the individual (e.g., whether or not the person committing the abuse was abused himself or herself as a child, lack of practice in the parenting role), microsystem (e.g., marital conflict, coercive family interactions), exosystem (e.g., involuntary job loss, work-related stress, neighbourhood isolation), and macrosystem (e.g., the level of violence in society, social norms that sanction corporal punishment for disciplining children) (Future of Children 2009).

Most PAR projects described in this issue deal either with school environments or neighbourhoods. These are very worthwhile endeavours. In the process of learning about how to change schools or communities, children learn about the root causes of problems in schools, such as racism (see Van Sluys 2010; Ozer et al. 2010), gender discrimination (see Chen et al. 2010), and ageism (see Clark 2010).

Health orientation. The mental and physical health of children can be considered the outcome of the relation between risk and protective factors. Incidence, the number of new cases of a disease in a population in a specific period of time, can be decreased by either reducing risk factors or enhancing protective factors. *Risk and protective factors* may be defined as circumstances, events, or

characteristics of a person that either enhance or reduce the likelihood of mental health problems (O'Connell et al. 2009). Examples of risk factors are organic vulnerabilities; stressful life events, such as separation, divorce or death; sexual, physical, or emotional abuse; and economic exploitation. Some protective factors include self-esteem, coping skills, social supports, and material resources.

The dynamic interplay between risk and protective factors has led to the concept of *protective mechanisms.* Rutter (1987) has identified four key protective processes. These are (a) the reduction of risk impact, (b) the reduction of negative chain reactions stemming from stressful life events, (c) the enhancement of self-efficacy, and (d) the creation of opportunities for educational and personal development. These processes not only guard against mental health problems, but they also contribute to wellness and inclusion. A case in point is opportunities for educational and personal development, without which wellness and inclusion are unlikely. This process identified by Rutter is fully congruent with the value of personal growth I identified earlier as a key value for inclusion. The same applies to self-efficacy, which has strong parallels to the value of self-determination. Many of the risk and protective factors involved in living with a parent with a disability are eloquently presented by Patil in Kellett's paper (2010).

Partnerships with Children and for Children

I have outlined changes required in several areas to promote child wellness and inclusion. The key question now is what will it take for these changes to take place? We have gleaned part of the answer in our discussion of power. Powerless children and youth cannot effect the changes required in social institutions on their own; they need partners and advocates. Youth can be articulate defenders of their rights, but they need appropriate forums to express their views. To develop these forums they need assistance. Several exemplars have been presented here, as in the case of Holicek's project (2010) in which children participated in municipal discussions about budget allocation in Banja Luka.

Most social institutions looking after children—schools, clubs, the welfare system—have only token representation of children in their affairs. There is much talk in the social and human services about the need for partnerships to tackle social problems. Rarely, however, do these partnerships invoke the need to partner with children. As political orphans, children are relegated to the status of silent beneficiaries of adult benevolence (Imig 2006).

To bring children to the level of partners in institutions affecting their lives we need proper training and proper structures. Based on the premise that no one can defend your rights better than yourself, I submit that we have to train children and youth to articulate their wishes and needs, just as Foster-Fishman et al. (2010), Clark (2010), Chen et al. (2010), Ozer et al. (2010), Ren and Langhout (2010) and others have done in this issue. Just like human services have training for their board members and staff, so should organizations looking after children train a cadre of young people to use their voice. We often conduct advocacy training for workers in the social services, but we rarely involve youth in the same. Consumer groups organize themselves to protect their rights against the assault of the medical and welfare system. Why couldn't we help children organize themselves for advocacy?

Although this proposition may sound radical and unrealistic, it is merely an extension of two ideas. The first is the idea of partnerships with stakeholders affected by organizations, and the second idea is consumer advocacy. Why shouldn't we partner with children and regard them as consumers in services affecting their wellness and inclusion? I would recommend that each institution looking after children, from schools to recreational facilities to hospitals to the welfare system, engage in methodic training of children for advocacy. Once advocates are trained there would have to be adequate places for the young to exercise their voice. I would recommend that professional advocates be appointed to safeguard the rights of children and to work with them. Many ministries appoint consumer advocates to work with ex-psychiatric patients or with tenants of public housing. An extension of this idea would see a team of child advocates organize and support children in schools, hospitals and foster homes.

Children can have powerful voices, but they will remain unheard until spaces for their expression are created and nurtured. It is all too easy to create token spaces for token voices. In my view, a methodic advocacy plan could start with the definitions of wellness and inclusion presented in this essay. As a guide for action, the value-based definition of inclusion presented in Table 2 can help advocates identify gaps in child related programs and policies. The definition of inclusion I presented can facilitate the enactment of values in processes and outcomes affecting children and youth.

The value-based definition of inclusion provided in Table 2 can serve in the creation and maintenance of structures for inclusion of children. The enactment of these values will have to follow certain steps though; for we cannot expect children to feel at ease in the company of adults who usually make all the decisions. Along with Nelson and other colleagues, we have developed guidelines for partnerships with human service providers and with marginalized populations (Nelson et al. 2000, 2001). Some of these principles can be applied to work with children. To achieve a partnership with children, adults will have to (a) create a welcoming and friendly atmosphere, (b) reduce barriers to participation, (c) value the experiential

knowledge of children, (d) build collective ownership of process and outcomes, and (e) reinforce children and youth for their participation in the process.

Conclusion

Inclusion is an integral part of wellness, but it is not a substitute for it. Child wellness entails the satisfaction of personal, relational, and collective needs, not only of children, but also of their parents and community members. Child wellness is embedded in family and community wellness as well. To meet these needs, we, as a collective, have to enact certain values and principles. PAR is a wonderful methodology to achieve that goal, as amply demonstrated in this special issue. I identified a series of values as primordial in the enhancement of wellness: caring and protection of health, education and personal development, self-determination, collaboration and democratic participation, respect for diversity, collectivism and social justice. These interacting and mutually reinforcing values should guide programs and policies to promote child wellness. At the same time, these values can inform the inclusion of children in society. I proposed a value-based definition of inclusion that would see these values foster processes and outcomes for inclusion. Although inclusion relates more readily to collaboration and participation, self-determination and respect for diversity, I claimed that inclusion cannot take place in the absence of collectivism and social justice, for these two values support structures for economic and social inclusion.

To advance wellness and inclusion in society I argued that major changes ought to take place in various sectors. Inclusion does not happen only at the interpersonal level, but at the macro level as well. Hence, changes in our helping paradigms are called for. Developing proactive, universal and multigenerational interventions will prove essential in advancing wellness and inclusion. To achieve these transformations we have to involve children and youth in the very processes of helping them. Politically powerless, youth need advocates to help them advocate for themselves. Including children in the very decisions affecting their well-being will be a major step in the right direction. The institutionalization of such involvement will ensure that inclusion is not just a fleeting but rather a constant state of affairs.

References

Adams, M. (2005). *American backlash: The untold story of social change in the United States*. Toronto: Penguin.

Alsop, R., Bertelsen, M., & Holland, J. (2006). *Empowerment in practice: From analysis to implementation*. Washington, DC: The World Bank.

Andresen, J., & Siim, B. (Eds.). (2004). *Politics of inclusion and empowerment: Gender, class and citizenship*. New York: Palgrave Macmillan.

Baker, W. (2008). America the traditional. In T. Pettersson & Y. Esmer (Eds.), *Changing values, persisting cultures: Case studies in value change* (pp. 9–44). Boston: Brill.

Belfield, C., & Levin, H. (Eds.). (2007). *The price we pay: Economic and social consequences of inadequate education*. Washington, DC: The Brookings Institution.

Bell, D. (1993). *Communitarianism and its critics*. Oxford: Clarendon.

Chen, P., Weiss, F. L., & Nicolson, H. J. (2010). Girls study girls Inc.: Engaging girls in evaluation through participatory action research. *American Journal of Community Psychology*. doi: 10.1007/s10464-010-9328-7.

Clark, A. (2010). Young children as protagonists and the role of participatory, visual methods in engaging multiple perspectives. *American Journal of Community Psychology*.

Damon, W. (1995). *Greater expectations: Overcoming the culture of indulgence in America's homes and schools*. New York: The Free Press.

Duckett, P., Kagan, C., & Sixsmith, J. (2010). Consultation and participation with children in healthy schools: Choice, conflict and context. *American Journal of Community Psychology*.

Etzioni, A. (1993). *The spirit of community*. New York: Touchstone.

Febbraro, A. (1994). Single mothers "at risk" for child maltreatment: An appraisal of person-centred interventions and a call for emancipatory action. *Canadian Journal of Community Mental Health, 13*(2), 47–60.

Foster-Fishman, P. G., Law, K. M., Lichty, L. F., & Aoun, C. (2010). Youth ReACT for social change: A method for youth participatory action research. *American Journal of Community Psychology*. doi:10.1007/s10464-010-9316-y.

Future of Children (2009). Preventing child maltreatment. *The Future of Children, 19*(2), (Special Issue).

Gergen, K. (2009). *Relational being: Beyond self and community*. New York: Oxford University Press.

Gil, D. G. (1996). Preventing violence in a violent society: Mission impossible. *American Journal of Orthopsychiatry, 66*, 77–84.

Imig, D. (2006). Building a social movement for America's children. *Journal of Children in Poverty, 12*(1), 21–37.

Institute of Medicine. (1994). *Reducing risks for mental disorders: Frontiers for preventive intervention research*. Washington, DC: National Academy Press.

Kellett, M. (2010). Small shoes, big steps! Empowering children as active researchers. *American Journal of Community Psychology*. doi:10.1007/s10464-010-9324-y.

Kitchen, B. (1995). Children and the case for distributive justice between generations in Canada. *Child Welfare, LXXIV*, 430–458.

Klasen, S. (1998). *Social exclusion and children in OECD countries: Some conceptual issues*. OECD: Centre for Educational Research and Innovation. Available from http://www.oecd.org/els/edu/ceri/conf220299.htm.

Liegghio, M., Nelson, G., & Evans, S. D. (2010). Partnering with children diagnosed with mental health issues: Contributions of a sociology of childhood perspective to participatory action research. *American Journal of Community Psychology*.

Lord, J., & Hutchison, P. (2007). *Pathways to inclusion: Building a new story with people and communities*. Concord, Ontario: Captus.

Maglajlic Holicek, R. A. (2010). "Big organisations" supporting "small involvement"—lessons from Bosnia and Herzegovina on

enabling community-based participation of children through PAR. *American Journal of Community Psychology.*

Minow, M., & Weissbourd, R. (1993). Social movements for children. *Daedalus*, 122.

Nelson, G., Amio, J., Prilleltensky, I., & Nickels, P. (2000). Partnerships for implementing school and community prevention programs. *Journal of Educational and Psychological Consultation, 11*, 121–145.

Nelson, G., & Prilleltensky, I. (Eds.). (2010). *Community psychology: In pursuit of liberation and well-being* (2nd ed.). Palgrave/ Macmillan.

Nelson, G., Prilleltensky, I., Laurendeau, M. C., & Powell, B. (1996). A survey of prevention activities in mental health in the Canadian provinces and territories. *Canadian Psychology, 37*(3), 161–172.

Nelson, G., Prilleltensky, I., & McGillivary., H. (2001). Value-based partnerships: Toward solidarity with oppressed groups. *American Journal of Community Psychology, 29*, 778–794.

Newman Phillips, E., Berg, M. J., Rodriguez, C., & Morgan, D. (2010). A case study of participatory action research in a public New England middle school: Empowerment, constraints and challenges. *American Journal of Community Psychology.*

NIMH Committee on Prevention Research. (1995). *A plan for prevention research for the National Institute of Mental Health (A report to the National Advisory Mental Health Council)*. Washington, DC: NIMH Committee on Prevention Research.

O'Connell, M., Boat, T., & Warner, K. (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. Washington, DC: The National Academies Press.

Orr, M. (Ed.). (2007). *Transforming the city: Community organizing and the challenge of political change*. Lawrence, KS: University Press of Kansas.

Ozer, E., Gaddis, M. L., & Ritterman, M. G. (2010). Participatory action research (PAR) in middle school: Opportunities, constraints, and key processes. *American Journal of Community Psychology.*

Porter, G., Hampshire, K., Bourdillon, M., Robson, E., Munthali, A., Abane, A. et al. (2010). Children as research collaborators: Issues and reflections from a mobility study in sub-Saharan Africa. *American Journal of Community Psychology.* doi: 10.1007/s10464-010-9317-x.

Prilleltensky, I. (1994). *The morals and politics of psychology: Psychological discourse and the status quo*. Albany, NY: State University of New York Press.

Prilleltensky, I. (2008). The role of power in wellness, oppression, and liberation: The promise of psychopolitical validity. *Journal of Community Psychology, 36*(2), 116–136.

Prilleltensky, I., & Nelson, G. (2000). Promoting child and family wellness: Priorities for psychological and social interventions. *Journal of Community and Applied Social Psychology, 10*, 85–105.

Prilleltensky, I., & Prilleltensky, O. (2006). *Promoting well-being: Linking personal, organizational, and community change*. New York: Wiley.

Prilleltensky, I., Prilleltensky, O., & Voorhees, C. (2007). Psychopolitical validity in the helping professions: Applications to research, interventions, case conceptualization, and therapy. In C. Cohen & S. Tamiami (Eds.), *Liberatory psychiatry: Towards a new psychiatry* (pp. 105–130). New York: Cambridge University Press.

Ren, J. Y., & Langhout, R. D. (2010). A recess evaluation with the players: Taking steps toward participatory action research. *American Journal of Community Psychology.* doi:10.1007/s10464-010-9320-2.

Rutter, M. (1987). Psychosocial resilience and protective mechanisms. *American Journal of Orthopsychiatry, 57*, 316–331.

Sandel, M. (1996). *Democracy's discontent*. Cambridge, MA: Harvard University Press.

Taylor-Ide, D., & Taylor, C. (2002). *Just and lasting change: When communities own their futures*. Baltimore, MD: Johns Hopkins.

Van Sluys, K. (2010). Trying on and trying out: Participatory action research as a tool for literacy and identity work in middle grades classrooms. *American Journal of Community Psychology*. doi: 10.1007/s10464-010-9319-8.

Wagner, A., Castella Sarriera, J., & Casas, F. (2009). *Os direitos da infância: A perspective das crianças, seus pais e professors [Children's rights: The perspective of children, their parents and teachers]*. Porto Alegre, RS, Brazil: Nova Prova.

Watts, R., Williams, N. C., & Jagers, R. (2003). Sociopolitical development. *American Journal of Community Psychology, 31*, 185–194.

Wilkinson, R., & Pickett, K. (2009). *The spirit level: Why more equal societies almost always do better*. London: Allen Lane.

Wong, N. T., Zimmerman, M. A., & Parker, E. A. (2010). A typology of youth participation and empowerment for child and adolescent health promotion. *American Journal of Community Psychology.*