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Promoting Child and Family Wellness:

Priorities for Psychological and Social Interventions

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Abstract

In order to foster the well-being of children and families I propose a shift in the priorities of psychological and social interventions. Following a brief discussion of the concept of wellness I present a framework for assessing interventions and for changing priorities in the field. Strategies to promote child and family wellness can be grouped into psychological and social interventions. Each group contains four distinct dimensions. Psychological interventions vary according to (a) time and scope of intervention, (b) level of intervention, (c) child welfare orientation, and (d) health orientation. Social interventions, in turn, differ on (a) generational focus, (b) value orientation, (c) social change orientation, and (d) social salience. These eight dimensions lead to recommendations for improving child and family wellness.

Promoting Child and Family Wellness:

Priorities for Psychological and Social Interventions

We all know the adage that prevention is better than cure, but departments and ministries of health in Canada and the United States devote less than 1% of their budgets to prevention of mental health problems. Most of the money goes toward treatment (Goldston, 1991; Nelson, Prilleltensky, Laurendeau, & Powell, 1996). We understand that brain malleability is greatest during the first years of life, but we spend very little on early intervention (Keating & Mustard, 1996; C. T. Ramey & Ramey, 1998; Steinhauer, 1998).

We want teenagers unprepared for parenthood to stop having children, but we are unwilling to invest in family planning, educational and preventive services (Harris, 1996; Rickel & Becker, 1997). The result: Statistics from 1990 in the U.S. report that "1,040,000 adolescents under the age of 20 became pregnant, approximately 530,000 (51%) of whom gave birth" (Levine Coley & Chase-Lansdale, 1998, p. 152). In Canada, teenage pregnancy has sharply risen in recent years, an increase from

39,340 in 1987 to 45,771 in 1995 (Mitchell, 1998).

We know that about 26% of children experience behavioural, learning, emotional or social problems (Offord, Boyle, & Szatmari, 1987). Of those, at the very least 12% "have clinically important mental disorders, and at least half of them are deemed severely disordered or handicapped by their mental illness" (Offord, 1995, p. 285). Similarly, the Institute of Medicine (IOM) (1994) reported that at least 12% of children in the U.S. "suffer from one or more mental disorders--including autism, attention deficit hyperactivity disorder, severe conduct disorder, depression, and alcohol and psychoactive substance abuse and dependence" (p. 487). Using this figure of a prevalence rate of 12% for mental, behavioral and developmental disorders in children around the world, Kramer (1992) argued that "the total number of cases of mental disorders in children under 18 years of age would increase from 237.8 million in 1990 to 261.5 in the year 2000, an increase of 10%. In the more developed regions the number of cases would increase from 37.8 million to 38.2 million@ (Kramer, 1992, p. 15). Despite the fact that these are alarming figures, no major health or social policies are being launched to curb the problem.

We hear the economy in North America is doing very well, but the number of children growing up in poverty in Canada and the U.S. continues to be much higher than in all other industrialized countries. Close to a million and a half, or 21% of Canada's children live in poverty, half a million more than in 1989, when the entire House of Commons voted to end child poverty by the year 2000 (Campaign 2000, 1996; Canadian Council on Social Development [CCSD], 1997). In a report entitled Towards Well-Being, the Standing Committee on Health of the House of Commons (1997) stated that "poverty among children in Canada is especially troublesome when compared with the rate in other industrialized countries. The rate of child poverty in Canada after government redistribution is four times the rate in Sweden, twice as high as in France and Germany, and 1.4 times the rate in Great Britain. Only in the United States is the rate higher than in Canada" (p. 7). "As of 1994, 22% of American children lived in families with cash incomes below the poverty threshold. In addition to being more economically disadvantaged than their counterparts in other Western industrialized countries, American children today are faring less well that their American counterparts three decades ago" (McLoyd, 1998, p. 185).

We are aware that health is determined by multiple factors, but our interventions focus on single solutions. Population health frameworks show that health outcomes depend on five key determinants: social and economic environment, physical environment, personal health practices, individual capacity and coping skills, and services needed for health (Canadian Public Health Association, 1996; Hamilton & Bhatti, 1996; National Forum on Health, 1996). Yet despite our sophisticated ecological notions of health, interventions typically focus on the person and fail to change pernicious environments (e.g., Albee & Gullotta, 1997; Institute of Medicine, 1994; Weissberg, Gullotta, Hampton, Ryan, & Adams, 1997).

These contradictions pose a great concern to psychologists interested in advancing child and family wellness. Unless there is a shift in social priorities, it is unlikely that wellness will be promoted and that child maltreatment will be averted. In order to foster the well-being of children and families I propose a shift in the priorities of psychological and social interventions. Following a brief discussion of the concept of wellness I present a framework for assessing interventions and for changing priorities in the field.

Child and Family Wellness

Child wellness is predicated on the satisfaction of material, physical, affective, and psychological needs. Wellness is an

ecological concept; a child's well-being is determined by the level of parental, familial, communal, and social wellness. Parents who enjoy physical and psychological health, and who have access to adequate financial resources, will be in a good position to provide a wellness enhancing environment for their children. Parental wellness, in turn, is based on the opportunities afforded them by the community in which they reside (Rickel & Becker, 1997; Trickett, Allen, Schellenbach, & Zigler, 1998).

Family wellness can be considered a state of affairs in which everybody=s needs in the family are met. This requires that people reach a balance between pursuing personal aspirations, such as careers and studies, and contributing to the well-being of other family members. Family wellness is more than the absence of discord; it is the presence of supportive, affectionate and gratifying relationships that serve to promote the personal development of family members and the collective well-being of the family as a whole. Family wellness comes about through the creative satisfaction of personal and family wishes at the same time. When this creative and delicate balance is attained, parents find energy in themselves and support in their partners or others to devote attention to their children (Basic Behavioral Science Task Force of the National Advisory Mental Health Council, 1996; Moore et al., 1996; Standing Committee on Health, 1997; Stinnett & DeFrain, 1985). While parents do most of the giving during the children=s early years, children gradually develop the ability to reciprocate and contribute to family well-being in many ways.

Cowen (1991, 1994, 1996) has done much to advance the notion of wellness enhancement. According to him, wellness is

> the positive end of a hypothetical adjustment continuum -- an ideal we should strive continually to approach....Key pathways to wellness, for all of us, start with the crucial needs to form wholesome attachments and acquire age-appropriate competencies in early childhood. Those steps, vital in their own right, also lay down a base for the good, or not so good, outcomes that follow. Other cornerstones of a wellness approach include engineering settings and environments that facilitate adaptation, fostering autonomy, support and empowerment, and promoting skills needed to cope effectively with stress. (Cowen, 1996, p. 246)

Wellness entails positive social, cognitive, and emotional functioning. Social functioning entails occupational and academic performance, as well as problem solving skills and the ability to deal with stress. Positive emotional adjustment pertains to subjective feelings of well-being and personal satisfaction; whereas cognitive adaptation relates to a sense of mastery, self-efficacy, and control (Cowen, 1991; Dunst, Trivette, & Thompson, 1990; Peters, 1988). "Mental health promotion entails more than seeking freedom from disorders or ailments. It represents attempts to seek a sense of coherence, health, wellness, zest, resilience, self-efficacy, empowerment, energy, flexibility, order, balance, harmony, and integrity" (Muñoz, Mrazek, & Haggerty, 1996, p. 1121). In Mental health for Canadians: Striking a balance, psychological wellness is defined as follows:

> Mental health is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective, and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality. (Epp, 1988, p. 7)

This definition of wellness is predicated on the presence of a healthy and just society that affords citizens opportunities for

growth and development (Albee, 1986; Canadian Public Health Association, 1996). Wellness, then, is based on the fulfilment of psychological as well as social needs. In order to ensure that these needs are met, we require a framework to evaluate the adequacy of social and psychological interventions.

A Framework for Assessing Interventions and Changing Priorities

Strategies to promote child and family wellness can be grouped into psychological and social interventions. Each group contains four distinct dimensions. Psychological interventions vary according to: (a) time and scope of intervention, (b) level of intervention, (c) child welfare orientation, and (d) health orientation. Social interventions, in turn, differ on (a) generational focus, (b) value orientation, (c) social change orientation, and (d) social salience.

Insert Figures 1 and 2 About Here

Figure 1 brings together the psychological domains of health and child welfare orientation, as well as time, scope, and level of intervention. The figure depicts current priorities of interventions in child and family wellness. Very few programs are devoted to strengthen families, promote wellness, and operate at the universal and macro-levels. Ideal programs would be proactive and population-wide and would help all families with either economic security or parent-training. Similarly, few are the programs that help all families to enhance wellness. More programs are dedicated to maintain health or reduce risks for groups with some identifiable risk factors than to promote wellness. Indeed, most programs in child welfare and child mental health deal with subgroups experiencing significant stressors (Schorr, 1997).

Figure 2 represents the tendencies of current social interventions. As we shall document below, the focus of most interventions is unigenerational, individualist, and ameliorative. These types of interventions are the most salient ones at the present time. I will describe below the shift in orientation that is required in order to pursue more vigorously child and family wellness.

It is worth noting the uses of the framework for analyzing intervention efforts and for discerning where our priorities are. The framework can be used to plot current interventions and decide where to go next. If indeed we are placing more emphasis on indicated programs and are neglecting universal ones, we should do well to plan how to correct this imbalance. Similarly, if we know that interventions at the micro level are of limited use, we ought to consider how to expand the scope of policies so that we may address risk and protective factors at the macro level as well.

Priorities for Psychological Interventions

In order to promote child and family wellness we have to redirect our efforts concerning (a) child welfare orientation, (b) health orientation, (c) time and scope of intervention, and (d) level of intervention. Each of these vehicles for the promotion of child and family wellness requires a tune up. We derive from these recommendations four priorities.

Priority in Child Welfare Orientation: *Strengthen Families, Don=t Just Fight Maltreatment!*. We can imagine a continuum in the field of child welfare. The continuum ranges from interventions dedicated to strengthen families on one end, to actions to minimize maltreatment on the opposite end. Numerous calls have been made to allocate more resources to strengthen

families, as the current and dominant focus of child welfare is the protection of children at risk. That is the situation in Canada (Armitage, 1993; Wharf, 1993), the U.S. (Emery & Laumann-Billings, 1998; Melton & Barry, 1994; Schorr, 1997), and the U.K. (Burton, 1997; Hearn, 1995). Many reasons account for this imbalance, not the least of which is the lack of resources to do preventive work. For one reason or another, very little is being done to promote wellness and prevent the deterioration of family life.

It is clear that when everybody=s needs in the family are met in a loving and harmonious atmosphere, maltreatment is unlikely to occur. This is why it is essential to foster wellness, develop strengths, and impart the necessary skills to reduce stress and increase interpersonal understanding, mutuality, and tolerance. The more we invest in wellness now, the less abuse we will see in the future (Belsky, 1993; Emery & Laumann-Billings, 1998; Harris, 1996; Rickel & Becker, 1997; Schorr, 1997). By promoting family wellness we enhance the chances that parents and children will get along and develop loving relationships (Cameron, Vanderwoerd, & Peirson, 1997; Dunst, Trivette, & Thompson, 1990; Emery & Laumann-Billings, 1998; Garbarino, 1992; Hearn, 1995; Kagan & Weissbourd, 1994).

Families are not fixed at any one point of the wellness -- maltreatment continuum. Because of a myriad of circumstances families experience more or less stress, and have more or less supports. When resources are depleted, the level of stress is high, and psychological problems with aggression are unresolved, child maltreatment looms large (Trickett et al., 1998). To avoid maltreatment in the first place, more efforts should be invested in strengthening families. Once maltreatment, however minor, has already occurred, feelings have been hurt, relationships have been permanently marred, psychological disorders are likely to ensue, and serious harm, possibly irreversible, has already taken place. If all or even some of these negative outcomes can be averted by strengthening families, then it is our obligation to make it a priority. Successful family support programs in the form of home visitation (Olds & Korfmacher, 1998), parent education and self-help (Cameron, Vanderwoerd, & Peirson, 1997) are examples of what can be done to make this a priority.

Priority in Health Orientation: *Promote Wellness, Don=t Just Minimize Risks and Deficits!*. 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. A useful formula to depict this notion has been proposed by Albee (1982) and further elaborated by Werner (1985) and Gullotta (1997). In this formula, shown below, the numerator consists of risk factors, and the denominator of protective factors.

$$\text{Incidence} = \frac{\text{risk factors}}{\text{protective factors}} = \frac{\text{organic causes + stress + exploitation}}{\text{coping skills + self-esteem + support systems}}$$

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 (Muñoz, Mrazek, & Haggerty, 1996; Reiss & Price, 1996; Rolf, Masten, Cichetti, Nuechterlein, & Weintraub, 1990). 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.

Risk and protective factors are moderated and mediated by personal and contextual variables and processes. In other words, a particular stressful life event will have a differential impact on people depending on their psychological make up, availability of external resources, and ability to enact protective mechanisms (Rutter, 1994). This is why it is difficult to predict with certainty the outcome of specific negative life events on particular children. Some will cope better than others. In light of the negative sequel of risk factors, efforts should be directed at minimizing risk and maximizing protective factors and mechanisms.

We can argue then that children's mental health is determined by the presence or absence of risk and protective factors, and by the extent to which the child and his/her care-givers successfully engage protective mechanisms in coping with stress (Haggerty, Sherrod, Garmezy, & Rutter, 1994; Rolf, Masten, Cichetti, Nuechterlein, & Weintraub, 1990; Rutter, 1987). In terms of the mental health formula advanced by Albee, this means that a reduction in the numerator and an increase in the denominator should enhance psychological well-being. It follows from this that the mental health of children can be improved by both the *reduction of risk* and the *promotion of protective factors and mechanisms*. Although the former route has traditionally predominated in the field of prevention, Cowen (1994) makes a compelling argument for the pursuit of wellness, and not just the elimination of disease.

> Wellness is not the same as the absence of disease. Rather it is defined by the presence of positive marker characteristics that come about as a result of felicitous combinations of organismic, familial, community, and societal elements that may provide a psychological Salk vaccine, with inoculative values for many different types of >risk invaders= and the negative outcomes they predispose. Wellness enhancement has broader, more basic objectives than risk-driven interventions. (Cowen, 1996, p. 247)

At the other end of the health continuum we find risks and deficits. Historically, most efforts and investments in the physical and mental health fields have been directed toward the reduction of risks and the correction of deficits. When the primary mandate of health professionals is to fix problems, not to avert them, little attention is paid to wellness promotion, even though it is a more humane and cost efficient method of securing health and safety (Albee, 1996; Cowen, 1996).

Risk reduction is a very legitimate endeavour, but it has to be balanced with strategies to promote well-being. In promoting life satisfaction we build a buffer zone against stressful events and transitions. Hence, we diminish the chances of negative chain reactions when faced with adverse circumstances.

Wellness enhancement is an ongoing task; it is part of a deliberate plan to achieve optimum health and satisfaction through the actualization of personal and social values. This entails the promotion of values such as caring and the protection of health, education and personal development, self-determination, and social justice. Prilleltensky (1994a) has detailed how parents, schools, communities and social policy makers can enact these values for the promotion of child and family wellness.

Priority in Time and Scope of Intervention: *Be Proactive, Don=t Just React to Crises!*. *"A stitch in time saves nine,"*

"pay now or pay later," "an ounce of prevention is worth a pound of cure." We all know the logic of prevention, but, as we saw, most resources in human and medical services go toward treatment, not prevention. Like the calls to strengthen families and promote wellness, the request to be proactive is echoed in many quarters.

> To understand the shift in orientation we propose we should familiarize ourselves with the language of prevention. *Universal* preventive interventions are targeted to the general public or a whole population group that has not been identified on the basis of individual risk. An example of a universal preventive intervention for physical health is childhood immunization.
>
> *Selective* preventive interventions are targeted to individuals or subgroups of the population whose risk of developing problems is significantly higher than average. A Head Start or other early childhood programs for all children living in a socioeconomically depressed neighborhood is an example of a selective prevention intervention. *Indicated* preventive interventions are targeted to high risk individuals who are identified as already having minimal, but detectable signs or symptoms, or biological markers, indicating predisposition for the mental disorder, but who do not meet diagnostic criteria. An intervention to prevent depression in children with one or both clinically depressed parents is an example of an indicated preventive intervention. (NIMH Committee on Prevention Research, 1995, pp. 6-7)

This terminology, widely promoted by the Institute of Medicine (IOM, 1994; Muñoz, Mrazek, & Haggerty, 1996), is helpful in clarifying what we mean when we talk about various preventive interventions.

Applied to the field of family wellness and child maltreatment, *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 (Stilwell & Manley, 1990); whereas others work on more comprehensive community development initiatives driven by a philosophy of family empowerment (DeChillo, Koren, & Schultze, 1994; Dunst, Trivette, & Deal, 1994). Schools, public health services, and child care are some of the routes to deliver universal programs (Zigler, Finn-Stevenson, & Stern, 1997). *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 a deterioration in their life conditions. Weissberg and colleagues (1997) describe successful programs that address psychological and social problems; while Burt, Resnick, and Novick (1998) suggest comprehensive community programs for adolescents at risk. *Indicated* preventive measures should take place when familial and ecological risk factors endanger the welfare of children. It is at this point of crisis that intense family support programs come into place (Cameron, Vanderwoerd, & Peirson, 1997). For some families, the preferred universal and selective preventive measures would not avert serious risk. This is where family preservation and other programs try to restore a measure of well-being to prevent the child from accessing the alternative care system.

When we consider in combination the three priorities stated so far, we can visualize a continuum for the promotion of family wellness and the prevention of child maltreatment.

The continuum ranges from universal programs and policies designed to promote wellness in families that are functioning well, all the way to indicated programs and policies to prevent deterioration in families requiring intensive protective services.

Priority in Level of Intervention: *Intervene at All Levels, Don=t Just Work with Individuals!*. "Child maltreatment is now widely recognized to be multiply determined by a variety of factors operating through transactional processes at various levels of analysis (i.e., life-course history through immediate-situational to historical evolutionary) in the broad ecology of parent-child relations" (Belsky, 1993, p. 413). So varied are the sources of influence on children and families that we require an ecological perspective to understand their lives and to devise useful programs. 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 (i.e., the family and social network); the exosystem, which mediates between the individual and his/her family and the larger society (i.e., work settings, schools, religious settings, neighbourhoods); and the macrosystem (i.e., 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) (Belsky, 1993; Garbarino, 1992). As Belsky put it,

> Although most child maltreatment takes place in the family and thus "behind closed doors," this immediate and even developmental context of maltreatment itself needs to be contextualized. Cultural attitudes, values, and practices, as well as the economic circumstances of a society and its cultural history, play an important role in the etiology of child maltreatment. (1993, p. 423)

The example of child maltreatment illustrates the presence of risk factors at different levels of analysis. At the same time, there are protective factors at the individual (e.g., coping skills), the microsystem (e.g., a supportive relationship with one parent), exosystem (e.g., neighbourhood cohesion, a supportive employer), and the macrosystem (e.g., social norms against corporal punishment, economic safety net).

"Optimal development of wellness...requires integrated sets of operations involving individuals, families, settings, community contexts, and macrolevel societal structures and policies" (Cowen, 1996, p. 246). Despite what we know about the impact of various systems and levels on families, most preventive and reactive interventions in child welfare and mental health deal with individuals or dyads, such as parent-child or marital relationships. Our actions seriously lag behind our understanding of wellness. An enormous corpus of evidence points to the powerful impact of socioeconomic, cultural, and contextual factors in shaping the lives of children and families (Basic Behavioral Science Task Force of the National Advisory Mental Health Council, 1996; Bronfenbrenner & Neville, 1994; Garbarino, 1992; McLoyd, 1998; National Forum on Health, 1996; C. T. Ramey & Ramey, 1998), yet in apparent disregard for this knowledge, workers continue to focus on counselling, therapy, or person-centered prevention as the main vehicles for the promotion of wellness (Albee, 1996; Cowen, 1985).

The causes for maintaining an individualistic and intrapsychic orientation in child welfare and mental health are many and have been reviewed elsewhere (Fox & Prilleltensky, 1997; Prilleltensky, 1989, 1994b, 1997; Wharf, 1993). A culture that promotes selfishness and blames victims for their misfortune is bound to want to fix people and not structures. So ingrained in our society is the individualistic mentality that professionals rarely question the narrow focus of social interventions. In a sense, changing individuals in light of ominous social forces is like searching for the penny where there is more light, never mind the penny got dropped in the dark. We offer counselling because it is what we are accustomed to, not necessarily because it is the best means of helping. Never mind societal structures and economic policies need a serious overhaul to lift people out of poverty, we sit down with our clients and teach them how to budget their ever shrinking dollars, sermonize them not to get too upset with their children even if there is not enough to eat, and urge them not to expose their kids to lead when all they can afford is deplorable housing with lead paint and lead pipes (McKnight, 1995). Nothing short of an urgent wake up call is needed to shift priorities from the individualistic aid that is offered to the systemic transformations that are required. Willis and Silovsky (1998) address the multiple societal roots of violence and urge citizens and professionals to eradicate poverty, curb substance abuse, eliminate television violence, and demand public policies in line with child and family wellness.

Priorities for Social Interventions

Child and family wellness depend on propitious psychological and social conditions. Just like we need to change the focus of psychological help, we need to shift the orientation of social interventions. We propose changes concerning the following dimensions of social interventions: (a) generational focus, (b) value orientation, (c) social change orientation, and (d) social salience.

Priority in Generational Focus: *Concern Yourself with the Future, and Not Just with the Present!.* 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, preventionists 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; O=Neill, 1994).

In the case of child abuse and neglect, a multigenerational orientation would direct us to prevent abuse from happening again, not only in 5 or 10, but also in 15, 20, and 50 years from now. If we know that children of teenage parents are at risk for abuse, it makes sense to work with preadolescents to ensure that they don=t have children before they are fully ready. This would help reduce the incidence of abuse in future generations. Similarly, 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 behooves 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. A third 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 (Campaign 2000, 1996; McLoyd, 1998; Willis & Silovsky,

1998.

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).

Figure 2 shows that most of our programs aim to help one generation, children or single parents for example. It shows that some have a bigenerational focus, helping parents communicate better with children; but that very few adopt a long range perspective (Albee & Gullotta, 1997; Institute of Medicine, 1994; Rickel & Becker, 1997; Weissberg, Gullotta, Hampton, Ryan, & Adams, 1997). Thinking about the generational dimension of priorities would be a first step in balancing our investments between the present and the future.

Priority in Value Orientation: *Promote Communitarian Values, Don=t Just Reinforce Individualist Principles!.* Values can be plotted along a continuum that ranges from individualist to collectivist principles (Avineri & De-Shalit, 1992; Sandel, 1996; Schwartz, 1994). Individualist values are those concerned primarily with the well-being of the person. 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 various classes and groups is a collectivist measure. It makes some people less rich, but it makes the enjoyment of social resources more even.

Some values may be conceptualized as belonging in the middle of the range (Schwartz, 1994). 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. 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 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. The problem is not investing in individuals, 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 private citizens to pursue the good life (O'Neill, 1994).

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. 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).

Our North American society has been rightly described as highly individualist (Bellah, Madsen, Sullivan, Swidler, & Tipton, 1985; Lerner, 1996; Saul, 1995). 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; Kohn, 1986). When the main social message is Aget what you want in life, now, no matter what,@ others are reduced to instruments of immediate self-gratification. Unwelcome interference with this motto may result in domestic violence or white collar crime.

Our current priorities in social interventions are skewed toward individualism (Cowen, 1985). We define, analyze, research, and treat human problems as if they were all within the individual or the microsystem (Ratcliffe & Wallack, 1986). At best we think also about the mesosystem. Rarely do we think about the macrosystem (Prilleltensky, 1994). Future priorities should reflect a more balanced approach.

Priority in Social Change Orientation: *Seek Transformative Interventions, Don=t Just Try to Alleviate the Impact of Social Problems!.* Social and preventive programs vary in the degree to which they seek to transform society. Some workers attend to the wounded without concerning themselves with the societal causes of suffering. Others, on the other hand, recognize the societal roots of problems but feel too impotent to do anything about them. Yet a third group may vigorously engage in social change. For without a serious transformation of structures of oppression and inequality, avoidable pain and sorrow will never diminish.

We can divide social and preventive 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 (Prilleltensky & Nelson, 1997).

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 Atoo political@ (Albee, 1996; Albee & Perry, 1995; Cohen, 1997, 1998). Some preventive interventions opt for a reformist focus and promote organizational changes to better serve the needs of clients. In the case of child welfare agencies, restructuring processes try to have single points of access and to co-ordinate services with other bodies. Reformist initiatives attend to meso-level structures but, by definition, do not challenge the societal causes of distress (Burt, Resnick, & Novick, 1998).

Suggestions to transform social structures to make society more decent and humane may be discredited as utopian and impractical (McQuaig, 1998). In an era in which some suggest that conservative discourse is the social discourse, proposing transformative interventions may sound totally heretic. Major and drastic initiatives like eliminating child poverty, however, have been sounded not only by people who may be branded radical, but by the entire Canadian House of Commons.

Parliamentarians understood that a profound problem required a profound solution. Although the number of poor children has increased dramatically since that promise was made in 1989, the fact remains that politicians acknowledged the urgency of substantial change in social priorities. Drastic problems call for drastic measures. Child advocates, practitioners, 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. Example of lasting social changes include changes in taxation, in discriminating policies, and in eliminating cultural models of violence. Social justice movements, like the feminist and human rights movements, have done much to advance transformative as opposed to merely ameliorative changes in society (Cohen, Jones, & Tronto, 1997).

Priority in Social Salience: *Place Collectivist, Multigenerational, and Transformative Initiatives at the Foreground of our Concerns!.* This dimension refers to the attention given to the different types of orientations. Some approaches occupy the foreground of our concerns, while other remain hidden in the background. This continuum can be used to evaluate to what extent we are concerned with individualist or collectivist values, or with one or more generations. Similarly, we can assess whether ameliorative or transformative models are at the foreground or background of our agenda.

This concept is a useful tool to set priorities because it forces us to question what we have left in the background and what we consider essential. Such inquiry may reveal that individualistic values occupy the centre of our agenda, whereas collectivist ideals are relegated to the background. Why, we may ask. Such inquiry can also discover that most preventive initiatives are of an ameliorative as opposed to transformative type. Again, why? A methodic questioning of our priorities may either confirm or challenge our allocation of resources.

Conclusion

I have claimed that most programs to promote child and family wellness have individualist values in the foreground and that they attend primarily to one or two generations. In addition, ameliorative programs are accorded a larger space than transformative ones. On the other hand, programs that promote collectivist values, transformative initiatives, and that target multiple generations are very few. We previously saw that most programs are reactive, indicated, address micro units of intervention and have a risk reduction orientation. When we combine the figures on psychological and social priorities we obtain a picture of current allocation of resources. This visual depiction of priorities is a guide for future action. If we seek a more balanced approach to social and preventive interventions, the figures tell us what cells we need to increase and which ones to decrease. To restore a balanced approach to prevention, and to infuse innovation into our work, we need to give more thought to universal, multigenerational, transformative, collectivist, proactive, macro-level interventions that have a wellness promotion orientation.

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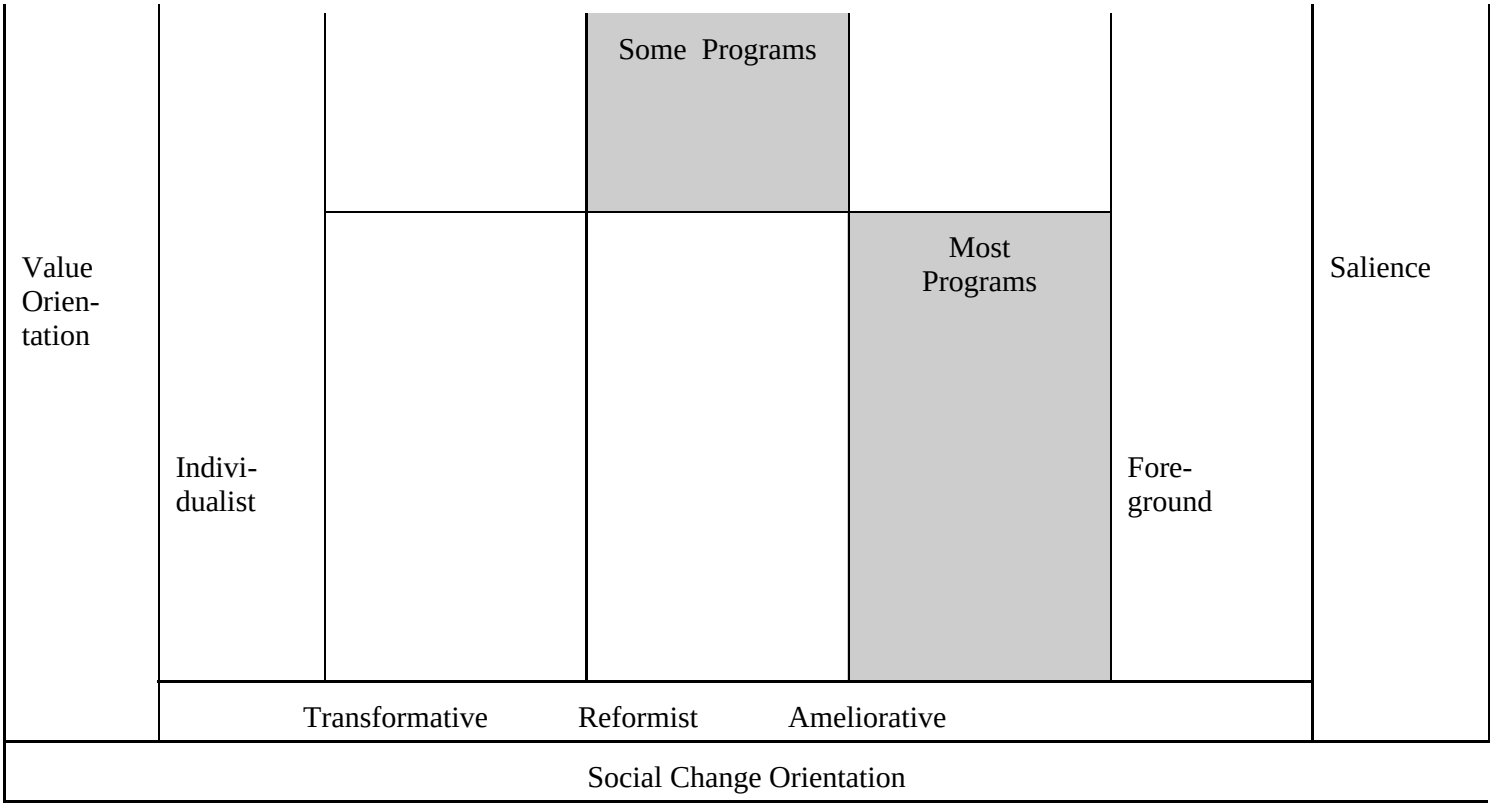
Figure Captions

Figure 1. Current priorities of psychological interventions: Focus on level, scope, health, and child welfare orientation.

Figure 2. Current priorities of social interventions: Focus on generations, values, social change, and social salience.

Scope of Intervention					
Level of Intervention		Universal	Selective	Indicated	Health Orientation
	Macro	Very few Programs			Wellness Promotion
	Meso		Some Programs		Health Maintenance
	Micro			Most Programs	Risk Reduction
		Strengthen Families		Minimize Maltreatment	
Child Welfare Orientation					

Generational Focus					
		Multigenerational	Bigenerational	Unigenerational	
	Collectivist	Very few Programs			Background


Some Programs
Most Programs
Value Orien-tation
Indivi-dualist
Fore-ground
Salience
Transformative
Reformist
Ameliorative
Social Change Orientation