THE NATURE OF EMPATHIC CARE: CARE AND ABUSE INSIDE AND OUTSIDE THE ZONE OF INTIMACY[1]

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Abstract

In this paper I will try to explicate the conditions that facilitate empathic care and identification with the child on the one hand and those that obstruct this care on the other. In the first part of the paper I present empathic case as a component embedded in the normal communication between caregiver and child. This implies that care is not seen as a one-sided contribution from the caregiver to the child, but a dialogical product where both contribute. In the second part of the paper, I introduce the concept of a "zone of intimacy" into a child can be included and cared for through empathic identification and sensitive availability of the caregiver to the child's needs. But a child can also be expelled from the zone of intimacy with subsequent blockage of empathic identification, affective withdrawal leading to neglect and possibly abuse. Through this theoretical metaphore, I try to systematise some of the conditions and processes involved in sensitive empathic care on the one hand and neglect and abuse on the other. Finally I try to summarise the conditions facilitating empathic care and relate these to the newly emerging field of "ethics of closeness" and Levinas' ideas of the "appeal of the face"(Bauman 1996).

INTRODUCTION

An important insight from studies in communication between caregivers and infants is that the infant shows a disposition for empathy and care for others from the earliest years in life. This is supported by other studies showing that shortly after birth infants are able to participate in a primitive form of dialogue with an exchange of expressive gestures, called *proto-conversation.* This early dialogue shows that the infant is sensitive to the qualities of the mother's communication – whether they are correctly

[1] Thanks to Pedro and Irina Mendes and the Angolan team for providing many of the examples I have used in this paper.

synchronized and attuned in relation to the child's initiative, state, rhythm and emotionality. Furthermore, other studies also show that the committed caregiver, usually the mother, is also able to adjust to and participate in this early dialogue, most often without any form of learning taking place. Her contribution appears to arise as a spontaneous response to the infant's expressive initiatives. This appears to be an immediate, non-reflective process which I have termed *the primary care cycle,* not to be confused with the more reflected, cognitive-moral ability that is investigated in the studies of Piaget, Kohlberg and Gilligan by way of introducing moral dilemmas (Bråten. 1998b; Hoffman, 2000; Skoe, 1998), and which is associated with later stages of development.

With the primary care cycle as a point of departure, I will in this paper review some examples how this early the form of empathy which I call *empathic identification with the child* can be facilitated and obstructed. At its worst, such obstruction can lead to objectification of the child, with neglect, infringement and abuse of children (and adults) as the consequence. Accounts from situations of high stress from traditional institutions and from situations linked to poverty and war, may throw some light on these phenomena.

1. CARE AS A SENSITIVE COMMUNICATIVE PROCESS: THE PRIMARY CYCLE OF CARE

Recent research within early communication has shown that human care is not always a one-way process in which the caregiver provides and the child receives care, independently of the child's initiative and responses (Sameroff and Fiese, 1990; Dunn, 1978; Papousek and Papousek, 1991). Rather it seems that *sensitive care is a communicative or dialectic process in which the caregiver's actions toward the child is dependent on the expressive appeal of the child's utterances,* and conversely, the child's responses are dependent on the caregiver's actions; on how they are attuned to the child's state and how they are received and apprehended by the child.

This indicates that sensitive care is a dynamic, dialectic process *in which the child (in this case) is an active co-creator of the care it receives* – or more correctly: the care that emerges and is created between them. Care can not be reduced to static recipes for

"what one should do when…". Neither is care a skill that can be attributed to the ability for caring in one person or the other. It is rather a process that is created between them (Hundeide, 2002).

In order for such a caring process to arise, a reciprocal and mutual sensitivity, and an ability to apprehend and recognize the quality of each other's expressive initiatives and responses is necessary. What do the child's initiatives and responses express? What is the purpose and meaning of a caring action?

"Attunement to the attunement of the other…"

Sensitive care therefore requires that the caring action itself is adjusted to the quality and meaning that the caregiver attributes to the caring expression or appeal of the child. On the other hand, the recipient, in this case the child, must be able to receive and understand the intention of the caregiver's caring action, i.e. both must interpret and adjust to each others' expectations in order for the care process to function optimally; there must be an "attunement to the attunement of the other" (Rommetveit, 1998). According to one of the most distinguished researchers in the field, Colwyn Trevarthen, this facility for interpreting the expression of others appears to be a fundamental ability existing in all of us. He writes:

> «…human perceivers have a remarkable sensitivity to beings with animacy and intentionality…they can readily detect parameters of motivation in other subjects' behaviour, such as «emotion» of an action, or its «effort» and «vitality»…But the ability to detect and observe qualitative differences in actions of others, and thereby to perceive their motives, is but a small part of the capacity for *imitative identification, emotional empathy and reciprocal communication* that all human possess. Most importantly, a communicating subject is trying to make an *effective complementary reply*, to enter into, and jointly regulate, a dyad of expressive «conversational» exchange with the Other… This is what Bråten (1988,99) means by the term «dialogic closure»…(Trevarthen 1995, p.8).

Such an effective complementary reply in an exchange between a committed caregiver and an infant will normally lead to a mutual exchange of smiles and positive expressions.

This “proto-conversation” is temporally precisely synchronized to a turn-taking schema, which the infant appears to be able to follow at the age of five weeks, and to which it responds with distress if disrupted (Trevarthen, 1989).

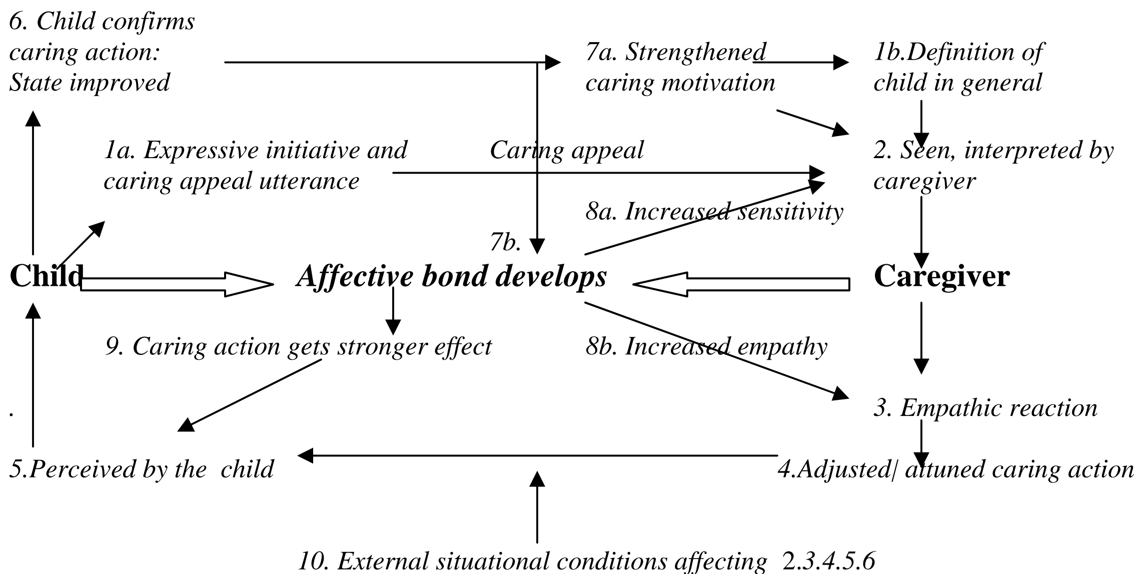
But this disposition (inclination) may also be apparent when one of the partners responds by expressing human care, empathy and comforting in a situation where the other is experiencing pain and suffering. This does not only apply to adults; one sees the same response in infants of less than a year of age. One of the leading researchers in this field, Eisenberg (1992), mentions as an example that when the father expresses sadness, the thirteen month old infant responds by giving him her favourite doll. There are many such examples (Eisenberg, 1992; Thompson 1994, Bråten, 1999).

This demonstrates that what I have called the primary cycle of care is a dialogic response of a fundamental and immediate character, which can be seen in the committed caregiver’s spontaneous and unpremeditated responses to the infant’s expressive initiative. It has also been shown that children respond three times as strongly to such expressions in people they are closely attached to than to strangers (Eisenberg, 1992). As we shall see later on, this shows that spontaneous caring responses in both children and adults are associated with psychological attachment, with being inside of the zone of intimacy (see page 23).

The component of dialogic caring behaviour

Let us take a closer look at the different components entailed in such dialogic caring behaviour. Figure 1 describes care and caring behaviour as a reciprocal dialogic process. Each component of the figure is described and is exemplified in the following text:

Figure 1. The primary cycle of communicative care



Let us start with the expressions and initiatives of the child (1a). When a child for one reason or another experiences discomfort, suffering or need, this will usually be apparent in the child's general expression; facial expression, gaze, body stance, movements and utterances. These expressions may have a greater or lesser aspect of an appeal for care. [2] This is a crucial aspect of the caring process, since a child who gives weak signals, or no signals, for example because of malnutrition, runs a greater risk of being neglected and ignored when no one can see or interpret its signals and identify its needs.

For this reason, the care-giver's perception and ability to interpret the child's expressive signals (2) is crucial for the subsequent development of the caring process. As Daniel Stern (1995) points out, parents experience their children as "understandable beings". This entails that they will always attempt to project meaning into their children's actions. When for example an infant expresses some inarticulate sounds, the mother answers in this typical manner:

[2] This is what in Levinas' term is called " the appeal of the face"

> - Oh, listen to him! Yes! That's right. Tell me all about it – oh, yes, you have so much you want to say. (Trevarthen, 1996, p. 11)

The mother continually seeks to find intentions, wishes and emotions in the child's utterances, and she responds accordingly - to her interpretation of the child's expressions. Thus, guided by the mother's interpretations, a dialogue develops, which is normally a positive and joyful exchange for both parties. This is another important point, because when one speaks of care, one usually thinks of the negative experiences in which one person needs the help and support of the other. However, good caring has its origins in shared positive and joyful experiences which create the strong bonds between those involved: a smile or another attractive expression from the child has an immediate and direct appeal to a sensitive care-giver, who usually responds with a similar joyful expression in turn. At the same time, she imitates the child by making a similar sound or movement, often pitching her voice high, and she comments on the child's utterances as if they were expressions of intentions or wishes. It is this form of joyful exchange which is also called "motherese register" that consolidates the mutual bond between them. In a context of intervention, it is important that this early form of dialogue is supported and facilitated (Bråten, 1999: Rye, 2003, Richter).

There may be considerable differences in care-givers with respect to attitudes and the ability to see and interpret children's expressions, however. As we shall see later on, the interpretations and actions of a care-giver towards the child may at times lead back to her more general definition of the child (1b). It may be the case that a child is perceived as being difficult, wilful or spoiled. In that case, it is quite likely that the interpretation of the child's expressive signals will be characterised by this general definition. This is a critical stage of the care-giving process. If the child's appeal for caring is not recognised and experienced by the care-giver, the entire process comes to a halt or is rejected. Thus, we can see that *the care-giver's definition of the child in general can open or close her sensitivity to the child's expressive signals*. This can in turn lead to a obstruction or limitation of the care-giving process.

If, on the other hand, the child's appeal for care is seen and experienced, an empathic affective response (3) will normally follow in the care-giver: she is moved and

emotionally influenced by the child's expressions, which conveys an emotional message that she can recognise, perhaps as an echo from her own childhood. She sees the helpless child needing her assistance – my child needs me. This is what activates a spontaneous caring response, or what Trevarthen calls an effective complementary response (1996, p. 2).

This is usually an immediate, unreflective participatory reaction, different from Piaget's concept of reflective decentration – thinking about the other (Hoffman 2000). In most people this spontaneous empathic response leads to an immediate wish to help and to care. This again leads to an adjusted/attuned caring action (4) where the care-giver adjusts her response (i.e. her caring action) to the child in line with how she has interpreted the child's expressive initiative, and according to her empathic reaction to it. Thus, there are no 'correct' responses to children's expressive signals; the same expressive utterance can be interpreted and experienced differently, and thus elicit different empathic responses in different people. For example, is a child's crying an appeal for food or comforting? Is the child stubborn? Does it want attention? The caring action depends on the interpretation. Box 1 gives a series of examples of which types of care actions are generally applied when a person – regardless of age – seeks the help of another. Nonetheless, the care-giver's ability for attunement and synchronization of her caring actions will naturally vary (Stern, 1995), probably reflecting both differing cultural standards and different models for caring as these are transferred from the care-giver's own childhood.

Box 1 Examples of typical caring actions

Acknowledgement and recognition of the other's pain or suffering
Help to alleviate pain, accommodate physical needs, survival: medicine, food, money
Comforting (consolation) and support when there is fear and traumatic experiences – to ensure security
Comforting and understanding when there is loss, sorrow or longing
Support, attention and contact when there is loneliness
Support when there is loss – create new hope
Help to negotiate the realities of daily life
Help to create new meaning
Confirmation of and support for the other's self confidence
Counselling and instruction within a particular area of expertise
Help to engender optimism and joy

However, the communicative caring process is not ended when the care-giver produces an attuned caring action. A crucial next stage comprises the way in which the child experiences and receives this caring action (5). Does the child accept to be comforted? If a child rejects the "reply" or focuses in another direction, or if the caring action is misplaced and not attuned to the child's state and situation, it will not be apprehended as a relevant response and pass the child by. Let us take a look at a description of the opposite, where the caregiver adjusts and provides responses that are relevant and attuned to the child:

> "In harmonious face-to-face interaction with infants, parents will reduce their tempo, exaggerate and repeat their movements, respond by imitating and enhancing their behaviour, turn-taking and respecting the infant's coincidental

> interruptions of the exchange. The infant appears attentive and contented..." (Field 1990, page 124).

As noted by Stern in his rich casuistics (Stern, 1985, 1995), there are often clinical cases where the care-giver is so badly synchronized and attuned to the child's state and emotional needs that care-giving actions are rejected or are counterproductive, thus worsening the child's state (op.cit.), for instance, in the case of a well meaning but domineering and insensitive mother or father imposing her or his own initiatives on the child, in conflict with the child's needs, rhythm or state. When, on the other hand, the caring action is experienced as being a relevant and attuned response which accommodates the child's needs and suffering, it will have a healing and comforting effect, as expected. The child's state is improved, it stops crying, and it often shows approval of and satisfaction with the care he or she has received. In this way, the child confirms and signals the reception of the caring action (6). It has understood the reply to its own "question" (the expressive utterance) and the caring action (the reply or response) has been effective. *This confirmation is crucial for the care-giver's subsequent relationship with both the child and to the further development of the caring process.*

As shown in figure 1, such confirmation has two parallel effects: on the one hand, it strengthens the motivation of the care-giver (7a). The child feels better, or it shows happiness, gratitude and affection for the care it has received. This strengthens the care-giver's incentive to continue caring, but it also strengthens the affective bond between them (7b). From being an indifferent person, the care-giver now becomes a person who can lend help, one who understands the child's state and suffering, one who is sensitive and who can adjust to the child's state. As Ainsworth et. al. (1974) point out, these are the qualities that are needed for the development of attachment, that is, for the child to establish a bond with the care-giver as a dependent recipient (attachment), but also for the care-giver to become bonded to the child (bonding) as a provider of care. *These are two complementary and interdependent roles, having their own unique motivations for their sustenance.* But as the child grows older, they need to be adjusted in order for the child to develop as an independent and autonomous being.

The mutual bond in turn leads to an increased sensitivity in the care-giver (8a), that is, she becomes increasingly sensitive to the expressive initiatives of the child, and more empathic in her responses (8b). This state of enhanced sensitivity, is what Winnicot describes as "*early maternal preoccupation",* in which the mother continuously follows the infant with her gaze, responding with imitation and empathy to all of the infant's responses as if the child were a part of herself (Stern, 1995). This is a state of extreme sensitivity and empathic attunement to the child. As concerns the child, this newly strengthened bond with the caregiver has the consequence that the caring actions become much more effective when they are initiated by people to whom they are attached (9). Mere comforting of the child is not enough; the comforting must come from the mother! (Eisenberg, 1992).

As an example of this, I had the opportunity some time ago to observe a young sensitive mother's relationship with her first born over a period of time. I was struck by her absolute accessibility at all times, and her participation in everything the child did. When the child was eating, she participated by opening her own mouth when the child did. When I played with the child and made it laugh, the mother participated all along, laughing with the child. When the child tried to attain one goal or other, such as putting something into a box, the mother was attentive and participating, and she made small movements as if to help the child to carry out the activity. She was sensitively accessible throughout, participating in everything the child did.

I have called this example of the early maternal preoccupation (to use Winnicot's term) *empathic identification with the child*.[3] The caregiver empathises with the child and participates in both its assumed experiences and in its activities as an alternative, supporting self. (See Bråten, 1999 on "the virtual other").

At the bottom of figure 1 I have included external situational conditions or circumstances (10), a component that refers to the components 2-6. It is a very important factor in all social interaction, but it is often overlooked or taken for granted. This is because we always function in situations that have particular *affordances* or invitations (Reed 1993). In our case there may be affordances that may promote or prevent good

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[3] Certainly fathers may have a similar commitment to the child as mothers. It is all about emotional investment and sensitisation through experience.

quality of care between the caregiver and the child. Thus, *the accessibility of the care-giver in terms of attention and emotionality in relation to the child's initiative is often dependent on the situation, for example situational stress and to how many other tasks the care-giver is committed to in the same situation.* The same applies to the child: how it experiences the caregiver's caring actions (components 5 and 6) also depends on whether the child's attention is accessible in the situation, for example in relation to how many other distractions or attractions are present.

From caring ability to caring processes

This account of care as a communicative, dialogic process has important implications for how we understand and analyse care. In the context of child care, the caring capacity of a parent is very often mentioned as critical. It has even come to the point of using intelligence testing as an indicator of the caring ability of mothers! This could hardly be more misguided. As I see it, this is an example of a completely misguided conceptualisation of caring capacity. If caring were only a matter of the abilities of the caregiver, for example sensitivity, one could talk about caring capacity or ability. *But this is not the case! The quality of caring that emerges between the care-giver and the child is a dialogical product to which the child, the care-giver and the situation all contribute; it cannot be attributed to some ability in one or the other partner*. The quality of caring, as opposed to an individualized ability for caring, is a two-sided process in which both the child and the care-giver contribute. This means, as has been confirmed by empirical research (Dunn, 1993), that the same care-giver can show completely different caring qualities in the interaction with and in relation to different children, even within the same group of siblings. The caring is dependent on the dynamics that are elicited between those involved, and the situation they are in. In this interaction the child is an important contributor to the care he receives, and not merely a recipient (see Sameroff and Fiese, 1990).

Therefore the caring process is not sustained by the care-giver alone. It also depends on the impact of the child's appeal-signals for care, and on the child's response to the caring action (6) whether the caring action has the expected effect and whether the child responds back with acknowledgement and approval (even gratitude) for the caring

action. A child who openly expresses approval and joy on receiving care from the other is well liked. This may in turn lead to a stronger mutual bond (7), with increased motivation and sensitivity to the child's needs (8). But if the child does not show the expected approval and satisfaction on receiving care, this may reduce motivation in the care-giver. In the context of social work with street children and child soldiers one often sees examples of this: when these children are placed in foster homes, they often have considerable problems of adaptation because they are adjusted to a completely different life. In addition, they have not learned the codes for mutual politeness, and this causes the care-giver to experience disappointment with the lack of gratitude and approval from the "care victim". The famous American pedagogue John Holt phrases it in this way: "the helping hand strikes back" with the demand for gratitude for "everything I have done for you" (1975). In this situation, it often happens that the former street child escapes back to the streets, where they are free from the pressures of such implied demands and expectations. Also this is a part of the caring process that is often overlooked.

I have described the caring cycle in such detail because the aspects that have been mentioned above represent critical points at which the process can be disrupted or stopped completely. Such a model can therefore be helpful in the development of a dynamic conceptualization which may have diagnostic value, and in the sense of providing new ideas for interventions, an aspect I will discuss later in this paper. Table 1 shows a diagnostic schema that corresponds with the model.

Diagnostic scheme of the functional components in the cycle of care between caregiver and child

Components in the cycle of care	Very positive/ strong	Positive/medium	Bad/weak	Very bad/weak
The caregiver's general definition of the child				
The caregiver's understanding of her role and task				
The child's expressive initiative and appeal for care				
Is seen, interpreted by the caregiver (sensitivity 1)				
Empathic response in the caregiver (sensitivity 2)				
Adjusted/attuned caring action (sensitivity 3)				
The child confirms the caring action: improved state				
Affective bond develops between them				
Care motivation increased				
The child prefers the caregiver				
Situation/setting and circumstances				

The primary caring cycle

I have called the model *the primary caring cycle*. In my view, this model expresses the completely fundamental aspects of the mutuality and reciprocity of caring, corresponding to what Trevarthen describes as primary intersubjectivity. This expression refers to the early, unreflected and immediate "musical" interaction between mother and infant, as one

can see in the proto-conversation, in early imitation and in what Papousek and Papousek call *didactic child rearing*.[4]

> "We have collected evidence which indicates that what we call didactic rearing can occur on a pre-adapted, non-conscious basis from the earliest stages of preverbal communication...Without being aware of it, the caregiver assesses, and if necessary, influences and stimulates the infant's attention with slow, repetitive patterns which are finely adjusted to the infant's response, encourages and rewards mastery, adapts and metes out stimulation according to feedback from the child's behaviour...." (Papousek 1991, page 24).

In other words, Papousek and Papousek appear to claim that there exists a predisposition in both the infant and in the sensitive and engaged care-giver for this intuitive child rearing. If this is the case, *then caring becomes more a question of triggering already existing communicative patterns (as a disposition) rather than learning a set of new caring actions and communicative skills. This means more concretely that intervention becomes a question of facilitating and sensitizing of something that is natural and emerges spontaneously, and which the infant invites under normal circumstances through its expressive initiatives* (Hundeide, 2000, 2001).

Not all caring has its basis in the primary care cycle, however. There are forms of caring adapted to older children and adults that naturally require a more reflective approach, mirroring society's varying conventions and values. This *secondary caring* does not have the same immediate and spontaneous qualities as the primary caring cycle; rather it represents the more reflected humanitarian values and principles of human rights that are a part of our culture (Berger and Luckman 1967). I will discuss this in more depth later on.

2. WHEN EMPATHIC CARE IS OBSTRUCTED

So far we have primarily been concerned with the positive sides of the primary caring cycle, but it is also apposite to look at the negative aspects – when care is obstructed.

[4] In other contexts they call this "intuitive child rearing" (Papousek and Papousek 1991, p.25)

Under normal circumstances, the primary caring cycle functions as described above. However, there are special instances in which grave abuse towards children occur, for example when children are placed in traditional institutions, when there is extreme poverty and the struggle for survival prevail, when there is brutalisation due to wartime violence, when there is family conflict involving alcohol and drug abuse, or when the child triggers negative images in the caregiver; images that may be associated with the caregiver's own problematic childhood. In the following section we will take a closer look at some examples in which abuse occurs, and in which the natural empathic caring mechanism - what I have called empathic identification with the child, does not appear to function, or has become obstructed (or blocked).

Children in institutions

In the book *The Politics of Mental Handicap,* Ryan and Tomas (1976) provide an analysis of an old fashioned medically oriented institution for mentally retarded children.[5] By way of participant observation, the authors give an inside perspective of the experiences and attitudes of the caregiving staff and the patients (the children).

According to Ryan and Tomas, typical traditional institutions tend to invite a differentiation between «them» and «us». Those who are in charge and are authorised to set limits are also those who determine which treatment is best for the patients; they decide which privileges the patients are to be given, and they can determine the nature of punishment for insubordination to the rules that have been set. This is a part of the logic of leadership characterizing traditional institutions. The differentiation of «them» and «us» is sustained by the use of stigmatising designations (labelling), use of uniforms, physical separation in different rooms and separation for meals.

Such segregation in which one group controlling the other can easily lead to exploitation and abuse as shown in Zimbardo's prison experiment (Zimbardo 1989). This occurs when one simultaneously uses negative and objectifying definitions of the patients, definitions writing them off both as individual persons and as human beings. In

[5] This description is extreme and hardly represents modern institutions for children in Western society today. Nonetheless, it shows some typical attitudes that may easily develop in traditional authoritarian regimes in which control and order are the most important values.

the following I will recount some descriptions from an institution in which patients were defined as «it» or «them»:

- In reality we have at least thirty patients we are supposed to have conversations with, play with and entertain (....) all of this is tedious. Making beds, changing bed linen, washing away dirt, cleaning toilets is what work is about. If «it» moves around, put «it» in its place. Wash «it», but don't bother to talk to «it». What is the point? It is a waste of time (...) (Ryan and Tomas, 1976, p 55)

Revulsion for the patients was also apparent in some of the staff:

- They are just like cattle – aren't they? They look like a bunch of fucking monkeys, right? (Op.cit. p. 62)

This attitude invariably led to abuse and brutality at any disruption of daily routines:

- We have to be a little cruel to be kind. This is the way it has to be. I am not saying we hate any of these patients, but they have to know who is in charge (...). Look at that guy over there. He doesn't like any of the staff, but when he sees me, he runs as fast as he can. He knows what's good for him, you see. I can't stand the damned bastard over there. All he knows how to do is stand there staring at you. Can you understand that - damned bastard! (Op.cit., p 50-51).

Negative definitions combined with segregation and distancing create an environment in which brutality and abuse may be experienced as legitimate. When members of the staff were asked about the patients' reactions, they refused to accept that the patients could even have reactions such as fear and anxiety:

I suggested that maybe one of the patients was anxious about something. Another member of the staff, Sarah, answered with a strange expression: - why should he worry? He has nothing to be afraid of. He gets all needs, his clothes, his food is free, and he has a

bed to sleep in. He should b grateful. There are many others who are worse off than him. Why should he worry?

- But don’t you sometimes worry about different things?
- Of course I do, but I’m normal, and that’s different (...). Not like these idiots here. They don’t have the brains to worry about anything (...). (Op.cit., p. 46.)

According to Ryan and Tomas (1975), an objectified relation in a care context has the following characteristic:

1 People are categorised as normal or abnormal, and there is no option for the abnormal to share any of the psychological characteristics of the normal.
2 There is no possibility for the abnormal to be anything other than what is designated by their social roles and negative definitions, in this case that they are mentally retarded - and nothing else.
3 There is *an unwillingness to accept their subjectivity as persons* - that they have their own subjective consciousness, feelings and thoughts and inner experiences of themselves and others.

Thus patients tend to be deprived of these values in the world of traditional more extreme institutions. (Certainly not all institutions are like this). In the worst cases they live in a dehumanised world in which they are being seen as objects (even a number – not as persons. This again invites abuse. I can to a certain extent confirm this pessimistic description from institutions in Norway in the 1960’s, and from traditional institutions for orphans and mentally retarded children in different parts of the world (Hundeide, 1991; Hundeide and Egebjerg, 2003). In addition to the characteristics that have been mentioned, there is often a shortage of staff in such places. I have seen institutions where there were thirty or forty children to one nurse. Under such conditions care will, at best, be limited to accommodating physical requirements; providing food, washing patients and keeping institutional discipline and order. There will be few opportunities for individual care and emotional accessibility.. The patients are treated in an authoritarian

and mechanical manner, and in the worst cases they are referred to by numbers (this was the case in several Norwegian institutions, as has been described in the media lately). Under such conditions they are not individual persons, but beings belonging to the category of «them», that means beings with no need of individual treatment and affectionate care. [6]

In general, there seem to be a tendency within institutions within this category, to always be concerned with the managerial, logistic, economical and the controlling aspects of directing an institution. These are the factors that have priority and set the agenda for all other events, and this does not leave much room for the individual needs of the patients, not to mention their psychological needs.[7] They are therefore susceptible to neglect and abuse. In extreme cases, they may spend all their lives in bed, on the grounds of lack of staff.

When children are negatively defined and stigmatised

As mentioned above, there are two conditions that are particularly conducive to neglect and failure of care, i.e. *negative definitions of the child and distancing*. These often occur together as part of a general pattern of rejection of the child and withdrawal of empathic identification and care (Pelzer, 1995).

Negative definitions in the relationship between parents and children often develop in situations where there is a high level of family stress and where children become a burden, both economically and emotionally. This is visible both in environments with extreme poverty in developing countries, but also in wealthy Western societies, where children may be experienced as a hindrance to the free career development of the parents. Under such circumstances, negative and objectifying definitions of children, with subsequent emotional withdrawal and distancing in relation to the children, may easily develop.

The anthropologist Scheper-Huges (1992) gives an example of this from her studies in the poorest quarters of Recife in Brazil. In the district where she was working, infant mortality was exceptionally high, close to fifty percent, she discovered that poor

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[6] It is under such dehumanising condition that the concept of a "person" becomes important.

[7] This is in fact the same criticism as been raised against the modern market- and economy oriented trends in education and in society in general: Economy is running human values.

mothers under such high survival pressure and high infant mortality sometimes withdrew emotionally from these infants as if to protect themselves from the ensuing emotional shocks and mourning when they understood that their chances of survival were minimal.

A weak and physically vulnerable child was labelled and defined by their mother as "a child who wants to die" and child that looked "ghost-like", they were also described as "small angels". Such children had little chance of survival because of the maternal emotional withdrawal and the ensuing neglect. The negative definition of the child as "ghost-like" started a self-fulfilling process of emotional and physical neglect that usually ended in death. In some cases, it was said, the infants were helped by their mothers to die - "that was what they wanted"... When the researcher tried to help some of these children through special assistance, she was warned that this would be wasted efforts, because sooner or later these children would die, that was their destiny and that was what they wanted (Shepper-Huges 1990).

When infant mortality is so high the mother unconsciously tries to protect herself by withdrawing her emotional attachment to the child. It is like an unconscious calculus of risk and emotional investment, and if the conclusion is withdrawal, the whole caring mechanism is at risk and the chances that the negative assessment of the infant will be self-fulfilling, is considerably increased. Under such conditions, a more pragmatic economical survival approach becomes more feasible. As Scheper-Huges expressed it:

> "Part of learning how to mother in the slum includes learning how to "let go" of a child that "wants" to die."

In this way a self-fulfilling process was initiated on the basis of the mothers' negative diagnosis or apprehension of the child. According to the anthropologist, «there was no expression of great joy nor of sorrow»; at the child's funeral, «the infant was seldom even the focus of the conversation at all (...)» (Op.cit, p.418).

It is nonetheless misguiding to interpret this as a general deficiency of empathy and caring ability in these impoverished mothers, because it was evident that the same mothers were sensitive and caring towards the other siblings that showed signs of vitality and robustness. Such an emotional withdrawal response can therefore be understood as a

strategic reaction of self- protection with the purpose of avoiding repeated experiences of loss and depression following the death of weak and physically vulnerable children. Such reactions may be interpreted as adaptive strategies that emerge under difficult life circumstances where survival, both physical and psychological, has become a challenge (See also LeVine 1989).

In connection with social work directed towards vulnerable children in extreme situations I have witnessed similar examples of the stigmatisation of children in relation to local superstition of possession and bewitchment. In the rural districts of Angola there is a prevailing belief that if a child is divergent for one reason or another - it may be anything from physical defects and impairment, to psychological handicaps following traumatic experiences of war – this deviation as explained as result of bewitchment of the child and possession by demons. An evil spirit is thought to have entered the child and it is this spirit that creates aberrations in appearance or behaviour (Hundeide and Egebjerg, 2003). As a consequence of this definition (that was very often performed by the local witchdoctor) they are rejected by their families, both physically and psychologically. In the worst cases they are expelled from their homes and left to beg in the streets for survival.[8]

The most extreme example I have witnessed in this context is a group of impoverished orphans in North-Angola. They had been diagnosed (and defined) as being possessed by demons after consultation with the local witch doctor. These children were blamed for most of the local accidents, from deaths to crop failure and drought. They became public scapegoats, thus providing an explanation for the adversity experienced by the local society.

These children were usually expelled from their homes, ending up in treatment centres owned by the same witch doctor that had diagnosed them. Here they were subject to different forms of torture or exorcisms in order to "drive out Satan". For example, they had chilli-pepper applied to their eyes, which then became swollen and red, so that they acquired the look of monsters. They were also subjected to painful cleansing rituals in which they were beaten and tormented. This went on for several months. When we[4] were

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[8] In social sense these children serve as scapegoats being held responsible for any negative occurrence within the family or in the local community, thus functioning as scapegoats for uncontrollable misfortunes in the community.

given the opportunity to visit this «institution» following one such treatment, the children were already totally subdued, subjugated and traumatised. This in turn led to the unwillingness on the part of their parents to take the children back, and most of them ended up as workers on the farm of the witch doctor who had originally «diagnosed» them. An important factor in this context is that the children were themselves convinced of their own possession, and they told the most incredible stories about what they could do at night, all corresponding to the local beliefs about possession. In other words, the children dramatised the expectations, the «diagnosis» and the conceptions they were attributed. It became a part of their understanding of themselves and their behaviour.[9].

More generally, one can say that we approach other people according to our definitions of them. We continuously interpret and attribute characteristics to our fellow human beings, and behave towards them accordingly thus initiating a process that can easily become a self-fulfilling process... (Bråten, 1999, p. 98).

In a context of child care, this implies that the most important diagnosis a professional can do is to assess caregivers' definitions of their children, and their children's definitions/expectations of themselves. Rather than making absolute diagnoses of a child's deviations in relation to our norms (which is the normal practice in testing), it becomes more important to gain some knowledge of which characteristics are attributed to the child by the people surrounding it, as these attributions may become self-fulfilling.

Thus, one of the most important tasks of psycho-social intervention in such cases is to attempt to positively influence the care-giver's definition of the child, helping them to see the child as a "person" and fellow human being with the same needs for affection and love, and the same need for respect and inclusion as they themselves have. In the ICDP programme (see footnote 5), some methods have been developed to facilitate positive re-definition of children, methods appearing to be effective in most contexts. The most important thing is to activate the mechanism which I have defined as empathic identification with the child. This often occurs when the care giver sees and experiences the vulnerable and helpless aspects of their child, for example when its negative attention seeking behaviour is shown to overlie a desperate need for contact with and attention

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[9] This appears like a hidden contract between themselves and the healer about who they are, what their symptoms and powers are, and how they can be healed. (Hundeide, 2003 b and c).

from the parents. When the care-giver experiences this appeal, that «my child needs me»», the way towards a new and more sensitive and empathic caring relation with the child becomes possible (Hundeide, 2001). The child is then included in what I have called the zone of intimacy, which I will discuss later on.

Objectification and abuse

Extreme physical abuse and torture usually involve objectifying and demonising definitions of the victim. «Traitor» is one such definition that appears to legitimize abuse and torture. Working with child and teenage soldiers in Angola, we[10] learned about extreme abuse in this category. These youngsters had been kidnapped as children and re-socialised as guerrilla soldiers in the UNITA. The soldiers were trained according to the principle of «the son of a snake is also a snake», and this implied that entire family and all relatives were killed if one of the family members were accused of treason. They were also trained in different torture techniques to be used on alleged traitors. In an area on the border of Namibia a group of teenage soldiers participated in the execution of a group of people accused of treason. This was perpetrated by having the victims themselves collect wood for a pyre on which they were subsequently burned alive. These teenage soldiers were highly regarded among the officers because they were «totally loyal, they carried out orders and killed without hesitation».

An interview with a young female soldier from the war in Sierra Leone gives a certain impression of what they had been through:

- Have you ever killed rebels in this war?
- Yes, many times. When the soldiers came back to camp with the rebels, I was often ordered to «wash» them.
- What does that mean?
- Kill them.
- Did you shoot them with a machine gun?
- No, bullets are expensive. I killed them one by one (with a knife).
- Did you feel that you did something wrong?

[10] “We” implies collaborators inside ICDP, particularly Pedro and Irina Mendes, Milu and Santana

- I was defending my country.
- Did you ever feel pity for the rebels you killed?
- In the beginning when I saw their dead bodies I sometimes felt sorry for them, but we had to kill them, otherwise they would have killed us if they had the chance. These rebels killed and cut open the stomachs of pregnant women. They raped all women they could get their hands on (Peters and Richards, 1998, p. 87-89)

These are of course extreme cases, but they contain some of the legitimising components one finds with lesser abuse as well.

- *An objectification, and often a demonising definition of the victim who is seen as morally inferior, non-human, traitors and therefore deserves to be abused.*[11]
- *That they were following orders - and if they did not comply, they would be killed themselves.* [12]
- *That this was in fact a noble and necessary action performed in the service of their country.*
- *These legitimising arguments seem to absolve the perpetrators from a feeling of responsibility and awareness for their inhuman actions.*

For the child soldiers, this ideological rationalization was an important part of their indoctrination and preparation for their role as "under-aged soldier"[13] (Bracken and Petty, 1998). Many of these youngsters sustained serious psychological problems when they

[11] It is important to note that this type of legitimising and stigmatisation also occurs in violations of UN human rights conventions in the pursuit of what are called "terrorists" like the abuse of Iraqi prisoners in the xxx Prison. One can also find comparable justifications in violence prone racist gangs, such as new Nazis (Bjørgo, 1997; Hundeide 2003a, 2003b).

[12] These experiences were a part of the teenage soldiers' training: in some cases they were instructed to kill prisoners – in some cases members of their own families - while the others were watching. If they were unable to comply with the orders or showed signs of weakness in crying or clutching, they were themselves shot in front of the other recruits. This is the terrorism that led to blind obedience to "the sergeant", who often exploited them with extreme cruelty (Bracken and Petty, 1998; Hundeide, 2003b).

[13] "Under-aged soldiers" is now the politically correct term as child soldiers is starting to have a stigmatising effect due to the violence associated with this term.

were subsequently to be integrated into civil society after having lived for years in brutalizing war conditions with totally different values (Hundeide, 2003b).

The dehumanising of «outsiders»

It is worth noting that in conditions involving dehumanisation and objectification, an invisible line appears to be drawn between «them» and «us». «We» who are on the inside of this line may experience mutual love, empathy and human care and friendship from the others on the inside, while those on the outside are at best treated with indifference, and at worst as objects deprived not only of their rights, but also of their subjectivity - to be understood and viewed as “persons” and fellow human beings with the ability to feel, wish and need as human beings. Under such conditions it can be important to intervene in order to promote human conditions, particularly between care-givers and children.

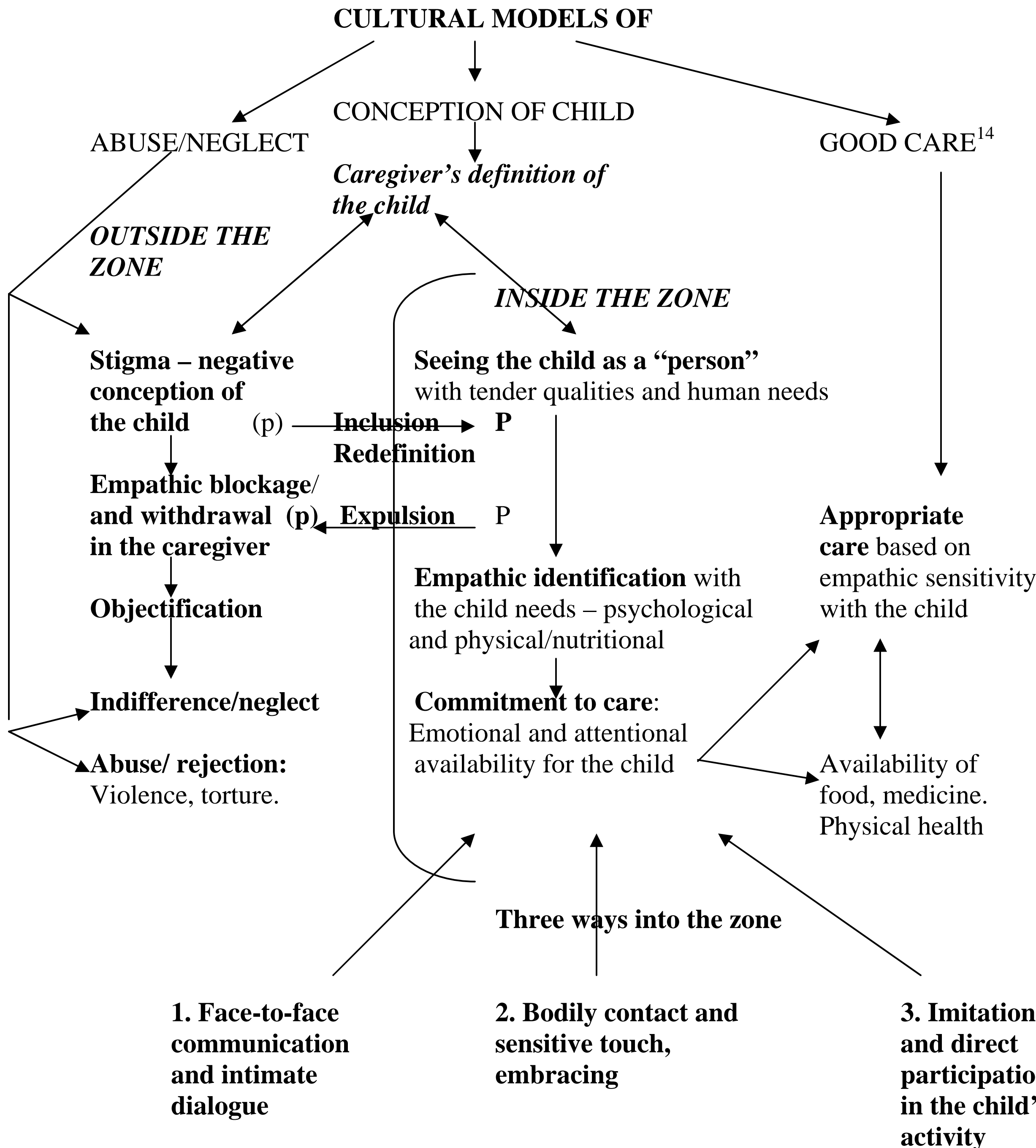
3. THE ZONE OF INTIMACY

Variation in human empathy can be metaphorically described as if we have a zone for intimacy between ourselves and our nearest and dearest. Those who are on the inside of this zone are the people we love and who are close to us - they are a part of our family. With these people we *co-experience* their state and their needs through empathic identification, and we act accordingly. Those who are outside of this zone we do not apprehend in the same sensitive and empathic way. They are surely human beings, although they are strangers, and as participants within a shared community we understand them according to conventional codes and rights that apply among human beings. However, this is *an outwardly conventional* relation (secondary care), different from the spontaneous co-experiencing we have when someone in our family is exposed to a tragedy or a great joy. In that case *our experience is inward as if it involves us directly and personally.* Tragedies happening to people outside of our zones of intimacy affect us to a much lesser extent and less spontaneously. Although we may on reflection respond to the miseries of the world, this is nonetheless a different matter. Those who are outside of our zone of intimacy may be strangers to whom we are indifferent or show an externalised sympathy. At worst they may appear as enemies we relate to by rejection, objectifying, hatred or revenge.

The zone of intimacy can be metaphorically described as a physical barrier indicating who is on the inside and who is on the outside, as shown in figure 2. Here we can see how we locate people with whom we have a personal relation (I-you relation) within the zone of intimacy. These are people who are close to us, with whom we identify empathically. We co-experience their feelings, wishes and intentions for good or bad. In relation to them, it is easy to be caring because it is a natural extension of the relationship we already have with them. The impetus for caring itself is already in existence. This is not the case for people who are outside our zone of intimacy, however. These are people we have an external, at worst an objectifying I-it relation to, characterized by indifference or rejection. In this situation it is not easy to influence and promote good caring because the relationship does not in itself comprise a natural extension of the relation.

The deepest goal of sensitisation and psychosocial intervention in such a situation is therefore to attempt to influence the relation itself, and this means that we try to bring the outsiders in from "the cold" by trying to include them in our zone of intimacy so that they are experienced as persons with whom we can identify empathically (see figure 2).

By including the child into the caregiver's zone of intimacy, it is possible to elicit her empathic identification with the child, which in turn provides a deeper and more sustainable basis for care. When this mechanism functions, the caregiver is always «with the child», and it is therefore easy to influence the relationship between them in a positive way, whether it concerns the child's physical or its psycho-social health.
This is illustrated in the figure below:



As we can see in figure 2, both inclusion and expulsion from the zone can occur. Inclusion has already been discussed, but expulsion occurs when for example the child is

[14] Just as there are cultural conceptions, folk-theories and practices of good care, there are also similar conceptions and models of abuse and neglect. Similarly there are conceptions of the child, childhood which

negatively defined and rejected by the family and forced to leave home and the family to live on the streets. In conditions of extreme poverty and hardship this is not uncommon: many street children have families still living in the same town, but they cannot return home because they, for different reasons, have been rejected and expelled. Even for those who have not been evicted in the physical sense, life within the family is so full of rejection, humiliation and brutality that they in reality experience themselves as outsiders. Therefore, to be expelled and to be outside of the zone of intimacy does not necessarily mean that one leaves the scene or home in the physical sense. Rejection and inclusion refers to relationships between people.

As the model shows, *seeing the child as a person*[15] *is the first step towards humanisation and inclusion.* This means that we see the child as a fellow human being with the same needs for security, love, approval, self-respect and human rights as we have ourselves. When this conception of the child is in place, the crucial mechanism, which I have called empathic identification, can take place. This means, among other things, that we are capable of recognising and identifying the child's expression and refer it to its mental state, its emotionality and its intentionality ("mentalising"). *This is how we would have felt ourselves; in this way we become capable of reading the other person's mi*nd (Fogany et. al., 1991).

The zone of intimacy is both flexible and permeable. It is flexible in the sense that an episode, such as a moving film or story, can temporarily open up and expand our zone of intimacy so that we may include and identify empathically with a suffering child who is normally outside of our intimate network: «it could have been my own child». But it could just as well have been an account of an enemy that makes us withdraw all empathic commitment so that the person (enemy) remains on the outside of the zone of intimacy - remote as an object. In figure 2, this definition (apprehension) of the other as a non-person is indicated with a (p), while the included person is indicated with a **P.**

[15] The concept of "person" as opposed to a non-person, a thing, has been used in social science to indicate the crucial importance of labelling, stigmatisation and negative definitions when violence, terror, torture, massacres and crimes against humanity are committed (see Buber, Bauman, Bråten, Christie and Smedslund). The concept of "person" is not necessarily limited to human beings; a loved animal, a pet, a dog or a whale, can become the object for person-attributions, which implies that they are perceived as having similar sensitivity to pain, suffering and humiliation and also similar needs for being secure, included, loved and respected – as we ourselves have… They are, in other words, co-human beings. This makes empathic identification possible.

The zone of intimacy is permeable in both directions in the sense that it is possible for a person on the inside to be expelled from the zone, i.e. P → **(p).** He then becomes a stranger or an object with which one no longer feels empathy and sympathy, but rather distance and remoteness.

In the same way, a person on the outside can be included in the zone to become a person who can take part in the human fellowship on the inside, in which one feels closeness and care for one another (p) → **P** [16]

Finally it should be mentioned that the zone can also be a constricted and limited through self-centred commitment, self-stimulation and hypochondria, or when there is no Other to respond to the child's invitations, a *virtual Other* (or "transitional object") may be created that may serve as a tool for interactive self-stimulation and phantasy-conversations. (Bråten 2000).

Ways in and out of the zone of intimacy

In order to arrive at this state of emotional sensitivity to the Other, it is necessary to be in close contact. This can occur by way of what I have metaphorically called the ways into the zone of intimacy. Such ways are

- *face-to-face communication and intimate dialogue*
- *bodily contact and touching*
- *imitation and direct participation in the activities of the other*

We will take a closer look at this through some case studies.

[16] According to Bauman (1996), this was one of the things the Nazis tried to prevent. Face-to-face contact with "the Jew next door" could be the basis of inclusion into the zone with sympathy and empathic identification.

Inclusion into the zone through face-to- face and gaze contact (p) → P

Face-to-face contact is one of the ways into the zone of intimacy and empathic identification with the child. Face-to-face contact will also provide eye contact and the reciprocal exchange of facial expressions and speech. A strong and direct emotional experience can create sensitivity and openness to the child's attitude, or the «victim's». «The appeal of the face» is brought to bear, as Levinas and the ethics of closeness has described it (Vetlesen, 1998). There is a body of literature on the importance of the face and gaze in the establishment of emotional contact that I am unable discuss here (Ekman and Friesen, 1975; Vanderberg, 1999; Oppenheim et. al., 2003).

The impact of face-to-face contact and gaze contact became clear to me through an experience recounted to me by a close friend. It was about his relationship with his son who had Down's syndrome:

When after scanning, the doctors told him that they would have a child with Down syndrome, he became very agitated and depressed, despite his daily contact with handicapped children at work. In the beginning after his son was born, he had great problems in looking at him, touching and holding him. Despite his explicit ideology about the acceptance of deviations there was something in him that was unable to accept that this was his own son. This continued for some time. He was unable to relate to the child, and he avoided and ignored him. But one day his wife asked him to hold the child - who was then an infant - in such a way as to gain direct eye contact with it. He then experienced that the child looked him in the eye, smiled at him and reached out for him - and this was what it took to break the ice. It gave him an emotional shock. For the first time he could see his son as a smiling, but vulnerable and helpless person who turned to him. This was a breakthrough in his relationship with his son.

Experiences such as these, where there has been emotional rejection of a child, are not unusual. It is as if the profound feeling of emotional contact and acceptance of the child breaks through when it is experienced as a helpless being, combined with a feeling of «my child needs me». This appears to be a fundamental aspect of all empathic care and a precondition for what I have called empathic identification with the child.

This example also demonstrates the strong effect which direct face-to-face encounter and gaze contact can have on the relationship between the care-giver and the

child. Since this is a two-way dialogical process and not confined to care-giver-to-child but also from child-to-care-giver, it is apparent that expressive children can have a humanising effect on adults: through their emotional expressive signals, usually experienced as expressions of innocence, vulnerability and helplessness, they invite care and empathy in most people - even people who rarely express such feelings themselves (Nafstad, 2004).

Not all infants or children have this immediate emotional appeal. Some are unattractive, even ugly to look at. Others are passive and not very expressive; they give weak or ambiguous emotional signals. In such cases it may be important to help the care-giver to establish contact with the child by identifying the signals that are there, gradually supporting a positive re-definition of the child as a person needing care (see the ICDP programme, Hundeide, 2000).

Let us compare two of the examples we have mentioned and relate them to figure 2 of the zone of intimacy. In the example of the «children who wishes to die» mentioned aobve, we see a mother who withdraws emotionally from the child because it was defined as an «angel who wished to die». A withdrawal of emotional identification occurs as a consequence of the negative definition, and the child is expelled from the zone of intimacy.(P ->(p)). In the example with the father who could not accept his child, but who experienced an emotional breakthrough in contact, we see the opposite. Through gaze and the experience of the infant's expressive appeal, the father gained a spontaneous emotional contact with the child, which in turn initiated empathic identification with the child - «my child». From being ignored and overlooked, the child was included in the zone of intimacy and care ((p) ->P). From being a non-person, the child has become a person for whom the father feels protective, i.e. there has been a movement from (p) to P. Furthermore, these two examples illustrate two important ways into the zone of intimacy, i.e. the importance of positive definitions of the child, and the importance of expressive exchange through face-to-face contact and gaze contact. Body contact is also an important way into the zone of intimacy.

Inclusion in the zone of intimacy through sensitive touch and bodily contact

In the ICDP's work with orphans and neglected children in different parts of the world, we have observed the importance of bodily contact and affectionate touching when treating children who have been subject to affective deprivation and traumatisation (Field, 1990). I will discuss two examples from Angola.

We observed a blind girl in an institution for children with multiple handicaps. When she arrived at the institution she was so weak and undernourished that she could hardly walk. After a period of time with supplementary feeding and care her condition improved, and this was when we discovered that she was almost blind. This made communication with her very difficult (the signals for mutuality were ambiguous), and when we met her, she appeared to ignore human contact while the physical care was seen to. Through sensitive physical communication it was possible to achieve contact with her again. We have video recordings of the emerging interaction between the girl and one of our female "facilitators", who first approaches the girl by taking her hand, holding it and gently caressing the hand with sensitive touch. We can see how this leads to a change in the girl's expression: she leans back, relaxes, smiles contentedly and appears to enjoy this intimate contact. The facilitator gradually expands the physical contact by first touching the girl's lips and then her cheeks with affectionate stroking. Finally, she puts her arms around the girl and holds her closely. The girl responds by putting her hands around the supervisor's neck and clinging to her as if a crucial need in her is satisfied. While the supervisor holds her like this, she speaks into the girl's ear, repeating her name and guiding her hands towards her eyes, nose, mouth and ears while repeating the girl's name and the names of the body parts she is touching. In this way they come to understand one another and speak of the same things – a space for intersubjective sharing is created... All the time the facilitator holds the girl tightly to herself, and there is a contented smile on the girl's lips. The ice has been broken and an intimate contact is in the process of developing between them.

Through sensitive physical contact, touching and intimate dialogue it was possible to bring the girl into the zone of intimacy - or more aptly; they included each other mutually in their own zones of intimacy.

Sensitive, affectionate touching that leads to close embracing is the prototype of closeness and mutual love, whether in relation to an infant or a partner in an adult love relationship. In a situation of sorrow, loss, neglect and despair, such contact can often release repressed feelings and tears, which may relieve pressure and provide a considerable sense of comfort and security. Nonetheless, this is a powerful form of intervention and contact, and it must be applied with sensitivity and respect for the other's limits - more as a spontaneous response to the other's expression and appeal. Because the danger of infringement is of course great in such situations and in relation to persons having such dependency needs. Therefore, this method must be used with prudence and follow-up in order to prevent new disappointments and new betrayals.

Inclusion in the zone of intimacy through imitation and sympathetic participation in the child's initiatives and activities

Another way into the zone is by first establishing contact by imitating the child's gestures and initiatives, and then gradually developing this into communication and participation in the child's activities. This is a way of responding by following the child's initiative. As long as a child produces expressive or goal oriented initiatives and actions, it is always possible to start a simple communicative cycle by imitating the child's actions, following the child's initiative and thus initiate a cycle of turn-taking.

The most well known example in this regard comes from Hunt's intervention study in Iran. In addition to instructing the care-givers to express an affectionate attitude towards the children, he particularly asked them to imitate the children's gestures and expressions so that a simple communicative cycle could begin. It was this simple, pragmatic instruction that turned out to have a very strong positive effect on the orphans' subsequent development when they were compared with a control group only receiving so-called responsive toys, in line with Piaget's theory on the important role of self initiated actions (Hunt, 1982).

In our work in Angola, the ICDP-team has occasionally employed the same technique, particularly in cases where there have been contact difficulties. In one case, one of our facilitators was contacted by a father who was an alcoholic and unable to take care of his two and a half year old daughter after his wife died. At that time the girl

functioned apparently normally for age and she was able to say a few words. Due to her father's condition she was placed in a very poor foster home with a foster mother who was only interested in the financial benefits of keeping the child, thus subjecting her to extreme neglect.

The child was placed in a small room where she spent the next two years without any form of human contact. There was a little window high up on one wall, but no toilet. The room was never cleaned, food was thrown in once a day, and the girl lived in her own dirt for two years. When this state of affairs was discovered, one of our facilitators intervened and got the child out of the prison. At this time, the child could no longer walk properly, but crawled about on the floor making sounds like an animal. She had rat bites all over her body. It was impossible to establish eye-contact with her or gain contact through face-to-face expressive exchange. She did not respond to normal communicative expressive signals, and her face was closed and devoid of expression. She avoided eye contact and she constantly moved restlessly around in the room. The only thing that caught her attention was when she was given food, at which she produced a specific sound - something like «tchee-tchee». While this went on it was possible to focus her attention on the food for a short time.

When one of our facilitators started working with this girl she was more than four years old. The facilitators was deeply committed to help this girl and in line with the ICDP approach she started by looking for expressive signals, initiatives and actions that she could relate to and imitate in order to start a communicative cycle. In the beginning, these signals were the same sounds that she made in connection with feeding. After a period of time, she was able to distinguish more signals from the child, and began to use them systematically in relation to food, washing, visits to the toilet and play. Little by little, *a rudimentary communicative system based on imitative signs and sounds began to develop between them that seemed to work well in their practical daily lives*. The girl also began to show signs of emotional attachment to the supervisor, showing joy when she visited her, and distress when she left. Gradually, her facial expression also changed, becoming more lively and expressive and it as also possible to obtain eye contact with her. Slowly she began to reciprocate the facilitator's expressive initiatives with similar expressive utterances, such as smiles and bodily contact, for example tickling. In time she

was also able to focus her attention on one activity over a somewhat longer period of time.

When I saw her at a later point in time it was possible to establish eye contact and exchange mutual expressive utterances; smiles and sounds, in the same way as one would communicate with an infant. She could walk, albeit a little unsteadily, and she showed a particular trust in her brother, and liked to sit on his lap. Evidently, there was a normalisation and humanisation process under way. This process started through sensitive communicative contact with another person, a facilitator, who managed to establish contact and communication with her through imitation of her *accessible* gestures and expressive utterances. This is where the development begins. At this level, one must begin where the child is, with the utterances and expressive initiative that are accessible.

4. CONDITIONS THAT FACILITATE EMPATHIC IDENTIFICATION

On the basis of the examples in this chapter, it should now be possible to summarise the conditions that may promote empathic identification with another person in need of human care (see figure 2):

1 In order for a care-giver to feel caring towards another, *the other must be defined as a person and as a fellow human being* with the same needs and rights as him or herself. This makes it possible to co-experience and empathically identify with the other.

2 It is easier to identify empathically – to sense their state, feelings and thoughts – when we relate to *people with whom we already have a close and intimate relationship, such* as our children and our family, friends and relatives (Eisenberg, 1992). These are people who are experienced as being inside of our zone of intimacy. Psychological and social distance appears to be a crucial factor. *The greater the social distance, the smaller is the chance for empathic identification* (Bauman, 1996; Vetlesen, 1998).

3 It is easier to identify empathically with the other when *we can see and recognise the feelings and intentions of the other person (child*). We do not identify with expressions that are outside of our own emotional repertoire for recognition. For this reason, people who have similar background also culturally will probably be more empathically responsive and sensitive because they recognise the feelings and responses of the other, than persons with different background.

4 It is easier to identify empathically with people with whom we have direct *face-to-face contact* (1). This makes it possible to exchange expressive and *imitative gestures* and expressions in a process of mutual affirmation (3) and intimate confidences. This also applies to persons with whom we have intimate relations through *touching and physical contact* (2) in an immediate and directly communicative and expressive interaction, as opposed to a more remote and reflected relationship (Trevarthen, 1990; Bråten, 1999)

5 The feelings that appear to elicit caring are primarily comprised of the *experience of the other's pain, helplessness and humiliation*, combined with an appeal for help, so that the other person is brought to the position of experienced responsibility.

6 It is easier to empathically identify with a person (a child) who is *responsive and who accepts and responds to our expressive appeals for contact and fellowship*, and who responds affirmatively to our caring actions.

7 Finally, it is easier to identify empathically with a person (a child) *when* our capacity for joining in with the child's initiatives and activities - for *"sympathetic participation*" - with others is not exhausted or engaged in other activities. In other words, when *we have the time and opportunity* for participating in interaction and common activities on the basis of the person's (child's) initiatives and interests, i.e. that we are not too busy with other activities making us attentionally and emotionally inaccessible. A mother or father with a heavy work

load and many children in a stressful family situation in which the struggle for survival prevails has little psychological space and motivation for active and empathic participation in the children's experiences and suffering at all times. Such things exist outside of his or her relevance structure in this situation - even though it may not be beyond their capacity in a different and more relaxed situation (Whiting and Edwards, 1988).

Beyond the primary cycle of care

It is important to be aware that there are more complex and subtle forms of human suffering that require human experience, insight and intelligence for the feeling of caring to emerge. For example suffering related to injustice, defeat, humiliation and insecurity, which people may experience in situations involving loss of face, honour and self respect. Without such insight and understanding, one can hardly imagine that empathic identification can occur. In other words, there are conditions of human suffering that probably require more reflection and experience from a care-giver than what is required in what I have called the primary care cycle. This is associated with a more secondary and reflected form of caring and altruism (Berger and Luckman 1967). In such a context, human experience and understanding of the more subtle aspects of human humiliation and defeat become crucial for the emergence of empathic care (Lindner, 2000). It is interesting to note that for several of the leading moral personalities of our time, from Mandela to Levinas, experience with human suffering has provided the background for their moral perspectives.

Natural care as opposed to professional help?

It is important to realize that professional helpers seldom have an immediate relationship to their clients, as described in relation to the primary care cycle and within the zone of intimacy. In fact, being a professional implies that one does *not* have such a close relationship. Rather, one is advised to avoid such relationships because they may burden the professional on a personal level so that he or she may more easily bring personal subjective and emotional issues to bear on the situation, issues that can obscure balanced and fair understanding and treatment. This viewpoint may have much in its favour. Yet

on the other hand, one must also acknowledge what may be lost in a professional distancing: the professional may easily come to be experienced as a bureaucrat who sees the other as a case in an abstract diagnostic category. It is precisely this remote and abstracted relationship without closeness and mutuality Levinas criticizes when he speaks of «the totalizing glance», or perhaps one can say «the totalitarian view». In this, the person or the fellow human being is not recognised, only the category, the case or even just a number. This is well known to be a pervasive danger in all bureaucracies and totalising institutions (Bauman, 1999, Foucault 1976). But this danger applies also to bureaucratic social work, whether in social security offices, child care offices, political asylum offices or medical institutions. The situation becomes even more serious when such attitudes are allowed to dominate the routine interaction with clients who are viewed as cases in a diagnostic category. The danger is that feelings of fellowship and sensitivity disappear altogether, and thus attunement and authentic communicative contact with the client. Rather than receiving help from fellow human beings, the client experiences bureaucratic attitudes and rules that can seem alienating and humiliating. The client's particular suffering and sorrow are not viewed and acknowledged as anything but a case history in a diagnostic category. This becomes anything but direct and spontaneous human fellowship – the primary cycle of care is obstructed.

Mother Teresa had a rather different attitude. When selecting who was to become her co-helpers in her work with the weakest and most ill in society, who were supposed to be doing what she described as «works of love», she always emphasised that they must have «the spirit of joy and compassion».This was her most important criterion. Not everyone has this, but when such qualities are present, they are very noticeable.

5. CONCLUSION: THE ETHICS OF CLOSENESS AND THE PRIMARY CYCLE OF CARE

In this account I have placed the main emphasis on what I have called the primary care cycle. This implies an assumption that caring has its roots in a pre-verbal and pre-theoretical disposition that is apparent in the infant immediately after birth. In more general terms, one can say with Trevarthen that there appears to be a «dynamic 'together-

with-the-other-consciousness' that comes first and that is sustained throughout our lives in our deepest moral core». He further emphasises this in the following quote:

> The human consciousness seems to emerge from a completely non-rational, non-verbal, concept-less and totally non-theoretical potential for participation and communication with other persons that one can see first in infants.(Trevarthen 1996, p. 8)

This is a radical claim that goes against the traditional view of how the human consciousness (the mind) is formed as a result of linguistic socialisation. According to the new perspective, it is rather a primary inter-subjectivity that is formed before language, comprising the basis for how further socialisation evolves. This viewpoint appears to accord with Levinas and his idea about the «first philosophy» in which ethical responsibility for the other through the appeal of the face itself comprises the basis for our subjectivity. In Levinas' words:

> «When the other looks at me, I am responsible for him without expecting reciprocity on his part (...) responsibility for the other is the crucial, primary and fundamental structure in our subjectivity».

Bauman further concludes with the claim: «morality is not a product of society, it rather is the moral relation that is primary, something that society manipulates, edits and confuses ..." (quotes from Bauman, 1996, p. 182-183).

In a review of the relationship between the new communicative developmental psychology and the ethics of closeness, Vanderberg (1999) points out that the new findings in early communication appear to support the basic perspective of the ethics of closeness, for example views on the moral relation as «the first philosophy», on the appeal of the face and expressive closeness as fundamental to the development of responsibility for fellow human beings, on the dangers of remote relationships which deprive human beings of the direct experience of the other's face and thus the feeling of direct responsibility, on the dangers inherent in the abstracted and totalitarian gaze of the

bureaucrat and the negative definitions that can legitimise dehumanisation and infringement, freeing the perpetrator from the feeling of responsibility for fellow human beings.

In accordance with this viewpoint, the care of others is not only something we do for others, but something we do in order to recreate our own human subjectivity - our deepest moral core.

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