Psychosocial care for disadvantaged children in the context of poverty and high risk (August 2005)[1]

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Abstract

The ICDP Programs is a psychosocial program directed towards caregivers and networks of care. The program is community based using local resource-persons who are trained to work with groups of caregivers. The training is facilitative in the sense that we try to support and reactivate the caregivers' existing positive resources for care.
The objective of the program is to *improve the quality interaction and the relationship between caregiver and child*
The program is intentionally made simple so that caregivers of any background can understand our simple messages about basic psychosocial care for children. At the same time these messages summaries current scientific knowledge about child care and development.

The five main components of the ICDP program are the following:

1. The child as a "person" and the significance of the caregiver's conception/definition of the child
2. The three dialogues and the eight guidelines for good interaction between caregiver and child.
3. The principles of sensitization and training caregivers.
4. The principles of implementation and sustainability.
5. Schedules adjusted to different target groups.

In this paper I will first have a look at the basic principles of ICDP[2] in order to assess their relevance in the context of care for disadvantaged and vulnerable children.

[1] This paper is based on a speech at a symposium in Oslo in July 2005. In this paper I try to convey a description of the ICDP Principles and Program from an experiential and participant point of view.
[2] All these principles are dealt with in more details in Hundeide (1996,2000, 2003)

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1. Seeing the child as a person, opening up for empathic human care.

Humanization starts with seeing the Other as a person. This means seeing the Other as a co-human being with the same needs and the same reactivity as we practice towards ourselves: We naturally empathize because we understand the other person's reaction in the same way as we understand ourselves – "this is how I also would have reacted" (Bauman 1996). It may be an Other which is closely related to us inside the family or it may just be another person whose suffering touch us and we feel with that person – *"it could have been me"*. We call this *empathic identification* with the person. This is the driving force in all human care because it is through direct empathic identification with the victim that we recognize the need for a caring action and intervention (Levinas 1992, Hoffman 2000).

As pointed out by many researchers in the field of early communication (Bråten 1998, Stern 2003, Trevarthen 2000), empathic identification[3] or participation is *a spontaneous participatory process that comes into operation when we see somebody close to us, somebody who is inside "the zone of intimacy", is suffering or experiencing something unusual, we feel with him or her without reflecting.*
Thus, seeing your own child as a person is for most people a natural and spontaneous process; when he or she expresses happiness and joy, you share spontaneously his joy, when he cries, you console him without hesitation, when is afraid, you console and encourage him, and when he laughs of joy, you join in and share in his joy. This is spontaneous participation in and with the Other is the typical feature of a compassionate relationship. It is direct, spontaneous and unreflective (Braaten 2001, Hundeide 2005). When this direct participatory quality is lacking, our response to human needs may be, at best, considerate human conduct in line with the codes and conventions of society – which is not exactly the same.

Therefore, seeing the child as a person as vulnerable being with whom we can identify empathically is a primary condition for sensitive human care (Levinas 1982, Vetlesen 1999, Stern 2003).

a. How the child is defined determines the care he receives.

But we do not always see children in this positive and spontaneous way, we are also to a very large extent influenced by our prejudices and previous conceptions of a child. When a child is "seen" as a "monster", as somebody who is possessed by an evil daemonic force, the reactions will naturally be to reject, avoid or punish the child, " to beat fear of God into him" or in extreme cases; to exorcise and "drive satan out of him"… These are extreme cases, but we know from stories of abuse from all over the world; about children who are defined as valueless objects and treated accordingly. In most of these cases, negative and stigmatizing definitions are part of this package of abuse, and may serve both as legitimations and as invitations for violence, abuse and neglect of children. (Hundeide 2004).

[3] Or "altercentric participation" to use a similar concept from Bråten's theory (Bråten 2001)

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On the other hand, we also know, when children are defined or "seen" as a sensitive and talented beings, such definitions invite (afford) human treatment and sensitive support for their burgeoning talents. In such cases we look for "zones of potential development" and we encourage and support the child accordingly. Such a child is defined positively in the sense that *the caregiver's definition opens up possibilities for growth and development* and for supportive and encouraging communication about and with the child. In this way *hope for development* is created both in the child and in his caregiver.[4]

Therefore, how a child is defined by his caregivers and by those around him, will to a large extent decide how he will be treated – either positively and in a way that opens up his development, indifferently, or negatively in way that reduces his potential and opens up for abuse and neglect.

b. When empathic care is blocked

When a child is stigmatized and labelled as "bewitched", "bad character" or "AIDS orphan", the caregiver's empathic identification with him may easily be blocked and withdrawn. The child is then "*expelled from the zone of intimacy*"[5] and becomes at best "Another" who is treated with indifference, or at worst he has become a valueless "object" that is treated accordingly, and that means he can be abused and exploited, i.e. sold, without any feeling of "empathic distress" in the caregiver (Hoffman 2000) – this is also called *objectivation.*

The most extreme form of stigmatization is what we call *daemonization*, the child is not only described as an object, but as an evil being, usually combined with the attribution of being possessed by an evil spirit. We have come across such cases of daemonization of children in parts of Africa. These children were supposed to possessed and as a consequence exposed to extreme forms of torture or exorcism in order to purify them from the evil force that they believe has taken possession over them (Mendes 2000).

There are also cases when children who are believed to be HIV infected are exposed to similar treatment, in order to purify them from the evil spiritual force that is assumed to have caused HIV/AIDS. In such cases the victim is not only treated with indifference, they are intentionally maltreated and abused. (see the story of " A child called "it" by Pelzer 1995)[6]

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[4] A famous psychologist has published recently a book on Down Syndrome children with the provocating title "Don't accept me as I am" – look for what I can become" – thus emphasising the potential for change and modifiability at all levels of human development. Not always clinical diagnostics serve this purpose!

[5] "Zone of intimacy" is a concept in the ICDP theoretical framework which is not explicated in this paper (see Hundeide 2001).

[6] When torture is taking place, this is usually combined with the negative definitions and daemonizing stigmatizations, as "Untermenchen", "traitors", "terrorists", "savages" or even "animals". Racism in its various forms is another system of dehumanisation – separation between "us" and "them", with stigmatization and demonization of "them"…

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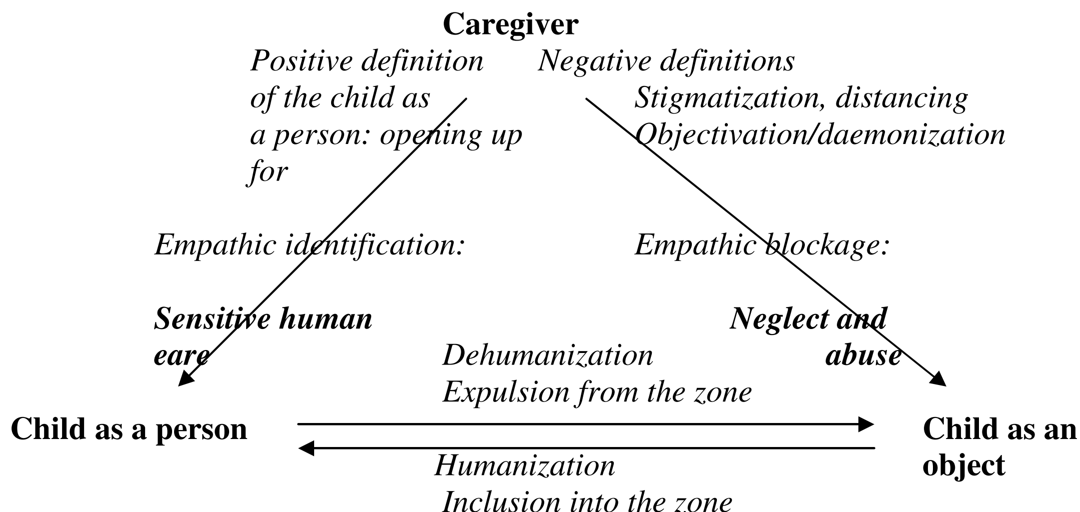
What characterize these different forms of negative definitions and stigmatisations is that *they invite dehumanisation and expulsions from the zone of intimacy with corresponding withdrawal of empathic identification and care.*

In the figure below some of these points are summarized:

Figure 1: The child as a person and the child as an object.



c. Counteracting negative definitions.

The crucial question then becomes: How is it possible to counteract negative definitions and stigmas and replace them with positive developing conceptions of the child?

In ICDP we have developed some methods that we have found useful for this purpose. These are:

- **Positive labelling of the child by influential Others**
  Most of the caregivers that we are dealing with, have low self-esteem both in general and low self-esteem as caregivers. For that reason they are quite susceptible to the influence of other persons with authority. *This can be exploited in a positive way by conveying some positive feedback to the caregivers by pointing out positive qualities in the child and if possible also attribute this to them as caregivers*. This is a very simple technique that we have found can be very effective to strengthen the caregivers positive conception of their child and of themselves as caregivers. Also this influences their commitment and interest in participating further in the sensitisation training.

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- **Using pictures to release positive stories about the child**
  Another powerful technique for promoting empathic identification is to use pictures of the child combined with telling positive stories about her or him. We have notice that *it is important that they themselves tell about their child while watching the picture. Telling about which qualities in their child that they appreciate most, about the particular nature of the child, what touches them mostly, arouses a feeling of care and love for their child…*When caregivers start talking like this to other caregivers in group meetings, an atmosphere of positive feelings and compassion emerges between them; they become deeply touched and the positive affective image of the child comes into the foreground.

- **Redefinitions**
  This is another technique much used for example in family therapy. If a caregiver is stuck in a negative conception or stigma about a child, for example that he is "dominating and bullying towards others – just like his father". In this case it is possible to reverse this by pointing out that "it is true that he is dominating and bullying, but at the same time "he has a stronger character, and if he can learn to control himself more maybe he can become a leader…"
  Or take a child that is timid and withdrawn and looked upon as a coward in the family, especially by the father. By confirming that it is true that he is timid and withdrawn, it is possible at the same time to point out, that this is maybe due to his sensitivity. Point out that this is a very sensitive child, who has many good human qualities, maybe he can become a social worker when he grows up because his sensitivity or compassion for others, or maybe he can become an artist… *These are possible ways to reverse and redefine negative conceptions by pointing out the positive pole without disconfirming their more negative description of the child. Help them to look for the positive pole.*

- **Sharing stories of good moments with the child in the past**
  This is another technique sometimes used in marriage therapy. This is particularly relevant when empathic identification with the child is blocked. By going back to positive moments in the past, like after birth, or when they were on holiday, when there was a special occasion where everybody felt happy. *Ask the caregiver to tell about such occasions in the past, and usually such telling or accounting arouses at the same time the positive feelings that they experienced at those moments. Such recounting of past positive emotional moments (Stern 2003), may be the start of new opening up of the feelings towards the child, reactivating the happiness, the tenderness and love that they at some time in the past experienced with their child. (This can also be combined with pictures).*

- **Using an emotional empowering and positive discourse**

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The way we talk about a child or about childcare, that is our discourse may influence our attitudes and the way we relate to children. Our discourse may open up towards more sensitive and loving care or it may close such attitudes by a negative disillusioned and stigmatising ways of talking about children and childcare. Sometime a medical objectivist or scientific way of talking about children as "cases" or as statistical entities, may inhibit a more humanizing, emphatic and empowering discourse and sensitivity in relation to childcare (Crossely 2004, Ryan 1978). In more general terms, our definitions and conceptions of children are embedded in ways of talking. *By adopting a sensitive humanising discourse where children are described as sensitive and unique persons with the same needs, hopes, anxieties, worries and sufferings as ourselves, this opens up and legitimises a more sensitive and empathic care: "It could have been me, it could have been my child"*

2. The three dialogues and the eight guidelines of good interaction.

The ICDP Program has been associated "the program that uses the eight guidelines of good care" (see WHO/ICDP publication 1992) This is partly true but there is more to it than that; more recently we have started to use the concept of "three dialogues of human care and development" as a more general concept that includes the eight guidelines as specifications of each dialogue (see figure page 13).[7]

In the text below each of the guidelines will be commented on as part of the three dialogues.

a. The emotional expressive dialogue of love and acknowledgement

The most important healing force in human life is love and acknowledgement from other people. This is what disadvantaged children very often are lacking. As already pointed out they are very often stigmatised and expelled from "the zone of intimacy", this means that they are also deprived of the intimate contact that is part of the emotional expressive dialogue.

This dialogue starts already from birth, or shortly after, through joyful proto-conversations and emotional expressive turn-taking and exchange, through early imitations and through sensitive confirmations and attunement to the infants state and expressivity. Already at this early stage the role of emotional confirmations and sharing of expressive initiatives and utterances are in operation, and it continues through out life as a source of joy and consolation. (Stern 1985,Trevarthen 1992).

[7] The concept of three dialogues, (1. emotional-expressive, 2. meaning and expansion and 3. regulation) seems to make more intuitive sense from a developmental point of view. Also these distinctions correspond to categorizations used in linguistics like "emotives", "descriptives" and "prescriptives"

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Expressive acknowledge and love has many different manifestations, from joyful expressive face-to-face exchange, to sensitive touching and embracing, to sensitive confirmations through expressive looking at the other, nodding, remembering the other's name and thus confirming that the other is "seen" and that his or her presence is appreciated – this means to be included with other, or as Daniel Stern describes as "moments of being-with-the-other" (Stern 2003), or in the language of ICDP being "included into the zone of intimacy"
When this dialogue is operative between caregiver and child, a bond of reciprocal acknowledgement develops between them, like a contract of reciprocal liking and dependency, which is also described as "attachment" and "bonding"[8]

As already pointed out, this emotional expressive dialogue has different manifestations. In the ICDP Program we have selected the following guidelines:

1. Expressing positive feelings and love towards the child
2. Seeing the child's expressive initiatives, acknowledging responding to and following them whenever it is appropriate. Tuning into the child state, feeling and intentionality.
3. Intimate dialogue of expressive exchange, disclosure of feelings and reciprocal sharing of experiences
4. Acknowledging and confirming the child, and eventually praising the child whenever that is appropriate

All these manifestations and aspects can be expressed in three different modes, namely through:

- Speaking and language
- Touching and physical contact including massage
- Looking and nonverbal expressions

All this can be summarised in the following table:

Table 1: Different aspects of the emotional-expressive dialogue

	Speaking	Touching	Looking
1.Expressing positive feelings			
2.Seeing/following child's expressive initiatives			
3.Intimate dialogue			
4.Confirm.praising the child			

[8] There is an enormous field of research related to attachment and disturbed attachment that I will not go into here. See .

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This table can be used to mark and analyse both the presence of different aspects of the emotional expressive dialogue (1-4) and it can also be used to analyse their different modes of expression. Some research indicate, for example, that in some communities the contact between caregiver and child can be more through touch and looking than through speaking and face-to-face interaction (Le Vine et al. 1987). In other words, there are different ways and modes of expressing the emotional dialogue and thus achieving a trusting relationship.

b. Creating comprehension and meaning (mediation – what? why?).

It was Bettelheim (1975) who once expressed that "love is not enough". In addition to having established a stable and trusting relationship to caregivers and Others in the child's environment, the child also needs to develop an understanding, in the sense of realistic expectations and meanings as to what is going on in his environment.
Already by the end of the first year of life the child starts exploring his environment by testing out the consequences of his actions, through repetitions and circular reactions with objects and with repetitive communication with people. It is at this stage that "joint attention and joint involvement episodes" (Shaffer 1996, Tomasello 2000), "guided participation" (Rogoff 2003), "scaffolding" (Bruner and Wood 1979) and "mediation" (Klein 1994) in "the zone of proximal development" (Vygotsky 1978) comes in. There are numerous description of this process of adult guidance and support to the child's emerging exploratory initiatives. The point here is that, a child also needs guidance and support in order to understand and master the complexities of our shared cultural world - love is not enough. The child is by nature an apprentice and it is our tasks as caregivers, not only to provide emotional support through the emotional expressive dialogue, but also to provide cognitive support and guidance through the second dialogue of meaning and expansion.

This dialogue has three aspects:

1. Joint attention and focussing ("Look !")
   Achieving attentional intersubjectivity either by focussing or joining in.
2. Descriptions and meaning of what is presently attended to ("What is it?") Labelling and demonstration of functions.
3. Expansions and going beyond what is presently given, creating a "narrative" of what is experiences ("Why…?")

There is a natural narrative sequence between these three aspects of second dialogue, naturally starting with joint attention or focus on something (1) that is further commented on or described (2) and then expanded and developed further through explanations and stories (3). As pointed out by Schaffer:
"Establishing a common attentional focus is an essential first step in setting up "joint involvement episodes", for it is only in the context of the child's own interests that the adult can then introduce additional material: a verbal label for the object the child is

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looking at, a demonstration of the various properties of the toy the child has just picked or an extension of the verbalization that child has just uttered…" (Schaffer 1996, p.254, see also Tomasello 1999).

In addition this dialogue can be initiated by the child or the adult, and it can be communicated through speaking or non-verbally through acting, as the table below shows:

Table 2 The meaning and expansive dialogue

Characteristics	**Speaking, Requesting**	**Acting**
Joint Attention	**"Look" – joint focussing on objects, events**	Pointing Showing Gazing
Meaning - describing here and now	**"What is it?"** Giving names, descriptions	Demonstrating objects' functions
Expansion - going beyond descriptions	**"Why?"** Giving explanations, comparisons, narratives/ stories.	Dramatizations and pantomime

The second dialogue arises naturally in a context of information seeking, watching something together, a picture book, TV, going for a walk and observing the surroundings etc. The initiative may come from the child or from the caregivers:

Look here! (request for joint attention)
What is this? Naming (request for meaning)
Why is it that ? (request for expansion)
Tell me a story…

This type of dialogue may seem trivial at first glance, but there is abundant research showing that it is exactly these qualities in the interaction between caregiver and child at an early age that seem to promote a child's social, linguistic, cognitive and moral development (Klein 1994, Schaffer 1996, Tomasello 1999, Hoffman 2000).

But the second dialogue has also a wider and deeper meaning when it comes to older children and adults. For example; a person may have gone through difficult or traumatic experiences which are "lost" or not assimilated into the persons' general system of meaning and awareness. In such cases there may be a need to recapture and create a new meaning of such experiences so that they become personally assimilated and understood. Or to phrase it differently, there is a need to provide *a narrative that provides a reference and anchorage for such experiences so that their anxiety provoking potential is reduced*

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and they become manageable inside that person's system of meaning. The person is able recapture his past in a more constructive way.[9]

An important aspect of coping and willingness to live, is the way we understand and create meaning in our lives. Some are able to survive psychologically because they are able to create an image of reality that has some hope and optimism that activates their potential resources for surviving and coping (Seligman 1990). While others create an image that confirms and strengthens their depressive and hopeless conception of reality and their possibilities. *Therefore, the way we create meaning and expansion in our lives, the stories we tell ourselves, the way we see ourselves in the world and the way we anticipate or construct our future, is closely related to how we cope and survive psychologically* (Janoff Bulman 1989).

For example, in the context of children experiencing the tragedies of parental suffering and death due to the HIV/AIDS pandemic, it is important to help children understand their experience of seeing their parents getting ill, slowly degenerate and die, the reaction of neighbours etc. In a world of magic this illness is sometimes understood as the result of an evil spell from some hostile neighbours or enemies. As an example Aiko (1998) tells the story of an orphan boy in Kenya who no longer wants attends school. The boy believes that his educated parents died of AIDS because members of their extended family, envied them their education and used witchcraft to sicken them. As a consequence of the meaning that he attributes to what has happened, he does not want to be bewitched in the same way. Therefore he does not want to attend school. This is the story he tells himself. In this case mediation of meaning and creating new story with a new explanation and understanding of why his parents died would be necessary to promote a change his attitude to schooling.

There are numerous stories connected with contracting HIV and subsequent death that may have dramatic consequences for how people adapt in the context of HIV/AIDS pandemic (Kruger 2003), as part of how they create meaning to what has happened to them.

The second dialogue of meaning and comprehension therefore is the key to how we "construct reality", and it is through this dialogue that a world of hope and a future may be reconstructed – or a world of resignation and pessimism.[10] In the case of illness, it is through this dialogue that the constructive resources for surviving and coping may be remobilised. (Crossely 2000)[11]

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[9] So called "memory work" and "memory boxes" is an example of application of this principle.(UNICEF coordinator's notebook,) and so is trauma therapy with reconstruction (Herman 1992).

[10] "Reconstruir Esperanca" or "reconstructing hope" is an organization that ICDP cooperates with in Mozambique. The term indicates an important aspect of human care.

[11] I will not in this context go further into the significance of second dialogue of meaning and expansion for the development of a child. This has been explicated elsewhere (Hundeide 2000)

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c. The regulative dialogue (how?)[12].

Regulation and the development of self-control is another aspect of coping. This develops *in the context of goal directed action and procedures* ("how can we do this?"): When father and child are working together on a project – a play project – *the father supports the child by keeping the goal steady, by clearing the field, by giving supportive comments and hints, support planning by asking questions about "what would happen if…", by helping the child to see alternatives and preview consequences. Altogether this supportive dialogue helps the child to reflect, see alternatives, to restrain and control himself and to act strategically. This is an important competence in a complex and challenging world.*

Regulation has many aspects and I will in this context mention three important aspects:

1. *Guiding and supporting the child's actions and initiatives without taking over*. This is the strategy which has also been described as "scaffolding" by Wood and Bruner (op cit.). This naturally leads to a regulative communication that is graded according to the child's level of competence on the one hand, and on the difficulty of the task on the other. There is a gradual transfer of responsibility for a task or an operation from the caregiver to the child as his competence increases. Guided supporting can take place both through verbal communication, but also through non-verbal pointing, directed looking and nodding…

2. *Planning and previewing the consequences of one's actions,* as described above. This is a precondition for self- and meta-cognitive control. This also involves taking away distractions and creating *an orderly environment with stabilised routines* and with objects that afford, invite, the activities that the child is supposed to carry out. When an environment becomes stabilised, orderly and predictable, it is possible to plan, preview and see the consequences of ones actions. This is another aspect of trust.[13] When this is in place, a child in distress may be supported to start focusing on the normal activities and routines of his environment and thus gradually regaining a feeling of mastery and control of his environment.

3. *Positive limit-setting.* [14] In opposition to negative limit-setting, positive regulation in the sense of "limit-setting" is carried out in a friendly atmosphere, the child is respected as a person, there is no shouting and negative humiliating commands. According to Hoffman (2000) one of the most important differences

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[12] Part of this is also called "procedural knowledge" or skills.

[13] Children living under extreme conditions of poverty and illness also tend to live in an environment of chaos , disorder and confusion (Lewis 1965, McLoyd 1990, Nunes 1994). This disorder prevents again the development of mental capacities of previewing, planning and gaining control. The locus of control becomes externalized through passive dependence on authorities or supernatural beliefs (Hundeide 1999)

[14] In this context, it is not possible to go into more detail with regard to other aspects of regulation linked to behavioral disorders (Hundeide 2000).

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between good and bad control-procedures in child rearing, is that *explanations are given for why things are not allowed and why certain rules or prohibitions are necessary, rules are negotiated and agreed on, also the consequences for breaking them***.** This forms the basis both for the development of accountability and altruism in children (Hoffman 2000).

Both within the Vygotskian and the Feuersteinian tradition there has been a strong emphasis on the importance of regulation; particularly on how "self-regulation" develops from "other-regulation" - how guided interaction between caregiver and child becomes automatised as self-control and then gradually internalized as inner control and anticipations of "what will happen if…" In this way the child is gradually enabled to guide himself and anticipate the consequences of his own action-initiatives, that is self-control. In this way; *outer control develops into self-control, develops into inner control*, according to Luria (1976).

At the same time, as a consequence of the child's successful regulation, a feeling of *efficacy and agency* – trust in his one's own ability to act and achieve (Bandura 1990) may develop. This is another aspect of coping. *Supportive regulation with gradual transfer of responsibility is therefore and important element in a process of helping a person to get out of a state of hopelessness and apathy. In fact, in most therapeutical work, helping the client to "take control" is an important aspect of psychological improvement and healing.* This dialogue as therefore, like the other dialogues, has a therapeutical aspect.

The three dialogues ave earlier been presented in more detail as the "eight principles of good interaction". In the table below the three dialogues and the guidelines are presented together, where the guidelines represent specifications of the dialogues:

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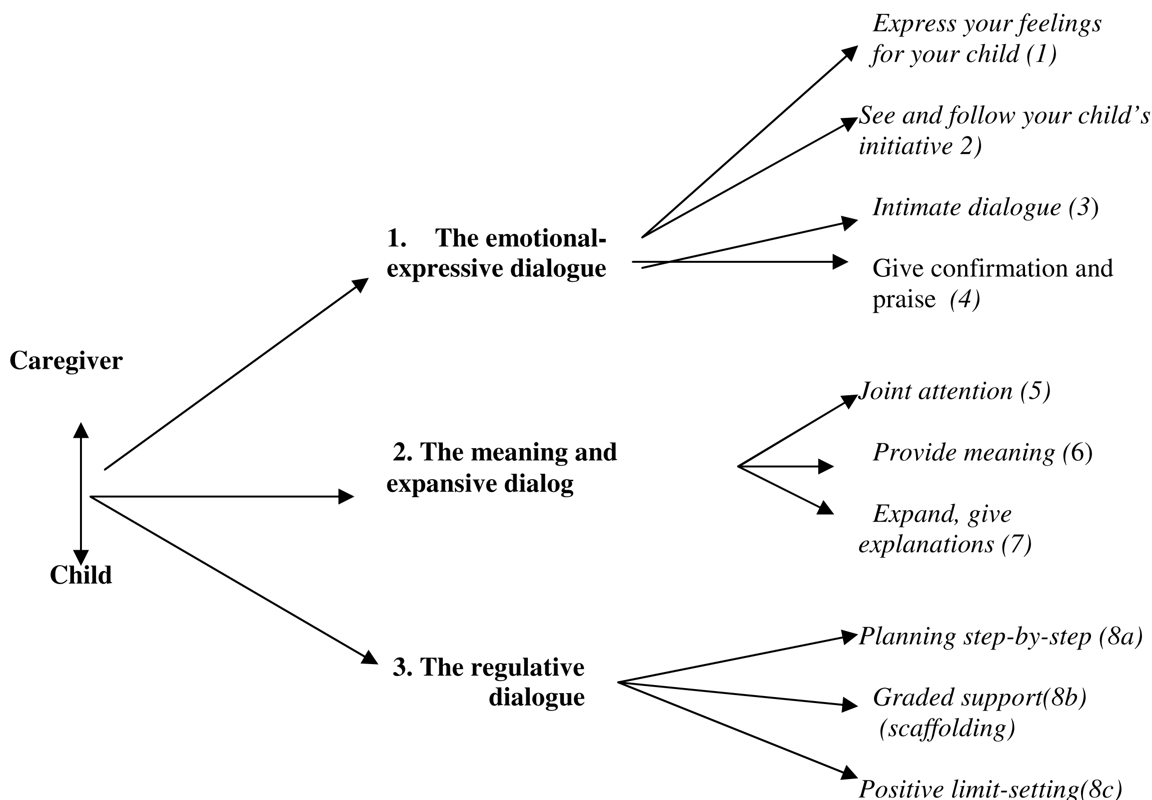
Figure 2: The three dialogues and the eight guidelines of good interaction



This figure summarizes the relationship between the three dialogues and "the eight guidelines of good interaction"

In a dialogue, both caregiver and child contribute: reciprocal sensitivity and responsiveness is required.

As interactions between caregivers and child can be initiated both by caregiver and child, this indicates that the quality of interaction between them is usually a dialogical product where both contribute. This is an important point because what very often happens with children who are malnourished, sick or in some way deprived of human contact is that they withdraw from further contact and become passive and do not produce the communicative utterances and initiatives that may invite caregivers to respond back. In this way they detract others from communicating with them by *not producing the communicative signals that invite others to respond back. In this way their passivity may initiate a negative cycle of withdrawal and isolation that may further aggravate their condition. We can see this in some institutionalised children, in addition to being physically sick and weak, they have withdrawn from human contact and thereby also from a source that could otherwise have supported their vitality and willingness to live, cope and develop*. Active and healthy children, on the other hand, tend to seek assistance from others by asking and requesting information. In fact, *"assistance-seeking"* seems to

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be an important “resilient” quality in children that otherwise might have been ignored and deprived of stimulating human contact and mediation (Resnick 2000).

For this reason it is especially important to be attentive of children who are passive, malnourished and sick, because such children may easily be ignored and neglected because they lack the initiatives to demand the caregiver’s attention and responsivity. With such vulnerable children, *sensitive attunement to the child’s state* is a prerequisite for arousing and mobilizing their activity and vitality (Stern 2000).

3. Principles of training/sensitizing of caregivers and networks of care.

Human care is not a complicated skill, it is something basic in human life that most persons are doing, like the three dialogues and the guidelines of good interaction, but due to stress, negative definitions and stigmatizations of the child (or victim/client) these basic social skills/competencies are often prevented from being practiced when they are most needed. Therefore it is important to create a positive and confident atmosphere where the caregivers feel at ease and where they can open up and express their feelings for their child.

As already pointed out, in order to promote empowerment and prevent dependency, the ICDP program uses facilitative strategy of training where we, instead of correction and focusing on failures, *point out the positive sides that already exist in the caregiver’s interaction with her child. In other words, we try to reactivate existing positive patterns of care and reconfirm these in such a way that the caregivers’ competence and confidence in himself as carer is sustained and strengthened.* This is an important principle in our training.

In addition, in order to promote change in the practical activities like caring for a child, it is not enough to talk and instruct, in order for a change to take place in practice, ***self-initiated practical caring activity is necessary.*** *Therefore those who go through our sensitization courses have to carry out a series of exercises in the form of observations, self-evaluations, testing out different initiatives (the guidelines) and reporting back is important in order to promote attitudes of agency and efficacy in the caregivers.*
Below is a summary of the principles and the sequences we follow when we sensitize or train caregivers:

- Establishing a contract of trust with clear information about the program and the course - both demands and advantages
- Restoring a positive redefinition of the child (see pages)
- Pointing out and confirming positive features in the caregiver’s interaction and relationship with her child
- The guidelines of good interaction and the three dialogues provide a common language and frame of reference for sensitization (see page)
- Activating caregiver in relation to the guidelines through different exercises, also homework

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- Sharing experiences of caring for own children in line with the guidelines of good interaction with other caregivers in a similar situation so that an enthusiastic committed atmosphere develops
- Using a personal and interpretive way of communicating with examples and stories that invites a caring positive attitude to their children.

All this is taking place in groups between 5 to 15 caregivers.[15]

4. Going beyond caregiver-child interaction to mobilising community and networks of care

The ICDP principles as stated above refer primarily to the *proximal* conditions that influence the child's experience directly, like the definition/conception of the child and the quality of caregiver child interaction indicated in the three dialogues, but there are also *distal* or secondary conditions like availability of caring alternatives, level of poverty, workload of the caregiver and size of family, housing and crowdedness, family and survival stress, quality of health, availability of adequate nutrition and water, social and health policy priorities etc. All these factors constitute "framing conditions" that influence the way the proximal conditions operate in relation to the child. If the distal framing conditions degenerate, like increase in poverty, it may be difficult proximally to sustain an adequate level of psycho-social care and quality interaction between caregiver and child.

Therefore it is necessary in most cases to intervene at other levels also in order to open up and sustain the quality of care between caregiver and child.
In the table below four levels of intervention are indicated:

Table 3 Intervention to improve psycho-social care can take place at 4 different levels [16]:

1. Intervention can be *individually* directed to the quality of care and interaction with the suffering child directly - in a traditional clinical way
2. Intervention can be directed towards sensitization of the caregivers' and *families'* interaction with the child(ren)
3. Intervention can be directed towards *community* - mobilization and awareness raising preventing risk behavior, or more directly; finding practical solution of new caring arrangements from extended family, foster care, to institutions/orphanages or support to child headed families.
4. Intervention can be directed at the *policy level*, improving economic conditions of families and children, human and children's legal rights etc Advocacy

[15] For more details see Hundeide 2000, 2001.
[16] There are different models for how this interaction may take place (Bronfenbrenner 1978, Sameroff & Fiese 1990, Mc Loyd 1990, Kagitcibaci 1996, Cole 1996, Rogoff 2003)

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As the table indicates, the ICDP Principles can be used in an individual clinical way by interacting directly with a withdrawn and traumatized child (see ICDP Film from Angola). This is very much in line both with clinical work in the object relations tradition (Fonnagy) and with research within early mother-child communication (Trevarthen, Stern, Tronick, Klein and Rogoff). A simple and idealized description of these forms of interaction is provided through the three dialogues and the eight guidelines of good interaction. This is what most people associate with the ICDP Program.

But the ICDP Program also provides guidelines for how the Program can be implemented through a community based strategy where resource persons in the community are trained to transfer this competence to caregivers and networks of care inside the community so that the impact becomes much wider and greater than through individual clinical intervention. In a development context this is the only realistic way of working, as expertise for individual consultation will not be available.

In summary we can say there are five modes of intervention in the ICDP Program these are summarized in the table below:

Table 4: Summary of five ICDP methods of intervention.

ICDP Modes of intervention:	***Level of interaction Family-care***	***Local community***	***National policy***
1.Redefinitions and focussing on the positive resources	To counteract a negative conception/ image of the child and stigmatization	Mobilization to counter-act stigmatization	Raise awareness mobilization to counter-act stigmatization media, radio, TV
2.The emotional Expressive dialogue (4 guidelines)	To promote love and affectionate care, trust and self-esteem	Raise awareness for the need for affectionate care for vulnerable children	Raise awareness for the need for affection and care – media, radio, TV
3.The comprehension dialogue of meaning/expansion (3 guidelines)	To expand the child understanding of the world and his situation (narrative memory work also)	Counteract prejudice and provide information/ stories, education that facilitate hope	Advocacy, policy and priority setting of psychosocial care for children
4.The regulative dialogue/ limit-setting	To help the child organize, plan and regulate his life, develop self-control	Create settings and opportunities where children can act in collaborative and organized ways …	“
5. Principles of sensitization – how to train/sensitize facilitators and caregivers	Sensitize primary caregivers in the 1-4 principles	How to train and sensitize community facilitators who train primary caregivers	“

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As the table shows, these modes of intervention can be applied at the interactive level of caregiver child, at the level of community and at the national level of policy, advocacy and human/children's rights, although the focus and emphasis in the ICDP Program will be on the interactive level.

5. How the program is implemented in practice.

Before any implementation of a program can be initiated, in a community, in an institution or in a family, certain conditions need to be in place, like carrying out a needs assessment, deciding what will be the target group, mapping the situation, and the goals of the intervention, getting access, selection key-persons to be trained, identifying the conditions that may block or prevent the implementation of the project.

As a competence building organization we generally work, not so much with individuals, as with communities, with established local networks/ organizations dealing with children at disadvantage

Below are some principles that we apply before starting the implementation of a project:

- Collect available statistics and relevant information on the state of the target group – what are the macro-factors contributing to reduced quality of care and neglect?
- Ways of getting access to the community have to be investigated in each case – usually through some influential local persons or organizations already established and working there.
- Focused-group interviews with key informants, parents, nurses and social workers in the community on these issues – the local conceptions of what are needed and relevant, local conception of why things go wrong...
- Interviews with both caregivers and children on their conceptions of children and ideal child care – parental assessment of their child(ren)
- Visiting typical families in the community and mapping a typical day of a child through observation and interview – routine activities and interactions when, with whom, why, how etc.
- What are the potentials for promoting better care inside the child's everyday context – the child's developmental niche?
- What are the obstacles?

- Before training starts there need to be a clear plan of intervention with material and manuals prepared both for caregivers and facilitators.
- In the first training (in a region) it is important to select and include resource persons who are committed and can become future facilitators and trainers
- We generally work in groups with caregivers. The meetings last about 2 hours and they usually follow a clear agenda inside which there is participatory activity. The sequence of meetings can be from 10 to 20 every week or every fortnight
- Follow up after the training is finished is essential in order to sustain the results achieved. This may go on for a year after the training is finished.

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In addition to these preparatory principles, we have also some **principles of implementation** that need to be investigated before implementation starts. This is important because *the impact of a program is not only dependent upon the quality of the program as such, but also on the condition, the context and the quality of implementation.* For this reason the following implementation principles are specified in the table below:

Table 5: Checklist of implementation

Principles of implementation	Evaluation 1-5
1. Support from relevant authorities?	
2. "Space" for the project:	
a. Time	
b. Organizationally	
c. Economically	
3. Willingness and commitment of the receiver (caregiver)?	
4.Plan of action and plan of implementation ?	
5. Quality and intensity of the implementation (including number of interventions)	
6. Willingness to adapt everyday-routines to facilitate implementation.	
7. Plan for follow-up, self-evaluation and internal reward-system.	

These principles of implementation are important also in connection with evaluation, because they specify the conditions under which the program should ideally be implemented. In case a program is implemented under unfortunate conditions, it then becomes difficult to separate whether the mediocre effect of the program is due to the program itself or to the conditions under which it has been implemented. For this reason any intervention should have some indicator that expresses the quality and intensity of the intervention. That is the whole point of having principles and indicators of implementation.

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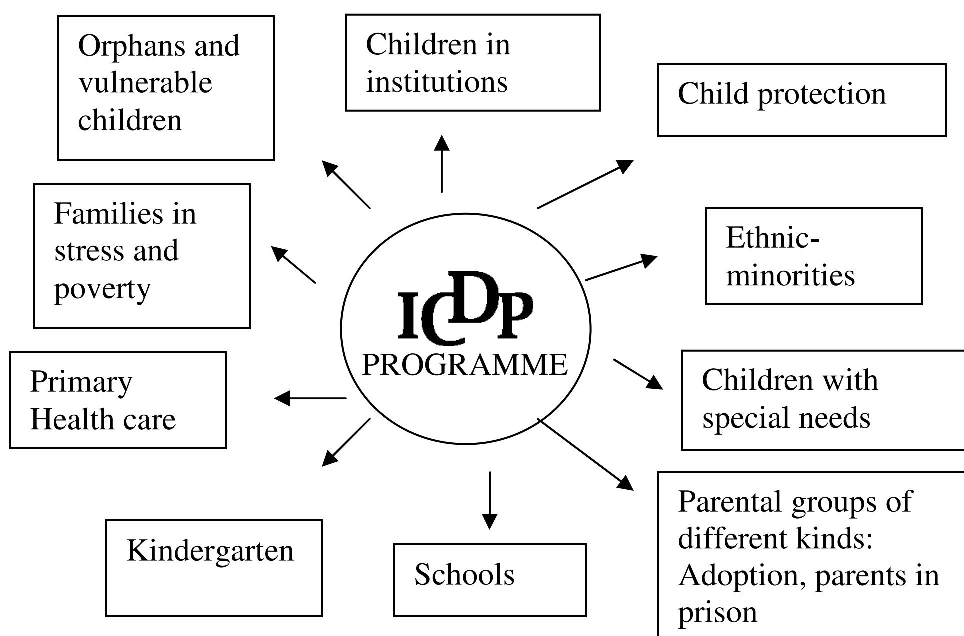
6. The ICDP Program in operation

The ICDP Program is now in operation in more than 15 countries in Europe, Africa, Latin America and Asia. Different versions of the program is developed for different target groups of caregivers from health clinics, preschools, schools, dislocated children in camps, who may be traumatized, immigrants, and children with special needs. As the core program is based upon universal aspects of care, like the three dialogues, these aspects will also reappear in any context where children's psycho-social care is at stake. *The strength of this program is therefore its simplicity and its wide applicability by focussing on basic process of human care.*
At the same time, as sensitisation, not instruction, is our methodology of training caregivers, local cultural practices are also reactivated in different settings and communities and this does not represent a conflict with the underlying universal pattern of our program represented by the three dialogues. In some way they seem to express universal aspects of human socialization and care.



All the areas of application indicated in the picture above are in fact implemented in different parts of the world, and special manuals are being prepared for the various target groups.

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