ENHANCING QUALITY INTERACTION BETWEEN CAREGIVERS AND CHILDREN AT RISK: THE INTERNATIONAL CHILD DEVELOPMENT PROGRAMME (ICDP)

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Abstract

Manmade disasters such as war, abuse, violence or physical punishment causing traumas in children, are all violations of children's rights. The International Child Development Programme (ICDP) is a universal psychosocial programme considered to be a helpful tool in implementing children's rights, protecting children from being violated and promoting psychosocial care for children at risk. The ICDP approach is based on the idea that the best way to help vulnerable children is by helping their caregivers. The article presents central elements in this programme and link them to core elements in trauma understanding and resilience based interventions dealing with traumatized children. We will then describe clinical vignettes from practicing the ICDP in two different contexts with children and their caregivers in South Africa and in a care center for asylum-seeking minors in Norway and discuss some of the aspects of the implementation of the programme.

Keywords: ICDP, children's rights, trauma, intervention, resilience

Rezumat

Dezastrele provocate de om, cum ar fi războiul, abuzul, violența sau pedepsele fizice cauzând trauma copiilor sunt în fapt, toate, violări ale drepturilor copiilor. Programul Internațional de Dezvoltare a Copilului (ICDP) este un program psihosocial universal, considerat a fi un instrument util în implementarea drepturilor copiilor, în protecția copiilor împotriva expunerii la violență, și în promovarea unor îngrijiri psihosociale pentru copiii la risc. Abordarea ICDP se bazează pe idea că cel mai bun mod de a ajuta copiii vulnerabili este acela de a-i ajuta pe cei care-i îngrijesc. Articolul prezintă elementele centrale ale programului și face legătura între aceste elemente și aspectele centrale ale intervențiilor bazate pe înțelegerea traumei și a rezilientei,în intervențiile practicate cu copiii traumatizați. Vom prezenta apoi vignete clinice privind aplicarea ICDP în două contexte diferite, cu copii și îngrijitorii lor, în Africa de Sud,

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precum şi în centrul de îngrijire a minorilor căutători de azil din Norvegia şi vom discuta unele aspecte din implementarea programului.

Cuvinte cheie: ICDP, drepturile copiilor, traumă, intervenţie, rezilienţă

Children's rights

When families are uprooted by social change, migration, poverty, catastrophes, or war, the caring system often breaks down and has to be reactivated through skilled help and support. Children who lose their parents or have been numbed by severe deprivation and emotional shock are especially vulnerable when the caring systems break down.

To meet these challenges many countries including South Africa and Norway have ratified the UN convention on the Right of the Child (UNCRC). This consists of 54 articles. UNICEF has chosen to promote the convention divided into three categories, commonly referred to as the "3 Ps":

1. The right to provision of basic needs
2. The right to protection from harmful acts and practices
3. The right to participation in decision affecting their lives

The 2009 annual report from the Children's Rights Center in South Africa (CRC-SA 2009) states: *"On paper, South Africa is deeply committed to children's rights, as evidenced by our ratification of the United Nations Convention on the Rights of the Child and five other child related conventions. The South African Constitution addresses these obligations and many of the points raised in the general comments. Despite these firmly documented aspirations, children's rights realization, protection and promotion too often remain elusive in reality. This is evidenced at a very broad level by the fact that as a country we are moving in the reverse direction in meeting our Millennium Developmental Goal commitments. Of equal concern is the public hostility to the idea of children having rights. The misunderstanding and myths about children's rights are a major challenge to right realization, Children's rights are not just material provisions or services, but are realized in relationships between people: between children and between adults and children in their attitudes and daily life practices."*

This quotation emphasizes two major issues: First; the attitudes towards children, their values and their rights, and second; the daily life practices between adults and children.

The rights to provision, protection and participation must be mediated through sensitive caregivers giving the child a voice, listening to her physical, psychological and existential needs and protecting her from danger and harmful practices.

The ICDP

The ICDP programme has sensitive, empathic care through the interaction between the child and its caregivers as its main focus. By developing meaningful dialogues with children and promoting children's active participation and initiative, the ICDP contributes in promoting children's rights (www.icdp.info).

The ICDP was developed by an international team led by Child Psychology Professor Karsten Hundeide, University of Oslo, Norway. Hundeide started to develop the programme in 1985 and the ICDP organization was founded in 1992. The ICDP has been adopted as a mental health programme by WHO, and close cooperation has been established with UNICEF, particularly in Latin America. The ICDP has conducted training in more than 20 countries.

The ICDP is an international competence building and training programme for psychosocial and educational care of children at risk, and it focuses on both the cognitive, social and emotional development of the child. The ICDP is community-based, cultural sensi-

tive and prophylactic, addressing established groups of children and their caregivers. The programme is influenced by social anthropology, popular traditions theories, attachment theories and recent theories on child development. The ICDP builds competence and confidence in members of an existing child caring system and transfers the training to the local resource persons. Sustainability is achieved by inserting the ICDP as a permanent component inside a network working with children. The programme is particularly relevant to caregivers of children 0-6 years, but it is applicable even with older children and teenagers and elderlies. The following contexts are recommended (ICDP leaflet, 2010):

- *Families and children. To prevent neglect or abuse of children and promote dialogue through group meetings and home visits*
- *Vulnerable children and orphans. To develop minimal standards for human care within a child-care setting related to war, migration, catastrophes, abuse and trauma or abandoned street children*
- *As an integral part of any primary health care programme sensitizing caregivers about their important role for the future development of their child*
- *In preschool- and school programmes, improving the interaction between staff and the children and the children's parents.*
- *Children in institutions. To sensitize staff and improve their quality of care*

Dialogues and guidelines on positive interaction

The content of the programme is formulated in 3 dialogues and 8 guidelines to promote good interaction (Hundeide, 2007).

The *emotionally expressive dialogue* addresses the emotional development and creates the basis of safety and trust:

1. *Show your child love and care*
2. *Follow your child's lead*
3. *Intimate dialogue.*
4. *Give recognition and praise*

The meaning creating and expansive dialogue addresses the cognitive development and creates the child's understanding of the world:

5. *Joint focus of attention*
6. *Give meaning*
7. *Expand, give explanation*

The regulative dialogue addresses the moral and behavioral development and helps the child learn planning and self-control:

8a. Step by step planning
8b. Scaffolding
8c. Positive limit setting
8d. Situational limitation

A positive conception of the child and empathic identification

Unless a child has an adult loving and caring for her, teaching her daily life skills and the ability to meet demanding challenges, her cognitive, social and emotional development will be impaired. In order to develop a positive interaction with the child it is necessary for the caregiver to have a positive conception of the child. The child has to be perceived as a person with potential for development, a person the caregiver cares about and with whom the caregiver can identify empathically with. There is a close relation between the way the child is perceived by her caregivers and the type of care the child is given (Klein, 1992; Smith and Ulvund, 1999). Consequently, the method of redefinition to change negative perception of the child is a central tool in the ICDP. Caregivers who participate in ICDP are taken through a process of self-reflection and encouraged to develop a positive conception of their children, as well as a deeper understanding and confidence about their own roles as caregivers.

Generally speaking, our conceptions of children are embedded in our culture and traditions, but with a wide range of variations reflecting individual life experiences, social and cultural backgrounds and positions. When working within a multicultural society or a culture different from one's own it is impor-

tant to show tolerance for variation. Caregiving practices must be carefully evaluated in their cultural context before being considered a deviation.

The caregiver's capacity for empathic identification is the basis for sensitive caregiving, sensitive interaction and sensitive pedagogy (Hundeide, 2010). Empathy facilitates communication and in order to communicate effectively the caregiver needs to be able to understand the child's affective and cognitive states. In this way the ICDP is inspired by recent caregiving ethics from the philosopher Levinas known for the expression *"face speaks to me and thereby invites me to a relation"* and that it is: seeing the other's face that commits us (Levinas, 2004). The Zulu concept of "Ubuntu", *"I am because you are"*, is also an example of how popular traditions have influenced the programme.

The ICDP is based on recent research on child development, particularly on early communication and the infant's competence and contribution to the interaction with the caregiver. The infant is born as a social individual with strong dispositions towards initiating interaction with others. Contrary to earlier perception of infants as passive, the infant is currently defined as competent of interaction (Stern, 1985; Trevathern, 1992; Bråten, 2004). This means that that the child is an active participant in creating the care she receives.

The emotional dialogue

The affective attuning of the caregiver constitutes the basis for the emotionally expressive dialogue. The emotional dialogue emphasizes that showing the child love and care meets the child's needs for a safe and comforting relationship. The emotional dialogue presupposes that the caregiver adjusts to the child's condition and states, and sees and follows the child initiative, expresses positive feelings and acknowledges the child.

Daniel Stern (ibid) constitutes an essential contribution to the understanding of emotional interaction between the infant and the caregiver, specifically through the concepts of imitation and nonverbal communication. Shared emotional conditions are necessary for the child to feel that she is cared for and understood. When the ICDP is referred to as a *"sensitization programme"* this involves training in seeing and interpreting facial expressions, gestures and body language or voice quality.

Donald Winnicot focuses on caregiver-infant interaction as well. The concept of *"the good enough mother"* alludes to the notion that the mother and the child are intuitively and biologically predisposed for interaction and gives evidence to the importance of the emotional dialogue. The concept of *"the potential space"* also draws attention to the importance of play for the emotional and cognitive development of the children (Winnicot, 1971).

ICDP is also leaning upon attachment theory (Bowlby, 1988). The child will search for protection and comfort when she gets scared (Smith, 2002). The child is dependent upon a caregiver who is able to read the signals correctly, and that her signals will subsequently trigger the caregiver's disposition to comfort and support the child emotionally as well as intellectually.

Pedagogic guidance - the meaning creating dialogue

During the last decades infant research has led to extensive exploration of guided interaction between caregivers and children and about how the child is gradually led into cultural community through communicative contact with her caregivers. The caregiver has a responsibility not only to acknowledge the child emotionally but to assume a pedagogic guiding role. The child needs an assistance in her exploration and guidance that promotes her understanding about the world she lives in. The child also needs to master the skills required to adapt to other people and meet the expectations and challenges in life. This type of interaction at an early age seems to fa-

cilitate and support the child's social, linguistic, cognitive and moral development (Rogoff, 2003; Hoffmann, 2000; Schaffer, 1996; Klein, 1992). In addition to safety and secure attachment, guidance for cognitive and intellectual development for children constitutes a vital part of care. If this fails, it may have serious consequences for the child's future development (Hundeide, 2001).

ICDP (Hundeide, 2010) is also influenced by the works of the Russian psychologist Lev Vygotsky and his ideas on learning and development. In order to develop new competences and acquire new knowledge about the world around her, the child needs an adult 'coach' who can challenge her into exploring the unknown. Vygotsky termed this 'The zone of proximal development (ZPD)', an innovative metaphor capable of describing not the actual, but the potential of human cognitive development (Vygotsky, 1978), considered to be the basis for the ICDP meaning creative and expansive dialogue

The regulative dialogue

To support the child in her development, mastery of skills and self-control are necessary. ICDP has as its aim to help the children develop moral understanding and responsibility. This means helping the child to plan carefully step by step and offering only the help that the child needs. Hundeide refers to David Woods stressing that:" *the child should only get the help she needs, because if the child gets too much help she does not develop the independent understanding and control considered important for the child's development of independence and autonomy*" (Hundeide, 2007 p. 62). Graded support and instructional scaffolding provide sufficient support to promote learning when children are exposed to new skills and concepts. Just as scaffolds are removed when a building is finished, it is important to remove support when the child is ready to master the task at hand herself.

The regulating dialogue is about developing control and responsibility. Sense of safety and trust, contrary to punishment, is a necessary prerequisite for the development of inner control and reflection. Hundeide (2007) refers to Martin Hoffman's concept "*induction*", meaning that control and behavior management is established through explanations and negotiations. This is different from programs directed towards conduct disorder based upon the idea of behavioral corrections through conditioning.

Sensitization and empowerment versus instruction

The ICDP approach to sensitization is to increase the caregivers' sensitivity enabling them to use their own empathic capacity and practical experience to interpret, respond and adjust to the child's expressed feelings. A sensitization programme is the opposite of instruction and ready-made, manual-based programmes containing detailed instructions how caregivers should act and respond to the child in different situations. The ICDP empowers and supports caregiver's self-confidence in caring. The programme is culture sensitive to local practices as long as they are in accordance with its core concepts. The ICDP facilitator needs to establish a close relationship with the caregivers in training, utilizing participatory and empowering methods. Practical application of the ICDP guidelines must be followed up in detail by the facilitators.

The ICDP programme has four levels:
1. Sensitized caregivers
2. Certified facilitators (running groups for caregivers)
3. Certified trainers (training, supervising and certifying facilitators)
4. Super-trainers (training, supervising and certifying trainers)

Trauma and resilience

Having presented central elements in the ICDP we will now present core elements in trauma understanding and resilience based intervention. Further on we will see how these main intervention principles correspond to

the ICDP programme.

The ICDP was developed for children in marginalized care situations, but does not have a specific trauma focus. In our experience, however, the programme has relevance to profylactic work with traumatized children.

Trauma and consequences

Trauma theory has emphasized the experience of singular traumas and the reactions summarized in the PTSD syndrome: the re-experiencing of the trauma, the avoidance pattern, and the state of hyperarousal.

Experienced trauma often fails to be integrated in the memory and continues to be a fragmented part of the consciousness (Van der Kolk, 2005). The episode feels unreal and as is it not happening to me (de-realization, de-personification) (Shapiro, 2009; Nijenhuis, 2006; Diseth et all 2005). Recent contributions in the literature have also looked at how multiple traumas can have serious developmental consequences (Mannes, Nordanger and Braarud, this journal). Complex trauma and developmental trauma consequences will have impact upon the self-perception (self-blame, low self-worth) and the lack of ability to regulate affects (depression, hypersensitivity, difficulties in calming down). The concept "*out of the window of tolerance*" was developed by Nijenhuis (ibid) to describe the hyper- and hypoarousal (dysregulation) a traumatized person often experiences when trauma is triggered. Developmental trauma consequences also include cognitive impairment (attention difficulties, confusion and misinterpretation). Relational problems, difficulties in trusting other people, being able to identify and feel belongingness to others might also be impaired. (See also Braein and Christie, and Mannes, Nordanger and Braarud, this journal; Shapiro, 2009; Van der Kolk, 2005; Herman, 1992).

Resilience - protective and moderating factors

However, exposure to traumatic events does not necessarily lead to traumatic symptoms. A trauma always activates the person's attachment pattern. According to Robert Pynoos a secure attachment to a caregiver represents a "protective shield". The caregiver representing this "shield" gives the child a feeling of protection and connectedness, regulating the child's emotions and helps to create meaning to the trauma experience (Pynoos, 1995; Christie, 1994a). An immediate reassurance of protection and care can, if present, be a tremendous moderating factor. A prolonged period before care and protection is available necessitates a rebuilding of the child's trust in the protective shield, otherwise the state of hyper-arousal will continue.

Resilience literature identifies protective or moderating factors on the individual level, the family level, and the societal/cultural level. Some of the most important non-genetic factors are: feeling of self-worth, autonomy, internal locus of control, good coping skills, sense of coherence (the world seems comprehensible, manageable and meaningful), creativity (symbolization), good child/parent interaction, clear family structures, (rules and rituals), common values between parents and children, having at least one significant other during childhood, and feeling of belongingness (Rutter, 2006; Masten, 2006; Waaktaar et al., 2004a; Waaktaar et al., 2004b; Waaktaar et al., 2000).

A comparison of the central trauma symptoms and the most important resilience factors indicates that they are interrelated:

Table 1. Interrelation between trauma symptoms and resilience factors

TRAUMA SYMPTOMS	RESILIENCE FACTORS
• Loss of sense of reality o Dissociation o Sensory and memory fragmentation	• Coherent personal narrative o Integrated memory o Ability to make plans for the future
• Lack of control o Deep feeling of helplessness o Impaired self-agency	• Internal locus of control o Coping skills o Manageability
• Emotionally overwhelmed, dysregulation of affects o Hyper-arousal o Hypo-arousal o Impaired symbolization capacity	• Adequate affect regulation o Symbolizational capacity o Creativity
• Breakdown of cognitive categories o Confusion o Lack of meaning	• Sense of coherence o Comprehensibility o Sense of meaning
• Impaired attachment and relational capacity o Loneliness o Withdrawal o Discontinued relations o Constant and permanent readiness for rejections	• Close attachment o Continued relationships o Sense of belonging
• Loss of self worth	• Sense of self worth

An intervention model based on trauma and resilience understanding

When faced with the challenges of helping traumatized children, one must bear in mind both their wounds and the protective or moderating factors (resilience) that can serve as resources in their process to heal. We will here propose an intervention model (table 2) that tries to address the most common trauma symptoms and the central resilience factors. We then try to point out which elements and principles an intervention must consist of to get the intended effect.

Table 2. Intervention model based on resilience factors

Mental domains	Characteristics of traumatic events	Trauma symptoms	Resilience-based principles of intervention	Effects of intervention
• Sense of reality	• External event • Threat to physical or psychological integrity	• Dissociation, feeling of altered reality, and/or sensory fragmentation	• Witnessing and acknowledging fragmented personal experiences	• Re-creation of a sense of reality • Reconnection of the fragmented experiences into a personal narrative
• Sense of self-agency, control, and autonomy	• Sudden, unexpected, uncontrolled	• Helplessness, victimization, lack of control	• Focus on coping skills, proactive capacity, and influence	• Re-installment of autonomy and internal locus of control
• Affective system	• Intense pain and fear	• Emotionally overwhelmed and dysregulated	• Sharing, containing, and training stabilization and emotional regulation	• Expanded affect- tolerance • Reinstalled regulation capacity
• Cognition	• Appear as chaotic and meaningless	• Breakdown of the ability to think and reason, • Confusion • Misinterpretation of guilt	• Providing explanations, and addressing sense of meaning	• Enhanced capacity to reflect, and to include the traumatic experiences into a coherent and meaningful narrative • Correct attribution of responsibility
• Attachment	• Activates attachment systems, and challenges the sustainability of the protective shield	• Impaired attachment and relational capacity, loneliness, withdrawal, and discontinued relations	• Offering a stable and trustworthy relationship	• Capacity for close attachment, sense of belonging and continuous relationships
• Self worth	• Attacks human dignity and self respect	• Humiliation, shame, and guilt	• Showing respect, giving praise and positive feed-back	• Enhanced sense of self respect

(developed from Christie, 1994b)

Linking the ICDP principles to the intervention model

The ICDP as a prophylactic and children's rights promoting programme can reach far more children than the group diagnosed as traumatized (PTSD) in the purely clinical sense (Hundeide, 2001).

The basis for the ICDP principles, *empathic identification* with the child, is a precondition for being a witness and to really understand how the child has experienced a traumatic event. The three dialogues also seem interrelated to the principles of the intervention model (table 2). The *emotional dialogue* addresses the significance of being a witness and hereby helps the child to reconnect and re-create the sense of reality. The dialogue also implies following the child's lead (guideline 2), listening carefully to the expressed emotions, helping the child regulate her feelings through the intimate dialogue (guideline 3) and through giving the child comfort and praise (guideline 4). However, showing the child love and protection, thus establishing a protective shield, is by far the most fundamental principle (guideline 1).

The meaning creating dialogue addresses cognitive processes. The child needs mediating assistance in several areas. First of all children need to understand what has happened during the traumatic event, whether there has been a political conflict, war, a natural catastrophe, an accident, or relational violence and abuse. The child will often need the help of an adult to make the outer world comprehensible.

Of equal importance is addressing the child's inner world. Sometimes trauma reactions like nightmares and mood swings can be as frightening as the memory of the event itself. That is why many intervention programmes address the need for psycho-education. The meaning creating dialogue can be used to help the child understand and accept her own reactions as natural and common reactions to unnatural and uncommon events and give her a vocabulary and an awareness for own emotions and thoughts (guideline 6). The expansion guideline (7) in the meaning creating dialogue can also be utilized to have an interaction with the child about existential meaning, a topic we sometimes underestimate children's need for.

We also know that children often attribute guilt to themselves. In order to grasp the child's own ideas the caregiver has to explore and share the child's associations and questions (guideline 5 – joint attention). If not dealt with, the misinterpretation of responsibility might result in shame and sense of worthlessness .

The regulating dialogue, emphasising scaffolding and step by step planning (guideline 8), can assist the child in developing good coping strategies and self-control. Living in circumstances with violence, abuse and neglect can be experienced as living in chaos. After experiencing traumas, it is of the utmost importance to address the child's understanding of values, of principles of responsibility for own actions and consequences for herself and others. The regulating dialogue addresses what values to agree upon and share in the family. Finally, the step by step planning assists the child in influencing and planning the future and enhancing the child's internal locus of control.

Clinical vignettes

Example 1 from South Africa

The ICDP was implemented by a team from Regional Centre for Child and Adolescent Mental Health (RBUP) in a township in South Africa. Participants were caregivers working in daycare centres , in training to become facilitators (www.icdp.info/ RBUP- Gamalakhe) In one group of caregivers the facilitator noticed that one of the participants seemed emotionally very affected by a discussion on sexual abuse. During the break the facilitator asked the participating mother whether it would be ok for her to share her personal experience during the rest of the group

meeting. The mother then told the group that her daughter had been violently raped and that they had reported the crime to the police without any action from the police. The daughter got pregnant from the rape and gave birth to a baby girl. The mother of the infant died and the little girl was now living with her grandmother (the participant in the ICDP group). The facilitator practiced empathic listening and showed comfort and support during the process (emotional dialogue). However, when following the mothers associations and lead, the most stressful part of the story showed not to be the burden of the past, but the worries for the future. According to the beliefs in her culture, the grandmother was convinced that a child conceived in rape would herself be exposed to rape and possibly die. The facilitator focused upon the meaning creating dialogue, explored the ideas and helped the grandmother to redefine her conception of the child, not as a victim to a predestined fate, but as a child in her care, a child now in a safe and caring environment. The cultural ideas of predestination were shared with other participant. Focus and attention was paid to exploring, explaining and expanding the understanding of the consequences of rape, the effects rape has on the victim, the family and the generations to come.

Example 2 from South Africa (same context)
In a group training to become facilitators one of the members presented a problem in her own family. She was a single mother of three children, and in addition she also had the child of her dead sister in her care. According to the rules in her congregation, she was strongly advised not to talk about death to the children. However, the little girl had now started to ask why there was no picture of her as an infant in their home. The siblings had also hinted something about her not being a real sister. There was a general discussion in the group on how to talk with children about death, what kind of questions they have, and what they need to know. During the next meeting the mother reported how she had sat down with the girl, initiating a dialogue that opened up for questions and explanations. She had given the girl a picture of the biological mother and together they had visited her grave. This gave an opening to a stronger bond and attachment between the caregiver and the child.

Example 3 from Norway
In Norway unaccompanied asylum seekers under the age of 15 years are the responsibility of the Child Protection Service and are placed in caring institutions. We conducted the ICDP with a group of professionals working at such a center. In spite of the experience the children carry from their homeland, the strain following their flight to Norway and the uncertainty about the future, many of these children show a resilient capacity in adapting to an entirely new environment. The caregivers were eager to strengthen these resilience factors in the children, but sometimes they were confronted with behavior they found difficult to understand. The professionals gave many examples of hoarding behavior among the children. Sometimes it was craving for food and hiding it and sometimes it appeared even more irrational, hoarding the Easter decoration or hiding all the plants from the sitting room under their bed. This behavior was often perceived by the staff as greediness, impoliteness, selfishness and being ungrateful. The staff was interested in how the ICDP could help them to understand the children better and to get a positive conception of them. Ideas were exchanged on how hunger and lack of material necessities had been their daily experience, creating a desperate craving. Helping the staff to get a new understanding of the behavior and a more positive view of the children motivated them to find better ways of dealing with hoarding behavior. This behavior had also caused conflicts among the children. Rejection and marginalizing was therefore important to prevent.
Through step by step planning with the children involved, they learned a way of controlling their impulse to hoard. The children further developed new coping skills to express

themselves.

Summing up

Evaluation of the ICDP programme has so far been limited. An extensive evaluation of the programme is conducted by Looraine Sherr, University of London in cooperation with Department of Psychology, University of Oslo. Preliminary results show promising effects. Final results will published in 2012.

However we have tried to describe and discuss how the ICDP principles can be applied in working with traumatized children and that the principles can be useful in addressing of the main trauma reactions, and reactivate central resilience factors.

The main components in the ICDP correspond to the core principles in the Convention on the Rights of the Child by addressing values in upbringing and the positive perception of children.

The ICDP sensitizes caregivers to children's psychological needs, consequently serving their right to provision, giving them a shield against harmful experiences (providing protection) and listening to how the children want to influence their own lives (confer the three P's). By strengthening the caregivers' sensitivity and improving the quality of interaction with the children, the ICDP can be seen as a programme promoting children's rights.

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HELPING FAMILIES FROM WAR TO PEACE: TRAUMA - STABILIZING PRINCIPLES FOR HELPERS, PARENTS AND CHILDREN

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Abstract

It is in the context of relationships healing after trauma takes place. What are the implications of modern trauma theory for teachers, therapists, community health workers, youth workers and parents to support the healing processes after horrors of war? This article is intended as a translation of modern trauma theory into 10 practical principles for people working with war traumatized refugee families. Complex trauma exposure can be caused by war, and children exposed to complex trauma often experience lifelong problems. Research tells us that refugees have psychological trauma symptoms 3 years after arrival to a safe country. The 10 principles for effective trauma stabilizing are developed after a 2 year project with Chechnian refugees in Norway. They are a derived through qualitative information, our clinical understanding combined with trauma theory. The trauma theory in this project has mainly been: Phase oriented treatment, in particular the phase of stabilization, the Polyvagal theory, to describe the universal functioning of the human nervous system in danger and the concept of bottom up processing in neuropsychology.

Keywords: Complex trauma, family treatment, war, Chechnia, Stabilization

Rezumat

În contextul relațiilor are loc vindecarea după traumă. Ce implicații are teoria modernă a traumei pentru profesori, terapeuți, lucrătorii comunitari în domeniul sănătății, lucrătorii cu tinerii și părinții implicați în sprijinirea proceselor de vindecare în urma ororilor războiului? Acest articol intenționează o transpunere a teoriei moderne a traumei în 10 principii practice pentru lucrătorii cu familiile refugiate traumatizate de război. Expunerea la trauma complexă poate fi provocată de război iar copiii care au fost expuși la traume complexe dezvoltă adeseori probleme ce le afectează întreaga viață. Cercetătorii arată că refugiații prezintă simptome de traumă complexă chiar și la 3 ani de la sosirea într-o țară care le dă securitate. Cele 10 principii pentru stabilizarea eficientă a traumei sunt dezvoltate în urma unui proiect de 2 ani cu refugiații ceceni aflați în Norvegia. Ele sunt derivate în baza unei informații calitative, a comprehensiunii noastre clinice, combinate cu teoria traumei. Teoria traumei în acest proiect s-a referit mai

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ales la: terapia orientată fazal, în particular faza de stabilizare, teoria polivagală, descriind funcționarea universală a sistemului nervos uman, în situații de pericol și conceptul proceselor considerate de jos în sus din neuropsihologie.

Cuvinte cheie: Traumă complexă, terapie familială, război, Cecenia, stabilizare

Introduction

Refugees

The Norwegian Refugee Council defines a refugee as: "any person who has left his/ her country based on well- founded fear to be prosecuted due to race, religion, nationality, political viewpoint or belonging to a certain social group" (Lindstad and Skretteberg, 2011, pp 33). UNHCR states that in 2010 there were 43, 7 million refugees. 27, 5 millions of these crossed the border of their country and applied asylum elsewhere. This is the highest number since the beginning of this millennium. 358 840 refugees fled to the western world, and 10 064 of these refugees came to Norway (Lindstad and Skretteberg, 2011).

The traumatic effect of war on families

Figley and Nash (2007, cover) write that "left unchecked, the psychological effects of combat exposure can be devastating to combatants, their families and communities". They further write that "war is likely the toughest challenge a person can face, especially for the teenagers and young adults..." (pp 17). They list up different physical stressors of war as sleep deprivation, memories of noises and blasts, fumes and smells: "Combatants in the field must learn to function on no more than 4 hours sleep at a time- sometimes considerably less." (pp 19). They go on listing up cognitive stressors as helplessness and the horror of carnage; "The greater the identification with the damaged person, the greater the threat to one's own sense of insecurity and vulnerability (pp 27)."

Many war refugees have faced the stressors described by Figley and Nash, especially those who have been in active battle. Lie (2003) found, in her study of 462 refugees, in Norway that 3 years after arriving to Norway the trauma symptoms were still high. The symptoms were worsened by unemployment, worries about family in their home country, lack of support and lack of family in Norway. Research done by the Norwegian Statistics Bureau shows greater psychological difficulties among immigrants in general compared to ethnic Norwegians. Refugees were included in the immigrant population in this study. Immigrants reported as much as three times as often nervousness, inner turmoil and feeling worried. They were four times more likely to experience fear and anxiety, hopelessness, depression (Blom, S. 2010).

Edward Tick says *(2005, pp 2): "War veterans and their families have helped me learn that the traumatic aftermath of war and violence creates wounds so deep they have to be addressed with extraordinary attention, extraordinary resources as well as extraordinary methods. Conventional methods are not adequate for describe these wounds".* War traumas are collective traumas; it is a traumatic experience that affects the entire family as opposed to one family member, the entire society as well as the culture. War affects existence: the meaning, the hope, the pride and the feeling of safety for a group of human beings, both children and adults. War affects parent's ability to be a safe haven for their children, as well as children's ability to trust that they are safe with their parents. "Under most conditions parents are able to help their distressed children restore a sense of safety and control...When trauma occurs in the presence of a supportive, if helpless, caregiver, the child's response is likely to mimic that of the parent – the more disorganized the parent, the more disorganized the child" (Van der Kolk, 2005, pp 403).