An introduction to the ICDP Programme[1]

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In order to assist children on a large scale, a new strategy is needed that goes beyond individual clinical consultation and therapy – it must be a strategy that can deal with groups, communities, institutions and networks. The World Heath Organisation recognized the need for such a strategy already in 1978 in a meeting in Alma Ata and since then it has spread all over the world, particularly in the poorest countries (see UNICEF annual reports)

The idea of a community based programme of psycho-social care.
We call this strategy or approach "community based" because the idea is that human resources in the local community should be mobilised and educated to a certain level so that the community itself can take care of its own needs in whatever field this strategy is applied. Instead of *dependence* on outside expertise, the idea of community based intervention is rather to *empower* the community to handle its own needs in line with its own traditional practices, and this may in addition require actions to reactivate and recreate new respect for its own local knowledge and skills in the relevant field. Through this approach it is hoped that sustainable systems may develop that can become an integral part of the local mentality and the traditional culture (Freire 1975, Hundeide 2000).

When the idea of a community based approach is adapted to the field of psycho-social care, there is a need to identify what are the psycho-social needs within this field. Are these needs also recognized by the community itself, or are they new creations from applying standards and criteria of a highly developed Western society? Is there evidence that neglecting these needs will have negative consequences for children's long-term development? For example in the field of psycho-social care, long-term effects of psycho-social neglect may first become visible when children enter school through delayed mental development and ensuing drop out of school.

When these needs are identified the next step is to identifying networks, groups or communities that can become the target for intervention. This also involves identification of local resource-persons that are respected and influential in the local community, who can, after some training, become local paraprofessional facilitators. The programme and the training should then be adapted to the local needs and traditions, so that they can be easily understood and adopted by the local community. In the ICDP Programme this is more like a process of facilitation and sensitisation than a process of imposive instruction.

These are some questions that should be raised initially, particularly in the field of psycho-social care because it is so closely linked to cultural practices and conceptions that we may easily ignore the local ways of dealing with such needs and problems (Woodhead 1999).

Adopting a community based strategy implies a change of the traditional expert role - *from being therapist in direct curative contact with the single clients to becoming an educator and*

[1] This paper is a short version of a more extensive paper by the same author called "An outline of the ICDP Program" which also includes evaluation studies and extensive references. For other information on ICDP, see: www.icdp.info

supervisor of local paraprofessional facilitators who may be working with groups of caregivers – very often mothers - in a preventive way. For many experts this is a difficult transition, because it requires a new more equalitarian role with new ways of communicating…

When a community based strategy is applied to field of children's psycho-social health and education, the focus will be, not so much on the child itself in a curative or therapeutic sense, as *to provide the child's caregivers with crucial preventive information and strategies that may have sustainable long-term effects for the child's well-being and development.*

The objectives of the ICDP Programme

In the ICDP programme we are focusing on the positive caring skills that the caregiver already possesses. It is our assumption that the problems of caregiving are not related to the acquisition of new caring skills, but how to help caregivers overcome the obstacles that prevent them from applying the skills or competencies they already posses in their daily life. The problem is therefore not of acquisition and instruction, but of facilitation and sensitisation – to reactivate the positive skills that they already possess.

In the ICDP programme we are focusing on the following objectives:

A. To **assist the psycho-social needs of children at risk through a simple program that can be implemented on a large scale** and in a community based way towards the child's caregivers or caregiving-networks.

B. In order to assist children's psycho-social needs, the primary objective is **to promote and improve the communication and the relationship between a child and its caregiver(s**), as this is considered the key to a child's development.

C. **To influence the caregiver's conception and experience of her child**, so that she sees the child in a positive way, identifies with and 'feels with the child', senses and knows his state and adjusts her caring actions and companionship to the child's needs and initiatives. In addition it is important to strengthen her self-confidence and joy as caregiver.

D. **To promote sensitive emotional expressive communication and interaction between the caregiver and the child** which may lead to positive emotional and playful relationship between them.

E. **To promote an enriching (mediational) interaction between the caregiver and the child** which extends and guides the child's experience and activity in relation to his or her environment. This includes also regulation and limit-setting.

F. **These objectives should be implemented in a non-imposive way through a process of sensitisation**, in which positive aspects of the caregiver's existing interaction with the child are pointed out and reactivated. This implies also a reactivation of the positive aspects of their existing cultural caring resources.

Points C and D above relate to the quality of interaction between the caregiver and the child. In order to convey this in as simple a way as possible, we have developed *'eight guidelines for good interaction'* (or the three dialogues[2].). These guidelines are not meant to be prescriptive and instructive, they are more meant to serve as a framework for exercises of reactivation and mobilisation of the caregiver's own experience of relating and caring for their child. By having these very general and common sense guidelines as a reference, it becomes easier for simpleminded caregivers to understand the task of reconstructing and evaluating the quality of their own interaction, relationships and care of their own children. (A short version of the guidelines is presented in the appendix). These guidelines have been formulated in as simple a way as possible so that caregivers without academic background can easily identify their own feelings and experiences with the examples of the guidelines.[3]

In general the construction and conceptualisation of this programme is based on an interpretive and empathic approach where we try to remain as close as possible to the conceptions and empathic experiences of the participants. *By supporting and expanding their own experiences of care, we also help them to rely on their own positive experiences and practices relating to children. Strengthening their confidence in themselves as caregivers is a key point in this programme.*

The programme itself is divided into five components related to the aspects mentioned above:

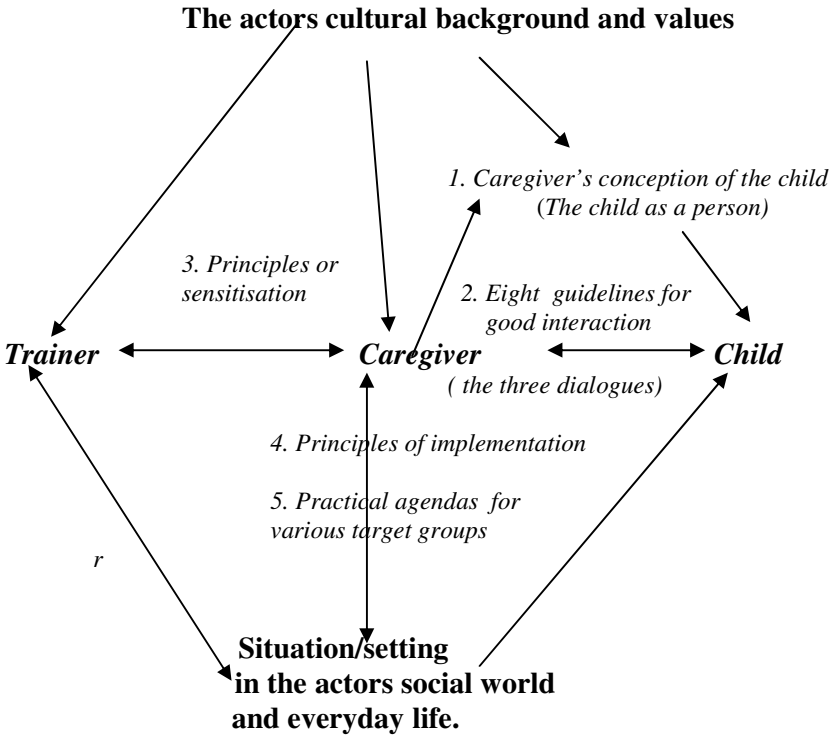
1. The caregiver's conception of the child
2. The eight guidelines of interaction and the three dialogues
3. The principles of sensitization
4. The principles of implementation
5. Applications: Special curricula based on the same basic principles are developed in the fields of health clinics, institutions and preschools, schools, community work in poor communities, in refugee camps, trauma, street children.

Each of these components is indicated in the figure below:

[2] The 8 guidelines are also described shortly as the three dialogues: 1. The emotional- expressive dialogue, 2. The meaning oriented and expansive dialogue. 3. The regulative and limit-setting dialogue (see page).

[3] Operating without any guidelines has proved to be difficult and leads to frustration and confusion. The typical response has been that 'it was only talk..' The 8 guidelines of good interaction on the other hand seem to give the caregivers something concrete to hold onto and in practice have proved to be an important tool for simpleminded caregivers.

Figure 1: Some central components in the ICDP Program.



The two first components; the caregiver's conception of the child (1) and the guidelines of good interaction and the three dialogues (2) refer to the relationship between caregiver and child as indicated in the figure. The next component; the principles of sensitization (3) refers to the interaction between the trainer or facilitator and the caregiver. The principles of implementation (4) refers to the conditions that need to be present in order for a sensitisation to be effective and sustainable, and the different curricula of application (5) are specifications of the programme directed towards different target groups like health clinics, home-based, institutions, pre-schools, schools and refugee camps.

In addition, all these components are framed, on the one side, by the cultural background and values of the target group, and on the other by its situational settings and the contexts of everyday life, as indicated in the figure above.

In the following section each of these components will be discussed.

I. The caregiver's conception of the child

Basic to the caring process is the way caregivers see and define their child: When a child's utterances and actions are taken as expressions of feelings, experiences, wishes and initiatives that the caregiver can recognize from her own experience in similar situations, this may open up and invite an empathic response in the caregiver so that she can join in and participate in

the child's experience.[4] The capacity to observe and 'feel with' the child's initiatives, experiences and mental states is therefore essential. This is what I have called *'empathic identification*'. There are here different descriptions for the same thing; like 'empathic responsiveness' (Robert Emde 1989[5]

It is our assumption that this gives a sustainable basis for appropriate care in line with the child's experience (Hundeide 1989, 1991, 2000).

Seeing a child as a person, gives only the general conditions for care, in addition comes how this particular child is defined as a person with special individual qualities of character, personality, motives, competence, (for good and bad). Caregivers will respond to a child not only as a person, but as a person with characteristic qualities and adapt their caring responses accordingly. Therefore, when a child is neglected or abandoned this is not necessarily due to lack of caring skills, it is just as likely that this is a consequence of being negatively defined by his caregivers. *When a child is seen as bad, psychopathic or evil and possessed, this will naturally invite a non-empathic objectified relationship, which may prevent the caregiver's potential for positive caring. Such negative labels may initiate and fixate a negative self-fulfilling developmental process in the caregiver-child relationship* (Woodhead 1990).

In order to prevent this from happening, we need a different approach where the emphasis is put on identifying and pointing out positive features and resources in the child, rather than the deficiencies and the deviant features - which is the traditional way of assessment (Hundeide 1991, chapter 6).[6]

Empathic identification and the zone of intimacy as the key to responsive care

As mentioned above, the participatory involvement with the child's experiences and feelings, is what I have called "empathic identification" with the child (or the 'victim'), and we assume this is the underlying mechanism behind sensitive human care and companionship (Trevarthen 1995, Braaten 1996, Stern 1996). If that is the case, how do we promote or facilitate such identification in caregivers that do not seem to possess or express this capacity? This is probably one of the most central issues in early care and psychosocial intervention in caregiver-child relationships.

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[4] Seeing the child as a tender person with human feelings and motives is not at all as obvious as it may seem; the amount of abuse that is reported all over the world indicates that this natural process is very often blocked or not developed.

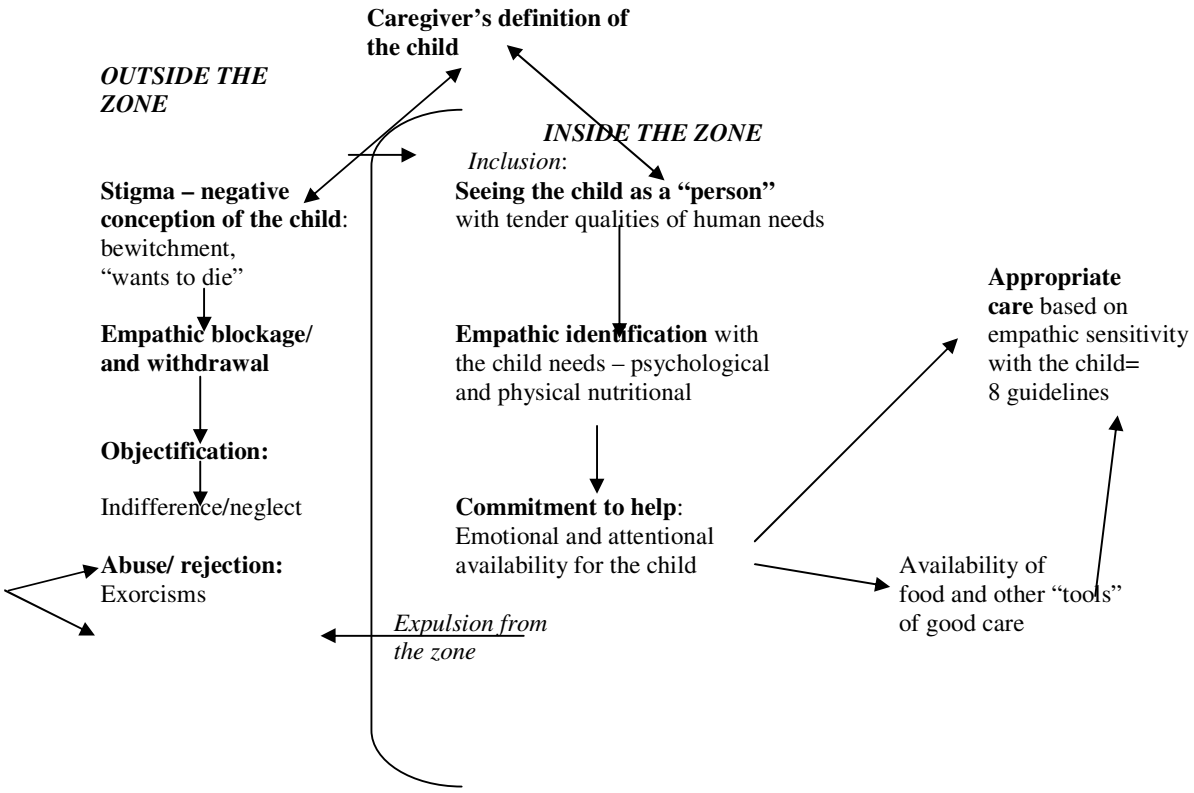
[5] This may be a process of a direct, unmediated emotional-participatory nature that Trevarthen (1996) describes as 'sympathetic appreciation of motives' and Bråten (2000) as "altercentric participation" with the child.

[6] Vygotsky also emphasizes, in his concept of 'zone of proximal development', the need for more positive and dynamic approach to diagnostics that looks for the child's developmental potential (Vygotsky 1987).

It seems as if we have a zone of intimacy around us (Hall 1978) and those who are inside that zone, are those with whom we feel more easily empathy, participation, companionship and compassion, while those who are outside that zone, we tend to feel more indifferent towards. Although we can cognitively recognize the suffering of strangers who are 'outside' the zone of intimacy, this experience does not have the same emotional, direct quality as when we empathetically share the emotional experience and purposes of someone close to us (Hundeide 1996).

Metaphorically, we can illustrate this zone as a physical border indicating the inside and the outside of the zone of intimacy. In this same conceptualization we can illustrate the process of empathic identification as opposed to indifference or objectification in the processes of inclusion and expulsion/rejection:

Figure 2: MODEL OF HUMAN CARE FOR THE CHILD IN THE ZONE OF INTIMACY



P = person (inside)
(P) = non-person (outside)

This model needs further clarification:

The border of intimacy is both flexible and penetrable. It is flexible in the sense that an episode, like a moving film or story, may temporarily **open up our zone of intimacy** so that we can include and identify empathically with a suffering child outside our intimate network;

'it could have been my own child'.[7] But it can also narrow down into petty self-preoccupation (constriction of the zone).

The border of intimacy is also penetrable both ways. This means that it is possible for an insider **to be expelled from the zone of intimacy** to the outside; p ⟶(p), so that he becomes an outsider, a stranger or even an object with whom the insider does not feel any more empathy or compassion. (I will mention examples of this later on).

Reversibly, it also means that it is possible to include and bring an outsider into our zone of intimacy (p) ⟶ p. In a context of intervention this implies sensitisation of the caregiver so that she starts to feel again the same positive empathic feelings for her child as she did earlier before he was expelled. (See example below).

In concrete terms, bringing in a person from the outside the zone of intimacy involves establishing conditions for empathic identifications (mentioned above) and through intimate dialogue establishes an intimate relationship.[8]

This metaphor of the zone of intimacy has proved to be educationally useful when we deal with caregivers in a process of sensitisation, as we shall see.

In the following section the eight guidelines and three dialogues will be represented as part of the conceptual scheme of zone of intimacy. This is important because the basis for these guidelines and dialogues are empathic identification with the child. Without this sensitivity to the state of the child, they become more like external behavioural procedures out of touch with the driving motive force for human care – namely empathic identification and compassion for the child.

II. The eight guidelines of good interaction, the three dialogues and empathic identification inside the zone of intimacy.

As indicated above, the eight guidelines are more like broad topics or issues that can serve as a framework to organize the caregivers' exchange of personal experiences and viewpoints relating to child-care (see appendix). When we selected these guidelines it was very much with the awareness that our target group would be, not be high educated psychologists, but simpleminded, and in some cases non-literate, caregivers who needed simple labels to direct their attention to those aspects that we know are essential for good interaction. Therefore these guidelines may appear simplistic to an educated mind, still they represent qualities which, when they are present, seem to have a powerful effect on the well-being and the development of the child

In the table below the eight guidelines are summarized and also how they can be presented as "the three dialogues". The guidelines are therefore split into three categories or dialogues: The emotional expressive (1), the meaning oriented and expansive (2), and the regulative and limit-setting (3).[9] These are illustrated in the diagram below:

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[7] Provided the child shows expressive features of feelings that we an recognize.

[8] Culturally there may be rituals of admission and inclusion which are more like institutional codes that go beyond the immediate expressive interchange, i.e. rituals of brotherhood (Turner 1978).

[9] Bornstein(1989) makes the distinction between the social and didactic dialogue.

Table 1: The three dialogues and the guidelines of good interaction.

Dialogue-type	Guidelines of interaction
A. Emotional-expressive dialogue (Emotives)	1. Show positive feelings 2. Follow child's initiative 3. Intimate dialogue 4. Confirmation, praise
B. The meaning oriented and expansive dialogue (Descriptives)	5. Shared attention and focussing 6. Mediation of meaning 7. Expansion and explanation
C. The regulative dialogue (Prescriptives)	8. Regulation: a. Planning step-by-step b. Graded support or scaffolding c. Limit-setting in a positive way d. Challenging the child

A. Emotional-expressive dialogue and the four emotional-expressive guidelines[10]

This refers to the early affectionate 'dialogue' of expressive gestures between caregiver abd child, where the caregiver sensitively adjusts, follows and responds to the expressive initiatives and body language of the child, confirming his signals by commenting approvingly on what he is doing. In this way a real dialogue of emotional expressive intimacy may develop, where a feeling of trust, joy and companionship is shared between them (Trevarthen 1987, 1996, Braaten 1994, Stern 1984, 1994).

This **early emotional-expressive dialogue** seems to be the key to the formation of affectionate relationships and for the child's opening up towards people.[11]

The four guidelines of emotional-expressive communication are the following:

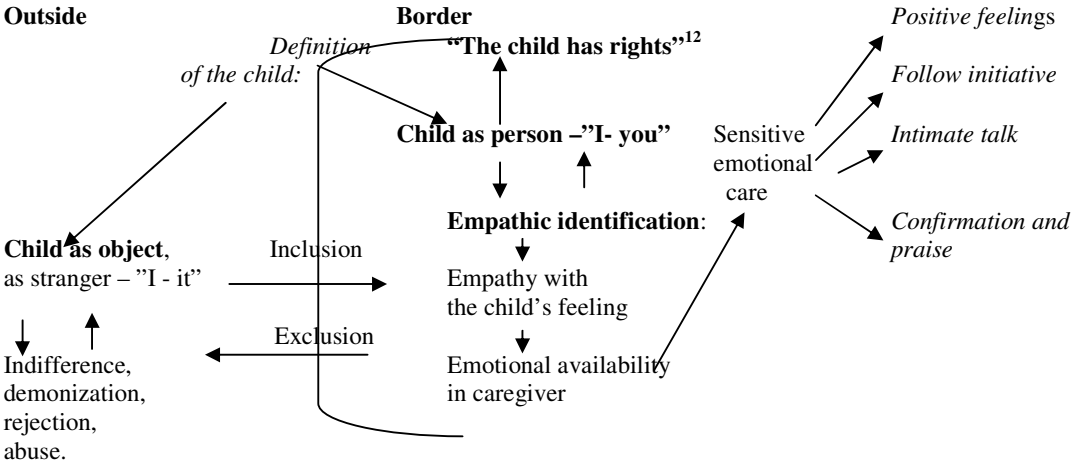
- Expressing positive and loving feelings
- Seeing and responding to the initiative of the child
- Establishing a dialogue of turn-taking (also non verbally)
- Confirming and praising the child for what he /she does well

As pointed above, the four emotional guidelines will appear as natural responses when there is an empathic identification with the child's feelings. This is illustrated in the following way: When a child, inside the zone of intimacy, is seen as a sensitive, tender person, the four emotional guidelines of *showing love, responding to initiatives, establishing a dialogue and giving praise, follow naturally when there is a need for it, because this is the way we naturally communicate with insiders*. Also this works both ways: By communicating with the

[10] We have selected these four guidelines or topics among many possible alternatives because they are simple and easy to understand, they seem to cover the most essential feature of the early emotional expressive dialogue and they are applicable to caregivers of very different cultural background.
[11] These guidelines are not restricted to infancy, they are just as applicable to any stage in life.

child in this sensitive emotional way, the empathic identification and the intimate relationship is strengthened - a positive cycle of care is started.

Figure 3: Zone of intimacy and the dynamics of sensitive care versus objectification and rejection.



If, on the other hand, the child is not an insider, this type of intimate communication is neither easy nor natural. The starting point of getting through the border into positive intimate relationship may in fact be through listening to the child's story, being attentive and responsive to the child's initiative and through establishing positive face-to-face expressive dialogue. This may bring the child inside our zone of intimacy so that the four guidelines come as a natural consequence of our intimate relationship. As the figure indicates, empathic identification with the child' states and feelings, leads naturally to *emotional availability* to the child's initiatives and states which again is the key to sensitive emotional care.

B. The meaning-oriented and expansive dialogue and the three mediational guidelines

A child certainly needs a safe emotional base (Bowlby 1987), but from the end of the first year the infant is also seeking guidance from the caregiver to explore the surrounding world - 'love is no longer enough'. This is the stage that Trevarthen describes as 'secondary intersubjectivity', where the child is able to relate both to the caregiver and to objects in the surrounding world at the same time (Trevarthen and Hubley 1984). This is the time for 'guided participation' (Rogoff 1990) and for what Feuerstein and Klein call **'***mediated learning experiences' MLE.* These are shared experiences which have been prepared by a 'mediator' to fit the child's focus of attention so that the child is reciprocally guided into a shared world of knowledge and values.

Based on Pnina Klein's MISC programme, we have selected three guidelines of mediation to facilitate this development:[13]

[12] "The child has rights" refers to the convention of children's rights. It is only when children are considered as "persons" that the idea of rights become relevant and natural.

- Focusing and shared attention (establishing intersubjectivity)
- Mediation of meaning and enthusiasm
- Expansion / explanation / comparisons beyond the present situation

See appendix where the guidelines are presented as opposites.

Feuerstein describes mediated learning experiences (MLE) in the following way: "In a mediated learning experience, the adult caregiver filters and frames the stimulus regulating the child's behaviour... She, for the primary mediator is usually the mother, organizes the stimulus in time and space... She relates the new experience to previous events and to those that will occur in the future... The child is taught how to focus, to observe and to differentiate."(Klein and Feuerstein 1984, Feuerstein 1980).

In his description of 'joint involvement episodes' (JIE) Schaffer (1996) comes very close to Feuerstein's description of mediated learning experiences especially when it is applied at an early age: *"Establishing a common attentional focus is an essential first step in setting up JIEs, 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 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).

As joint attention and topic sharing is achieved ("joint involvement"), there are different ways of going further depending upon the nature of the episode or task. If it is an *informative context,* the adult and child will be looking together at something, for example into a book, there is pointing at pictures, asking questions "what is that?" answering by labelling and giving explanations. According to the mediational tradition of Feuerstein, *expanding* comes in here as a crucial way of enriching the child's experience. Expanding means that the caregiver gives explanations and "goes beyond" what they see together (depending upon the child's age or stage of development): This can be by giving explanations of why, where it comes from, what it reminds of, what will happen further etc Or it can be by telling stories so that the pictures (or topic) becomes assimilated into a story, a drama or into a more logical conceptual scheme of comparison and classification.

According to Sigel (1977) one important aspect of expansion or "going beyond" is "distancing". The method for creating distance is through *reconstruction and symbolic representation of what the child has experienced* – this creates distance from his immediate experience. Questioning the child is another method that Sigel recommends to achieve this. (See also Blank 1977, Tharp and Gallimore 1988, Pramling 1990 and Rogoff 1990).There is a lot of research showing that joint involvement with expansion is the singly most important factor to promote a child's intellectual development (Sigel 1977, Klein 1995, Carew 1987, Schaffer 1996).

But there are different ways of expanding within an informative context; one way is *narrative-dramatic*: that is to tell stories and use drama and role-play as a method of expansion. The other way, which is more within the scientific tradition, is *logical-analytic* through classification and comparison, causal explanations etc. (Bruner 1989, Hundeide

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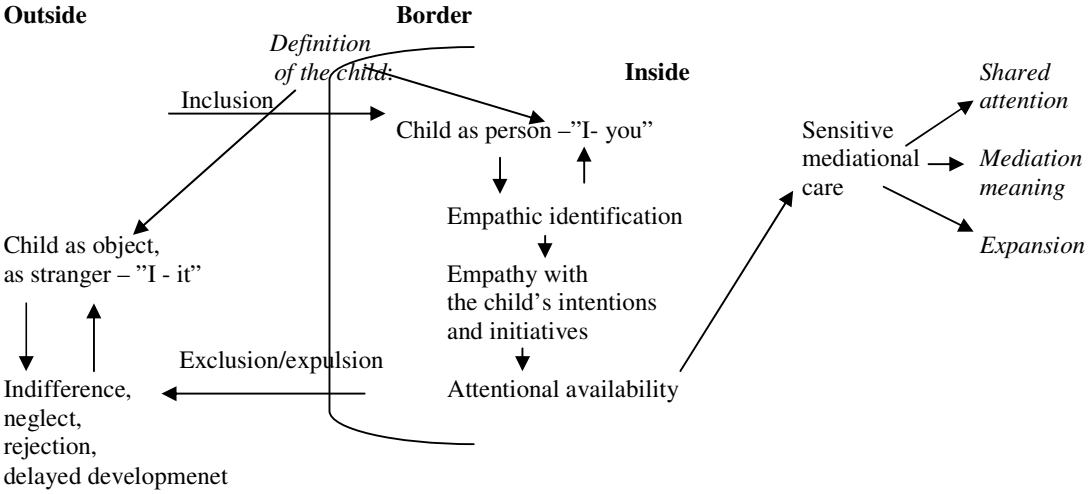
[13] In the same way as with the emotional guidelines, other aspects could have been chosen (Feuerstein 1989, Schaffer 1996, Tomasello 1999), still we believe these three guidelines are essential in order to trigger mediational interaction.

1996). Both these ways are important as they prepare children for different fields of human culture, namely the poetic-artistic and moral on the one hand, and the scientific-technical and computational, on the other (Engel 1995).

From the point of view of communication, mediation should be understood as a natural and contingent response to the child's explorative initiatives in a joint involvement episode - not as an artificial didactic procedure that the caregiver has to be taught out of context. In fact, mediation in this sense can be seen as *another manifestation of the process of empathic identification*. The difference from the emotional empathic identification previously described is that now it is not only the child's feelings but his explorative initiatives and intentions which are the focus of empathy.[14]

The model of zone of intimacy can therefore be applied in a similar way to the mediational as to the emotional guidelines:

Figur 4: Zone of intimacy



P = person (inside)
(P) = non-person (outside)

As indicated above; a slightly different perception of the child during mediational interaction compared with emotional expressive communication: In both cases the caregiver needs to see the child as a person with intentions, wishes, human feelings and reactions, and in both cases there is a need for the caregiver *to be available,* but in the case of mediation the focus is more on *attentional availability to what the child wants to know and explore*, his intentions and

[14] In her concept of 'guided participation' and 'intersubjectivity' Rogoff (1990) comes very close to a similar conception of mediation. She emphasizes the caregiver's facilitation of the infant's exploratory initiatives through, a) bridging between the new and the familiar skills / meanings needed in the situation, b) structuring the setting for the child and c) gradual transfer of responsibility for managing situations.

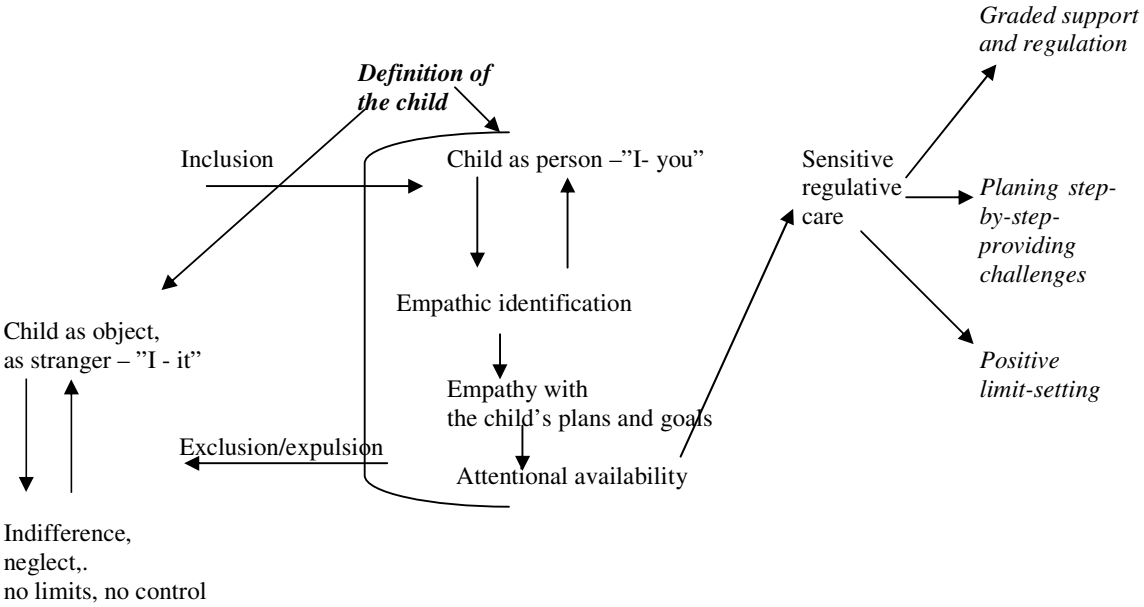
initiatives to explore the surrounding world and his capacities for acting and getting involved in action-projects, in socio-dramatic pretend play and in more problem oriented play-projects. Through his exploring initiatives, the child invites guided assistance or "mediation" from the caregiver. When this assistance is given in accordance with the child's need to sustain and complete the task at hand; neither too much nor too little, the optimal condition for mediational learning seems to take place, according to Wood (1989) and Bruner (1989).

C. The regulative dialogue and the three regulative guidelines

When the context is *regulative and goal-directed*, the assistance will take a different shape than when it is informative (see above). Within the regulative context expanding and explaining is usually not the essential point, *rather supporting, guiding, hinting and directing*: When a child is involved in a goal-directed activity like a construction task (building a tower with bricks), or solving a problem in mathematics, the adult tends to apply the "*scaffolding strategy*" by adjusting the level of instruction to the child so that the child is assisted, by hints and directive comments, when he fails. At the same time assistance is gradually withdrawn as the child gains more control and mastery of the task (Wood 1996).

In a similar as with emotional and mediational communication, the regulative or directive communication is also based on the caregiver's sensitivity to the child's initiatives. In this case it is the child's goal-directed initiatives, his plans and goals, as the figure below shows:

Figure 5: Zone of intimacy: Regulation



As with meditional communication, it is *attentional availability to the child's plans and action-initiatives* which leads naturally to a supportive "scaffolding" strategy of interacting with the child. Certainly in this case the danger is that the caregiver takes over the initiative task and thus prevents the child from feeling mastery and autonomy in relation to the task.

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

a) *Guiding and supporting the child's action initiatives without taking over*. This is the strategy which has been described as "scaffolding" and which has been described by Wood and Bruner (op cit.). This strategy is also arising from joint involvement episodes and shared attention and topics, but when the context is goal-directed, this leads naturally to regulative communication which is graded according to the child-s level of competence on the one hand, and on the difficulty of the task on the other.

b) Challenging the child "one step ahead". According to Heckhausen (1987) and Vygotsky (1978), the optimal strategy in a task and goal-oriented problem-situation should be based on the principle of challenging the child "one step ahead": The adult focuses the child's attention on those aspects of the task that is just beyond the level of his present competence - the child has to "stretch" to reach the goal indicated. This is a strategy that most caregivers spontaneously seem to apply. But of course it requires sensitivity to the child's focus of attention, intentionality and capacity. And even if sensitivity fails, it seems that most normal children are able to picks up the instructions or hints that they can use in their ongoing goal-directed activity.[15] In other words, a child is not only a passive recipient, but an active partner in selecting the guidance and care that he receives (Schaffer 1996,p. 267).

c) Positive limit-setting. [16]Positive regulation in the sense of "limit-setting" on the other hand is carried out in a friendly atmosphere, the child is respected as a person. Instead of shouting and negative commands, *explanations are given for why things are not allowed and why certain rules or prohibitions are necessary, rule are negotiated and agreed on, also the consequences for breaking them***.** This is according to Hoffman one of the most important differences between good and bad control-procedures in child rearing and forms the basis both for the development of accountability and altruism in children (Hoffman 1979).

At the same time, as prohibited actions are pointed out in a clear and firm way with explanations, the child's attention is redirected to what he is permitted to do.(Zahn-Waxler 1990, Eisen berg 1992) This is an important point, particularly with young children, because emphasising and pointing out what they are not allowed to do, sometimes fixes their attention on exactly the negative actions, and thus prevents them to act more positively. *Redirection of attention* is therefore an important strategy particularly with young children, but also at a higher age-levels where inactivity and aimlessness easily leads to a cycle of negative actions.

Both within the Vygotsky and the Feuerstein tradition there has been a strong emphasis on the importance of regulation; particularly on how "self-regulation" develops from "other-regulation", how guided interaction becomes automatized and internalized as inner control and anticipations so that the child is able to guide himself and anticipate the consequences of his own action-initiatives. This is the key to inner control, according to Vygotsky (1978), and it is assumed also within the Feuersteinian tradition, that guided mediational interaction in a

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[15] It is interesting that most sensitive caregivers do not have any problems in adjusting to the child's "level" despite lacking academic knowledge of stages. It seems as long as they are able to attend to the child's intentionality and initiatives, this is sufficient. Besides the child regulates what it needs (Heckhausen 1987).

[16] 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).

regulative context may also facilitate the development of control in the child in general – also in the moral field (Hoffman 2000).

III. Some principles of sensitisation in the training of caregivers[17]

In line with the theoretical conceptions developed in the previous section, the problem of sensitising the caregiver is first and foremost how to activate the caregiver's mechanism of empathic identification with the child. It is only when this process is operative that one can expect a more sustainable change in the relationship. The question is then, how do we achieve that.

1. Positive redefinition of the child

As already indicated, the caregiver's perception of the child is essential for whether a feelings of empathy and understanding may be released and a positive cycle of caring get started.

In the ICDP programme we have adopted the following four strategies to promote a more positive image of the child:

a. Pointing out positive features and qualities of the child

Always trying to point out some positive feature in each child. It can be anything, from beautiful hair and eyes, to how sensitively the child responds when you touch him gently. Talk about the child with respect and in a positive way which may influence the caregiver's attitude. This is a very simple, but powerful technique.

b. Re-label positively the negative features of the child

This is almost the same as point A. In many cases there are obvious negative features in the child's behaviour, like aggression and disruptive, disturbing behaviour. In such cases, it is sometimes possible to promote a more positive definition of the child by re-labelling the negative behaviour from aggressive and self-centred to 'attention-seeking' - why is the child always trying to be the focus of attention? This new label opens up for a more positive way of looking at the child's problem: How can we give him more attention and love so that his disruptive behaviour diminishes? This is one possibility. There are other examples, including the child's physical appearance, it is always possible to see a tender beauty in most children whatever their physical appearance. When caregivers see the tender helplessness of a child when it struggles to win the parents' love and acceptance, this tends to release 'empathic identification with the child'.

c. Reactivate good memories of an earlier positive relationship with the child

This recommendation applies particularly to parents who have, through the stresses of life, developed a negative or abusive relationship with their children. In such cases it may be helpful to go back to positive memories from when the relationship was good. Asking the

[17] The word sensitization is used here in order to indicate that *the objective of the ICDP Programme is not to teach or instruct some new caring skills, but rather to mobilize already existing positive skills in the caregiver's repertoire and to help her or him to use these skills to the proper subject and situation*. This is the reason why there is such a strong emphasis on how the child is defined and how empathic identification is released.

caregiver to describe her feelings and tell stories about the child during this period, and this may help to bring back a positive image of the child.

2. How to talk to caregivers[18]

As pointed out by Fonagy (1996), the 'capacity for mentalising' that is 'the caregiver's capacity to observe the moment to moment changes in the child's mental state' is critical for adequate care. Seeing the child as a person, as an intentional being with normal human feelings is part of that, but the question is how do we promote the caregiver's sensitivity to child's mental states - emotions and intentions?

How we talk to the caregivers about the child, is, I believe, important in this connection. Using an empathic interpretive way of talking where the focus is on the child's subjective feelings and experiences, is like opening up the child's subjectivity as a legitimate topic of discourse. In typical situations of neglect and child abuse, the child's subjective feelings are very often ignored and rejected as a non-acceptable subject for discussion (Ryan 1970).
Therefore, *using an empathic interpretive style of speech (genre) focusing on the child's feelings, intentions and experiences may help to sensitise and raise the caregiver's awareness in this field.* In order to do that, one has sometimes to pretend that one knows what the child is feeling; 'you know, when you praise your child for what he has done, he will feel much more confident and he will know that you appreciate what he does etc...' The point is not whether the child really feels this or not, the point is that this type of discourse opens up and legitimises the child's mental state as a topic to be dealt with. For some caregivers, even accepting to talk about the child's feelings and psychological states, is already an important step towards a more humanized and sensitive relationship.

When we combine the points above about promoting a positive conception of the child combined with sensitive talk about his state of feeling, we have already a powerful tool to promote a more empathic and human attitude towards the child. I will mention an example from a developing country to illustrate this point.

A case from Angola

In the rural areas of Angola the beliefs in magic are still quite strong and very often a child showing some deviant behaviour is believed to be possessed or bewitched. This stigma tends to have negative consequences for a child because he will be rejected by his family and very often expelled from the home. In our project we have quite a few such children. One case is Pedro, he had been through traumatic war experiences seeing soldiers killing his family. He lives with his grandmother and the other children do not want to play with him because they believe he is a 'witch'. He does not talk and play with anyone and he is all the time singing to himself. When someone approaches him he becomes aggressive and threatens them with a stick.

One of our facilitators, Abel, talked to his grandmother who is still alive, and she says she does not understand why he is always alone singing to himself. As Abel had learned that 'following the child's initiative' (guideline 2) is a good way of establishing contact, he started

[18] 'Caregivers' are used throughout this paper instead of mothers and parents. This is so because caregivers in our work in ICDP can vary from mothers, fathers, grandparents, leaders of institutions, nurses and older siblings.

to listen to the boy's singing and soon learned the song he was repeating. Next day he approached Pedro by singing his song. Pedro looked puzzled and stared at Abel; 'who is singing my song?' He grasped the stick, but did not know how to react. Abel went closer to him and said: 'I would like to hear you singing, it is such a beautiful song.' Pedro reacted by singing the song with Abel, who went further and said: 'Let us talk together and go on and play with the other children', but Pedro resisted that although there was a clear change in his attitude.

Later Abel talked to the other children and explained to them that Pedro was not possessed or bewitched, that he was acting strangely because he had been suffering so much after having seen his family being killed. He told them that he was withdrawing into himself and singing because this was his way of feeling safe in a world that he experienced as threatening. The other children were touched by his story and Abel taught them to sing Pedro's song and agreed with them, that next day they would sing the song with him. Next day Abel brought Pedro to the other children and told them that Pedro was a good singer and that he would sing a song for them. He started to sing the song, but to his surprise all the other children joined in. This was repeated many times and after that there was a dramatic change in Pedro. He started to play and sing with the other children who now accepted him. Gradually, Pedro got a new image of himself as an accepted member of the group. This was the start of his recovery.[19]

In this story we see a simple demonstration of how a facilitator is able to redefine children's negative conceptions of a child through sensitive and interpretive talk that explains his deviant symptoms as an understandable utterance originating in extreme suffering of loss, isolation and distrust. In fact, a child's story, when sensitively told, can be a powerful means to reactivate feelings of empathy and compassion, and to redefine positively stigma related to deviations from normal behaviour.

This story also illustrates that accepting a child's initiative (in this case the singing) as a meaningful and acceptable communicative utterance, has a strong impact on a child. It is at the same time both a confirmation of acceptance and inclusion with others and confirmation of the child's freedom and autonomy.

Using stories to raise the caregiver's interpretive-empathic sensitivity for the child is one function of using stories, but there is another function that is just as important. For most simple-minded caregivers abstract principled explanations do not have much impact, it is the story and preferably *the personal story* that makes an impression. Therefore, we recommend as a general rule that facilitators collect a series of stories preferably personal, in the form such as: 'according to my experience, when I was bringing up my child, I noticed that...'. *Explaining principles through personal examples told as stories, seems to be the most effective way to communicate with most caregivers - it becomes more like sharing experiences instead of instruction.*

3. Self-initiated activity and exemplification

The story is not only useful as a tool for assimilating messages, it is also useful for activation and personalizing ones own experience and tacit understanding. By requesting caregivers to

[19] This story was told by Milu, one of our trainers. Pedro lives in Huambo, a city that was completely destroyed in the recent war.

exemplify and tell stories about their experience in some field, they have to put their experience into words and into a story and that in itself is a consciousness-raising and interpersonal achievement that structures their personal understanding (Brown and Palincsar 1988).

In relation to the guidelines of good interaction, there are three techniques we use for activation and personalization:

a. Exemplification of own interactions with the child

The participants are asked to bring examples and tell stories about their own experiences with their children that illustrate the eight guidelines. This is another active educative principle that forces the participants to select and verbalize samples of their own interactions.

b. Observational tasks relating to the child

These are simple observational tasks that the caregivers bring home and share with the rest of their family. This can be tasks like - 'how does your child react when you..?' (i.e. the four emotional guidelines) or 'try to find what are the qualities that you appreciate most in your child?'etc. These tasks were quite popular and seem to help caregivers to discover their child as a psychological person with his entire human qualities and competencies.

c. Self-assessment of own interaction

This is used as an educational technique. By assessing their own interactive practice, this brings them into an active position in relation to the guidelines. This is important because these guidelines are so simple and common-sensical that their significance may easily be overlooked. First when they are applied in a practical context of personal self-assessment do their importance as guidelines for action appear.

d. Testing out new ways of communicating with the child.

After having gained some insight into their own strengths and weaknesses throughself-assessment, they will also have a notion of which parts could be strengthened or which kind of interactive episodes with the child could be improved or "dealt with in an alternative way". Based on this insight they construct their own exercises for improvement and for testing out new alternatives which constitutes an important part of a strategy of change.

All the exercises that are mentioned above constitute *home-work* – things that they should test out in their homes with their own children and report back to their group (see below). In this way also other family members may also share and support the implementation of the program in practice.

4. Using the eight guidelines as a basis of consciousness-raising, self-assessment and exemplification

These guidelines may appear simplistic to an educated psychologist, but for a simpleminded caregiver they provide a vocabulary and a topicalisation of experiences that they can all recognize from their own childhood. By providing them with *a booklet of these guidelines with some exercises*, they have got an anchorage of experiences that might otherwise appear

to them fleeting and vague. Experience has shown us that booklets with illustrations of the eight guidelines are important particularly for those who need it most – namely those with low educational background. This booklet with the eight guidelines are useful as a frame of reference for activating own experiences, for self-monitoring and for analysis of observations, either directly or on video.

5. Pointing out positive features in her existing practice

As mentioned earlier in this paper, the sensitisation approach starts by taking for granted that most caregivers have a repertoire of personal caring skills that can be activated and pointed out, instead of instructing new skills.

We do this by pointing out positive features in each caregiver's interaction with their children and explain why they are positive. This can be done, by using video filming with replay and feedback. Seeing themselves on video, doing something that is positively commented on by the facilitator, always makes a strong impact on caregivers (Aarts 1989, Biemans 1989). In the ICDP programme, we have used *video-feedback* only to a limited extent because it requires special training and videos may not always be available. Still we have used the same principles of positive feedback while observing the caregivers in action with their children. Recently we have started *using pictures from their everyday setting* – "where the action is" – and this provide useful clues for their own narrative constructions of how good interaction may take place in a concrete situation from their own daily life(Hundeide 2000,2001).

This is an important strategy because it brings out the most positive interactions within their repertoire at the same time as it strengthens their self-confidence and commitment as caregivers. As the usual procedure is to point out and correct failures, facilitators need to make considerable adjustments to get used to this new positive approach.

6. Sharing experiences in groups

Sharing experiences through telling each other personal stories about their children and reporting back exercises (see point 3 above), is very popular and makes a strong impact, and has clearly other more social functions than just to confirm caregivers' understanding of child care. Sharing experiences in a group is therefore another way of raising the caregivers' awareness; when they hear that other participants, with similar background as theirs, have similar experiences as themselves, this has a special effect that is quite different from when they are told by an instructor.

However, in order for equal sharing to take place, it is important that the facilitator lets the participants speak out. The facilitator should therefore take on a more facilitative role, where she guides the group by following their initiatives, focus on the relevant issues to be discussed and let the participants do the talking themselves.

The whole idea of sensitisation is to raise awareness and promote the practice of some qualities of care and interaction that are already available within the caregiver's own repertoire of caring activities. *Sensitisation is therefore different from behavioural instruction and direct guidance.* In sensitisation we try mainly to reactivate what is already present. This is achieved through consciousness-raising of the caregiver's own activities through a

sequence of exercises combined with story-telling and exchange of experiences in groups, through pointing out what they already do positively and through reactivation of their own experiences of situations where empathic identification with the child has been aroused.

Some newer methods of sensitisation.

Beyond the principles of sensitisation that have been described above, there are different levels of sensitisation which indicate some new methods of sensitisation, as the figure below shows:

Table 3:Table of methods of sensitisation corresponding to three different levels of interactive knowledge representation.

Levels of knowledge – representation:	Examples:	**Methods of sensitisation/ Intervention:**
1. Abstract knowledge of principles	The guidelines of good interaction. The principles of sensitisation	a. Using the guidelines in an instructive way b. Using the guidelines inductively as a conclusion and summary of experience
2. Narrative episodic knowledge – scripts, stories, pictures, dramatisations	a. Exemplification through stories and narrative construction, b. Pictures and films c. Role-playing and dramatization	a. Narrative methods: 1.Concretisation and exemplification, narrative construction, 2. Making scripts of dialogues b. Pictorial methods: four ways of using pictures, films c. Role-playing, miming, and dramatic reconstruction, also dolls
3. Direct practical participatory knowledge	The facilitator interacts directly with the caregiver-Child dyad or with the child, demonstrating how to interact/communicate. The caregiver carries out a series exercises with the child	Direct participatory interaction, adjust to the momentary initiatives: a. Using guided participation and scaffolding in direct interaction with mother b. Demonstrating and modelling c. Pointing out and praise existing practice

At the most abstract level there is verbal description of principles, like the guidelines of good interaction. This can be useful as a summary, bur it is *too abstract and general for most caregivers to function as a guide for practical interaction. S*till, as a reminder and summary of existing interactive skills, these principles have proved to be important and useful.

The second level of mimetic representation is closer to action and more useful in practice. At this level there are different methods from *narrative methods* of exemplification and telling stories of own experiences, or creating dialogues illustrating the principles of good interaction. There are *pictorial methods* like using photos as a reference for narrative constructions and there is video-feedback. And there are *dramatic methods,* which are similar

to narrative except that they are implemented in action. Sometimes these methods are combined, as when a photo of a typical situation is used as a reference for narrative construction, which is afterwards enacted as a drama of how interaction should or should not take place.

Finally there is sensitisation at the level of action itself. This is sometimes necessary with quite helpless caregivers, who themselves need a lot of care. In such cases there are *demonstrations with the child and graded support (scaffolding) where the facilitator both provides emotional support to the mother at the same time as she demonstrates and shows concretely the mother how it is possible to interact with the child.* The danger of this approach is that the mother may feel more powerless and the child may turn away from the mother and prefer the facilitator. It is therefore important to use demonstrations only as temporary measure and gradually hand over the responsibility for the interaction to the mother by supporting her and pointing out what she already is doing well.

IV. The principles of implementation and sustainability.

The impact of a program does not only depend upon the nature of the program itself, but also on the quality and intensity of its implementation (see also Ramey 1996). On the one side a program may be implemented sloppily and with low intensity, in addition there may be different kinds of resistance factors like opposition from the leadership of the institution or political authorities, to deficient motivation of the facilitators/staff or among the caregivers themselves. All these contextual and framing conditions may contaminate the impact and effects of the program. Below some of the factors that we consider important, are specified:

1. **Support from and co-operation with local authorities**

   To implement the program in a new community it is very important to get support and co-operation with the local responsible authorities. Getting approval from the senior staff. An information meeting should be held as the first step in the process, to give an introduction to the program. An agreement about the implementation should also be made.

2. **Clarify institutional and administrative-economical issues**

   When you have chosen where the program is going to be implemented, the following should be clarified:
   - Is there staff that has time available to implement the program?
   - Is the staff personally suited to be trained?
   - If needed, is there funding available for the project?

3. **Willingness and motivation for the training**
   When there is a request for training, we should consider carefully whether there is a serious intention to implement the program. For this reason comprehensive information about the program and the about the tasks involved should be provided. The training should not be initiated without a kind of agreement (contract) with the staff to follow the

whole training procedure. It is important to make the staff understand that this training implies and depends on their active participation.

4. **Plan of action**
   In order to implement the program in practice a plan of action is needed. This should specify all details of implementation with goals, sub-goals and time-limits. The plan should include who the target group is, who is responsible for the training, when, where and how the training is going to be carried out and how long the training will take. It should also specify who is responsible for what (the trainer/the trainees/the institution). A long-term training of facilitators and trainers should not be initiated without having presented a detailed plan of how the program is going to be implemented in the local milieu or institution

5. **Quality and intensity of the implementation (including number of interventions)**
   The plan of action should state how intensive the program is going to be implemented: Meetings held every week? For how long time? How many families and how many children will be affected by the implementation? Is this a pilot-project before a larger implementation? How broad is the larger implementation etc..

6. **Facilitating positive interaction through changing daily routines.**
   Very often the effects of intervention remain at a rhetorical level without influencing action directly. This is partly due to the fact that there is no opening for quality interaction in the everyday routines of the caregiver and child. For this reason one way of facilitating intervention is *to prepare daily routines that invite and have space for personal contact and interaction between caregiver and child.* In this sustainable effects may be achieved through the stability of the routines that have been established.

7. **Plan for follow-up, self-evaluation and internal reward-system.**
   In addition it is important that there is inside the implementation plan also included follow-up program of meetings and supervision every third month for two years for example….This is extremely important for the sustainability of the effect which has initially been achieved.

   In addition to follow-up, there is also a need for *internal monitoring* should assess whether or not the sub-goals of the implementation are achieved within the set time frames. In order to sustain the quality of the implementation it is important to introduce internal monitoring of quality. This could be either some questionnaire to be filled in every month or regular video-feedback showing the participants' interaction with the caregivers where they present themselves in regular meetings for the rest of the staff as a companion-training supervision.

   Finally regular reporting about the progress of the implementation to the authorities that support the program is important. Anyhow reporting is also important as means for self-monitoring and awareness-raising …

   When a group of facilitators or trainers have been certified, a network should be established, so that they can exchange experiences and support each other. If an ICDP network already exists, the new facilitators/trainers should be included in this.

   All these points are summarised in the table below:

Table 4: 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. Using 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 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.

V. The ICDP Programme in operation

The ICDP Program is now in operation in more than 14 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.

For more information, see internet site: **www.icdp.info**
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APENDIX 1

Emotional guidelines:

1 = Showing positive feelings of love
2 = Following and responding to the child's signals /initiatives
3 = Positive personal dialogue; verbal and non-verbal emotional communication
4 = Praising and giving confirmation

Mediational guidelines:

5 = Focusing the child's attention, sharing attention
6 = Conveying meaning; naming, describing with enthusiasm
7 = Expanding, enriching; comparing, explaining
8 = Regulating, guiding; setting limits, giving alternatives for action

I Emotional Communication

1. Show positive feelings - show that you love your child

Even if your child cannot yet comprehend ordinary speech, it can nevertheless understand emotional expressions of love and rejection, joy and sorrow. It is important for the child's confidence that you show that you are fond of it, hold it with love, caress it and show it joy and enthusiasm.

2. Adjust to the child and follow its lead

In interaction with the child it is important that you pay attention to the child's situation, to its desires, its intentions and its body language, and that you try to a certain extent to adjust to and follow what the child is concerned with. The child will then feel that you care for it and respond to its lead. It is also important for the child's development that, within boundaries, it gets to follow its own initiatives and is not always pushed into activities by others.

3. Talk to your child about what it is concerned with and try to get a conversation going by means of emotional expressions, gestures and sounds

Even after a short time after the birth, it is possible to get such an emotional dialogue going. This is done with eye contact, smiles and exchange of gestures and expressions of pleasure, where the caregiver comments positively on what the child is doing or is concerned about, and where the child "answers" with happy noises. This early emotional "conversation" is important for the child's future bonding and for its speech development.

4. Give praise and affirmation for what the child manages to do

In order that a child shall develop normal self-confidence and drive, it is important that someone transmits a feeling of self-worth and competence to the child, someone who reacts positively and affirmatively towards what the child does well, and who explains to the child why it was good.

II Mediation and Guided Participation

5. Help the child to focus its attention so that you have mutual experiences of things in your own environment

Babies and small children need help in focusing their attention and you can help the child with this by attracting and guiding its attention to things in the surroundings; "Look here", showing what one wishes the child to notice. Without mutual experience of things in one's environment it is difficult to speak or communicate with one another. It often happens that the child is concerned with one thing and the parents with something else. Mutual and reciprocal attention is therefore a precondition for good contact and communication.

6. Make sense of the child's experience of the outside world by describing what you experience together and show feelings and enthusiasm

As a result of describing, naming and showing feeling about what you experience together, the experience will "stand out" and be remembered as something, which is meaningful for the child. Meaning is not something the child experiences directly, but it must be transmitted to the child by parents' and caregivers' conversation and emotional reactions. Children need guidance in order to create a world around them, which is experienced as meaningful.

7. Expand and give explanations about what you experience together with your child

This can happen, for example, when you compare what you experience together with your child with something the child has experienced earlier. "Do you remember when we visited... then we also saw...?" When the child gets older one can tell stories, point out similarities and differences, do counting, and so on. All this is important for the child's intellectual development.

8. Help your child to control itself by setting boundaries for it in a positive way - by guiding it, by showing positive alternatives and by planning things together

Children need help in training their self-control and their ability to make plans. This happens to a large extent through interaction with caregivers who guide the child in a positive way, put conditions right, help it to plan things step by step and, when it gets older, explain why certain things are not allowed. Instead of always making prohibitions, it is important to guide the child in a positive way.

APPENDIX 2

A bipolar dimensional presentation of the guidelines

Positive pole:	Negative pole:
1. Showing positive feelings of love	Showing negative feelings, rejecting the child
2. Following or responding to the initiative of the child	Imposing your own intentions and wishes on the child's activity
3. Establishing a positive personal dialogue - verbal non-verbal	Not communicating with the child - ignoring him/her.
4. Praising and giving confirmations to the child	Discouraging and disconfirming the child
5. Helping the child to focus and share experiences	Distracting and confusing the child with conflicting experiences
6. Conveying meaning and enthusiasm to the child's experience	Being silent and indifferent to the child's experiences of the world.
7. Expanding and enriching the child's experience by explanations, comparisons and fantasy	Being silent or only stating what is present and needed at the moment Not going beyond for the sake of the child's enrichment
8. Regulating and guiding actions and projects. Setting limits for what is allowed in a positive way. Giving alternatives for action.	Ignoring the child - the child's laissez faire attitude, letting the child act as he wishes without any interference, support or limit.[20] Stating what he cannot do only

[20] Another negative version of the same guideline is commanding the child in an insensitive way, ignoring his needs and wishes.