ICDP

International Child Development Programme

A THEORY OF HUMAN CARE

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A: Human care as a communicative process

In this chapter I will use the early communication between mother and baby as an example and a model for the qualities that need to be present in sensitive and affectionate care between human beings. There is a lot of research which indicate that human care is not a one-way process where the caregiver gives care to the baby irrespective of his response. On the other hand there is evidence that care for babies is a communicative and dialogical process where the caregiver's response depends upon the baby's initiatives and utterances and reciprocally the babies response depends upon the caregiver's initiatives. This means that it is a dynamic communicative process where the baby becomes an active partner in producing the care that he gets - or more correctly - the care that emerges between them. This is a sensitive process cannot easily be fixated into simple prescriptions for «what to do when» …

But in order to become a partner in this sensitive communicative process that we call human care, sensitivity is required; sensitivity to see and recognise the quality of the child's initiatives and utterances (and state) - what does the child's utterances express? And sensitivity to how the caregiver's response is received, just as in any normal act of sensitive communication between adults where we sense each other's reactions and adjust our utterances to the expected reaction and sensitivity of the other; we «tune in to the other's attunement to ourselves»… As we shall see below, we can observe this already in very young babies and we can also see that this follows a sensitive pattern of turn-taking which requires temporal synchronisation from both partners in order to be sustained as a conversation (Lynn Murray's).

It appears that communication with babies is a spontaneous non-reflective process that is released by the baby's affective signals and utterances. When we observe the spontaneous joyful exchange between a normal mother and a baby, it does not have the character of a reflective -cognitive exchange of opinions, it is more like a dance or a musical exchange where the emotional expressivity is both the medium and the message. This is what I call **the primary code** and there are reasons to believe that its basic form is biologically precoded (Papousek 1989, Trevarthen 1980).

There is a certainly also a secondary or tertiary code of conversation with the baby or the young child which follows the cultural codes of appropriate discourse with children, which presumably vary culturally depending upon the functions that children fulfil within the family and the community (LeVine 1989, Schefelin and Ochs 1980, Laosa 1990).

Still basic to all communication at any level of development there is a code of mutuality which demands that there is some kind of reciprocal confirmation - otherwise we would not call it communication. As Rommetveit wisely concludes, «intersubjectivity has to be taken for granted in order to be achieved» (Rommetveit 1974).

In the following sections we will go through some of the assumptions and preconditions for sensitive human care.

On seeing and interpreting the child as a person

What does seeing the child as a person imply? It means that we see the child's utterances or actions as expressions of intention, feelings and wishes. When an infant reaches out it is more than just a movement. For most of us, it is the expression of a purpose - that the infant wants to have something, and we tend to react by giving the infant their hand or a toy. This is an automatic reaction in most sensitive persons; we interpret the infant's movements and utterances as expressions of intentions and feelings, and we respond accordingly by giving the infant an appropriate response without further consideration.

This over-interpretative attitude towards infants (Newson 1979, Hundeide 1987,91) is also expressed in the way that mothers naturally speak to children in what we know as "baby talk". Here the mother interprets and describes the child's utterances as if they reflect wishes and intentions. According to Colwyn Trevarthen (1995, p. 11) the typical utterances are

> "Really?; Oh Yes! That's right; Tell me a story; Oh what a lot you have to say" or, if the infant is just watching, "Aren't you going to talk to me? Come on then" … Or if the child is acting in some directed way, the mother tend to comment the action like:"Oh, you want this one. Look, how clever you are… Do you want something more?" and so on.

In other words, from the beginning most sensitive caregivers seem to interpret the child's actions as if they express will, purpose, feelings and wishes, and through the interpretative response of the caregiver, the child is drawn into a dialogue with its caregivers which gradually brings the child into a world of common human values, intentions, wishes and feelings - as we shall see.

Daniel Stern expresses it like this: "Parents attribute intentions and responsibility for its actions to the infant……These are qualities which makes human behaviour understandable, and parents will naturally treat their infants as understandable beings…"(Stern 1985, page 43).

On empathising with the child

When a child is perceived as a person in the sense described above, it is natural to sympathise with her or him, to show empathy and to identify with the child's experience as if it were one's own; one participates in the child's experience. I have called this "**empathic identification**". This is a non-reflective process of participation by which caregivers spontaneously seem to be able to identify or experience directly a child's state, feelings, intentions and needs (Winnicot, Bråten 1989, 1992, Trevarthen 1996). I assume that empathic identification with the child is the underlying mechanism behind sensitive human care and companionship, and it is therefore worth looking closer into.

The English psychoanalyst Winnicot described this sensitive condition in relation to the infant as "the primary **preoccupation**", which he considers as something that can occur shortly after birth in most normal mothers:

> "It is this preoccupation or concern which gives the mother her special ability to do the right thing. She knows what the baby could be feeling like. No one else knows. Doctors and nurses may know a lot about psychology, and of course they know all about body, health and disease. But they do not know what a baby feels like from minute to minute because they are outside this of experience..." (Winnicot 1965, quote from Davies and Wallbridge 1990, page 95).

In this sensitive state, the **engaged** mother or caregiver follow the child with their eyes when the child is taken away to be tended by another. The infant is already a part of her in the same way as her own arms and legs are a part of her, and when the child cries, it is as if a part of herself cries. This is what I call "empathic identification" with the infant, Emde (1989) calls it "empathic responsiveness". Both imply that the caregiver is "emotionally available" to the child when he needs support and emotional contact and confirmation. This is responsivity in the primary code. While other people may respond to the child from without (secondary code), the sensitive caregiver may respond to the child from "within", from an empathic identification with its feelings, states and intentions. This means, for example, giving confirmations and support to the child's emerging feelings of anxiety and uncertainty in a difficult situation, or joining in and sharing his feelings of joy and playful mischievousness in another (Trevarthen 1998). As Daniel Stern points out this sensitive accompaniment of the child's state and feelings becomes like a process of "shaping the child's feelings from within..." By accentuating, tuning into and confirming feelings that the parents can identify, recognise and approve, they at the same time direct and develop the child's repertoire of acceptable feelings and emotional expressions.

> As an example of this "maternal preoccupation", I have recently had the opportunity to observe a young sensitive mother's relationship to her first born baby over some period of time. The striking feature that I have noticed is her participation in everything that the child does. When the child eats, she joins in and opens the mouth with the child, when I play with the child and makes her laugh, the mother is all the time joining and laughing with the child. When the child is trying to reach some goal, like putting a thing into a box, the mother is attentively joining in watching the child, making slight movements as if to help the child carrying out her actions. .. She is all the time sensitively with the child, and nobody has taught her how to be that way.

This is an example of what Winnicot meant by "early maternal preoccupation" or what I have called "empathic identification" with the child. [1]

The caregiver feels with the child and participates both in his assumed experiences and in his activities like an alternative supportive self. (See Bråten on the «virtual Other»). In this state of sympatic participation s/he will also automatically and unconsciously tend to guide, direct and expand the child's initiatives in a sensitive way. This is what the Papouseks (1989) call didactic or **«intuitive child rearing**»; which they describe in the following way:

> "We have collected evidence which indicates that what we call didactic rearing can occur on a pre-adapted, non-conscious basis from the earliest stages of preverbal communication...Without being aware of it, the caregiver assesses, and if necessary,

[1] From my own experience I have no doubt that fathers may have the same "preoccupation". I think it is a matter of time for emotional investment and sensitization.

> influences and stimulates the infant's attention with slow, repetitive patterns which are finely adjusted to the infant's response, encourages and rewards mastery, adapts and meets out stimulation according to feedback from the child's behaviour...." (Papousek 1991, page 24).

This means that there is a disposition for this early didactic dialogue in both the infant and in the sensitive mother. If this is the case, it is more a question of triggering a communicative pattern, the disposition for which is already there, than one of learning a set of new communicative skills. This means that in those cases where such intervention is necessary, the question is one of facilitating and sensitising the mother or caregiver to something that is very natural, and which the infant itself under normal circumstances invites. This is an important point, because it implies that a completely different conceptualisation of early intervention than the one arising from more learning-oriented approaches. Here is a question of activating something already in existence as a possible pattern in the primary code, not intervention or intrusive instruction.

In time this early dialogue gradually develops into a dialogue with joint attention and involvement towards objects and persons in the child's surrounding world. This is what Trevarthen describes as «secondary intersubjectivity». As the child's interest more and more goes out towards the surrounding world, the caregiver's role also changes to become a supporter, a point of reference and gradually also a guide into the world that can expand and enrich a child's experience in what Vygotsky described as «the zone of proximal development». Different theories describe this guiding process as «scaffolding» (Wood and Bruner), as «mediation» (Feuersteind and Klein), as «distancing» (Sigel) and as «guided participation» (Rogoff).

It is important to be aware that the very earliest communication with infants has a strong emotional quality and therefore the caregiver's sensitive emotional responsivity is crucial to the quality of the contact achieved (in the primary code). But this does not only apply to the contact with babies, it applies at all age-levels throughout life; the companionship and the mutual care between partners who respond sensitively and appropriately to each others inner states, emotional needs and intentions/purposes is the essence of what a good relationship and what human care is about...

The basic idea is that we from birth seem to have a natural ability or disposition to tune in, relate and communicate with other human beings and to feel, participate empathetically and directly in their state, feelings and purposes. This spontaneous participation is not a reflective decentring process of the kind that Piaget described, it is something more basic and preconceptual. Colwyn Trevarthen refers to the Scottish philosopher Smith who argued that there is a «dynamic with-the-Other awareness that comes first and persists throughout life in our moral core». Trevarthen suggests further that «human consciousness appears to arise from a non-rational, unverbalized,conceptless, totally atheoretical potential for rapport with other persons» (Trevarthen 1995).

Similar points of view have been expressed by other philosophers like Buber (1959), Levinas (1972), and Bauman (1989)). See also Bråten (1999). Research on early communication between caregiver and baby seem to provide storing evidence in favour of this point of view, as we shall see in the next paragraph.

Communicating with a baby

The new, communicatively oriented developmental psychology has revealed a richness of nuance in early interactions which have exceeded all our expectations with regard to the baby's ability to communicate (Trevarthen 1980, Bråten 1992,99). It has become a fruitful area, not only for research, but also for personal experience. This is what I wish to express in this account; that interaction and contact with infants and very young children is a rich source for the exploration of the most fundamental processes in all humanity, love mutual joy and empathy. This is always a two-way process in which the caregiver and the child mutually influence and develop each other. It is this opportunity for personal growth and enrichment, which is inherent in the interactions between parents and children, that it is important to emphasise. That is the reason I have called this program a sensitisation program.

On responding to the child

A question demands an answer. Likewise an utterance or a movement expressing a wish or an initiative demands that someone responds. In the same way, one can view the actions of the infant as communicative initiatives or addresses that demand answers. When the infant receives systematic and consistent answers to its actions and initiatives in this way, it will in time develop expectations about what will happen next, and is thus already on the way towards becoming a participant in our common cultural world of meaning. In other words; in that the child advances utterances, which demand response and dialogue with an interpreting fellow human being, it will gradually be drawn into a dialogue, which includes it in our community.

On the other hand, should an infant repeatedly extend utterances that go unanswered, i.e. that they are psychologically neglected, initiative will naturally diminish. Instead of continuing to appeal to other people the child may withdraw into itself and become isolated in self-engaged activity which in the long run may sequester the individual and prevent socialisation in the normal way (Bråten 1989).

It is also important to realise that not all actions in relation to an infant will be apprehended as "answers". In order for the infant to experience and action as an answer, it must be adapted to the context and emotional state in which the child finds itself at the moment, so that the answers are experienced as relevant and "contingent" in relation to the child's own utterances.[2]

An initiative or an appeal from an infant may be sounds that are experienced as "prattling", or hand movements which are apprehended as though the child is reaching out to be picked up. It can also be emotional utterances, as when the child is upset and crying. This demands a response, which requires the caregiver's ability to "tune in" to the child's situation and emotional state. Stern (1985) calls this "tuning in" a "**confirmation from within**", consistent

[2] But the condition for giving an "appropriate answer" is that the caregiver is able to interpret the child's signals, i.e. utterances, gestures, sounds and body language. There are large differences between caregivers in this respect.

with the child's feelings - as opposed to an external confirmation of the child's actions. Such a process of confirmation will always be selective, i.e. that one confirms actions and utterances that are socially acceptable and ignores or responds negatively to actions that are viewed as unacceptable. This is a partially unconscious correctional process that has been described above as "**intuitive child rearing**".[3]

Early imitations

One of the most remarkable findings in recent research on infant-caregiver communication is the discovery of the infant's ability to imitate adults facial expressions like tongue protrusions and mouth opening (Meltzhof 1978). Already hours after birth it seems that the baby to imitate such expressions in the adult. (Heinemann 1989 1999, Kugiumutzakis 1983,1999)

This is quite remarkable taking into account the complexity of the operations involved in performing such imitations. Another interesting point is that this early imitation seems to be specifically social and directed towards human beings, not towards objects. It has not been possible to make the baby imitate, with tongue protrusion, when non-human objects are used as model like a pen which is protruded from a circular shape reminiscent of a mouth. (Bråten 1999).

Such findings strengthen our conviction that babies are born with a disposition towards communication, responding to and investigating, other human beings. Reciprocally infant's imitations are usually interpreted by sensitive parents as **signals of recognition**, just like a smile or a nod : In other words as utterances with a communicative intent.

Recognising the mother's voice

This is another remarkable capacity that has been demonstrated in newborn babies. In a classical demonstration of this a child is facing four women, the camera is directed towards the infant while each of the four women expresses his name: «Peter». On the video one can clearly see a strong reaction when the mother pronounces his name. This shows that foetal learning of maternal vocalisations must have taken place. This is another confirmation of the infant's readiness for communication (De Casper and Spence 1986). At present the discussion is no longer so much about the existence of this phenomena, as about how it can be explained (Trevarthen 1995, Meltzhoff 1999, Bråten 1999).

Dialogue and "proto-conversation" with infants

When the caregiver responds to the infant's expressive initiatives and appeals, it is just before one begins a dialogue. It turns out that even shortly after birth it is possible to initiate a dialogue-like exchange between the caregiver and the infant. As indicated above, it is as if the normal infant is born with an inner motivation, which drives it towards seeking contact with others. This leads, among other things, to an immediate preference in the infant for face-like

[3] In some contexts he also uses the expression "didactic child rearing" about the same process.

stimuli in favour of other kinds of visual stimuli, that they are capable of imitating facial expressions (Meltzhof and Moore 1987, Field 1990), and that they can participate in communicative exchanges of sounds, gestures and emotional expressions with their caregiver, which have the quality of a dialogue with turn taking and designation of roles. This early dialogue has been called "proto-conversation" (Trevarthen 1980, Smith and Ulvund 1991, Røed Hansen 1991).

One may think of the caregiver as the force that drives the infant in this interaction, but in fact the opposite it often the case; it may be the infant who is active, who is the one to extend appeals which the caregiver responds to. A smile and some attractive sounds from the infant has an immediate appeal to a sensitive caregiver; she may respond with a smile in turn, and at the same time she may imitate the infant's sounds and comment in an interpreting way**,** often in a high register ("motherese"), in which she makes assumptions about what the infant feels or wants. The infant in its turn responds to this initiative, and a joyful dialogue in progress. It often ends in laughter and in the infant being picked up and hugged. Field (1990) writes about successful interaction with infants:

> "In harmonious face-to-face interaction with infants, parents will reduce their tempo, exaggerate and repeat their movements, respond by imitating and enhancing their behaviour, turn-taking and respecting the infant's coincidental interruptions of the exchange. The infant appears attentive and contented...." (Field 1990, page 124).

Such dialogues appeal strongly to both caregivers and infants, and they possibly have the function of supporting and cementing their mutual commitment and attachment.

Physical contact with the infant

Face-to-face-interaction and baby talk with the child, as it is described above, is by no means the only form of loving contact between caregiver and child. We know that in other societies in which mothers to a greater extent must work in the fields, it is customary for infants to be carried on their mother's back for most of the day, and the opportunity for face-to-face-dialogue is rare. The child is, however, on its mother's body most of the time - also at night. In such societies, there is much greater emphasis on physical contact and touching than face-to-face dialogue when feelings of affection and love are expressed. This is naturally important in our society as well (see appendix). For example, Winnicot emphasises physical "holding" as a fundamental form of affectionate contact, which he sees as something that follows the child in its later relationships.

In later years, Field (1990) has shown that through experimental studies that bodily contact, particularly touch and massage, has a direct positive physiological effect. She found that premature babies revived much faster in cases where massage and bodily stimulation were employed compared to a control group, which did not get this treatment. See also Stack and LePage (1996). They showed that infants are sensitive to small changes in the mother's touch and that touching is an effective means to bring out attentiveness and reducing negative affects.

B: When natural care is blocked:

For different reasons, alienation and disturbance may sometimes develop in the relationship between caregiver and child, preventing the commencement of this natural humanising interpretative process (Sameroff and Fiese 1990). It may also happen that the caregiver sees the child as a physical object or as an organism with which is outside and with which she or he has no personal relationship.

When a child or a "client" is not seen or «defined" as a person

In order to illustrate this dehumanising process where children or clients are seen and treated as objects, I will take some examples from Ryan and Thomas (1970) excellent book on "The politics of Mental Handicap". This book gives an analysis of an old fashioned "medical" institution for mentally handicapped children and adults. Through "participant observations" they are able to give an insider view of attitudes and experiences both among wardens and caregivers and among the patients.

Traditionally an institutional setting invites a separation between "them" and "us", which implies that "we" who are in charge, can prescribe within limits, the treatment which is supposed to be good for "them", including, in many cases, the privileges they may receive if they behave well and the punishments they get if they don't. This is part of the managerial order of traditional institutions. This separation between them and us, is also sustained through the use of stigmatising labelling, through uniforms, and through physical separation, in different rooms and separation of meals.

> But such separations with one part in control of the other, may also lead to exploitations by persons with negative or objectified conceptions of their clients as neither persons nor human beings.
> Below follows some examples from an institution, where the client were referred to as "it" or "the lot" (Ryan and Tomas 1980, p.55).
>
> "... The fact that there are at least thirty patients to talk to, play with or enjoy - all this is boring. Making beds, clearing up shit, tidying lockers, now that's what work is. If it moves, change it, clean it, but don't bother to talk to it. What's the point? It's waste of time..."

Disgust of the patients are sometimes also expressed:

> "They are like cattle, aren't they? They look like bunch of fucking monkeys, don't they?" (Op. cit. p 62)

This attitude inevitably leads to abuse and brutality when there is some disturbance of the daily routine:

> "...We cannot always be nice as we would like to. We've got to be cruel to be kind. That is the way it got to be. We don't actually hate the patients, but they've got to know who is in charge... See that guy? He takes a poke at other nurses here, but when he sees me he runs a mile. He knows what's good for him, you see. Can't stand that

> bastard over there. All he wants to do is to stare at you. Can you credit that. Stupid bastard" (Op. cit. p.50-51).

Negative definitions combined with separation and distancing creates a climate where cruelty may become legitimate.

When the caregivers are asked about the psychological reactions of the patients, they flatly refused to accept that they may have reactions like fear and worry:

I suggested:

> "Perhaps he is worried about something?" Another nurse, Sarah, gave me an incredulous look. "What on earth can he have to worry about? He's got nothing to worry about. All his clothes are given to him, all his food is free, he has a bed to sleep in. He should think himself lucky. Other people are worse off than him. What is there to worry for him?"

> "... Don't you sometimes worry? Of course I do. But I am normal that is different. Not like these idiots. They have not brain to worry..." (Op.cit.)

According to Ryan and Tomas (1980), an «objectifying relationship» in the context of care as control, has the following characteristics:

1. People are divided or categorised into normal and abnormal and there is no way that the "abnormal" may share some of the same psychological reactions as the normal.

2. The absence of any possibility that people can be anything other than prescribed by their social roles or negative definitions - in this case as mentally handicapped.

3. The absence of the acknowledgement of subjectivity, of people's own consciousness of themselves...

> "In the world of the institution these values are denied...it is a dehumanised world, a world where maximum of objectification has become almost inevitable." (op. cit. p. 47-48).[4]

To some extent I can confirm these descriptions from visiting institutions for orphans and handicapped children in different parts of the world. In addition to the institutional atmosphere of separation between staff and patients, the scarcity of staff compared to the number of children, prevents any time for individual care and dialogue. Caring becomes physical care, feeding, cleaning and keeping the institutional order. As one of the wardens in the institutions above, described what "real work" is:

> "Making beds, clearing up shit, tidying lockers, now that's what work is."

[4] See Bauman 1989, where he describes "distancing" through stigmatic labelling as the precondition for the dehumanisation that took place during Holocaust.

The organisational and the managerial aspects of running the institutions have priority and set agenda and the scope for human care. Under such conditions children can be grossly neglected and abused. In extreme cases young children spend all their lives in their beds, they are fed and cared for in a machine-like way as if they are objects without any psychological need for human contact and love.

When I once asked the caregivers in one such institution what they consider their most important tasks as caregivers, most of them replied that their task was to give the children porridge and to bring them to the toilet. Beyond that there was no other care. Even doctors supervising the place did not monitor anything but the weight of the children according to standards of normality. It seemed as if the psychological needs of these children were invisible even for the doctors monitoring their physical health (Hundeide 1991).

The role of negative definitions

Such negative definitions of deviant children, as described above, we find all over the world: Visiting Guinea Bissau some years ago we found that the negative definition or stigmatisation of handicapped children was quite prevalent. A handicapped child is traditionally considered as the negative outcome of the intervention of the spirits in the process of conception. It may be revenge from some ancestor for some wrong action or some temptation that the mother has surrendered to. A child that is born handicapped is therefore considered to be close to the spirit world and it is sometimes assumed to be clairvoyant. It may also happen that it is abandoned by the sea so that the serpent-spirits can take it back....(Persson 1989)

Similar stigmas are also attached to children who in some way are deviant from the normal either in physical appearance or psychologically. In the rural areas of Angola such children are very often described as «witches». They are considered possessed and treated accordingly which may mean that they are expelled from the homes or at least not treated with normal human compassion. They are outsiders - outside the families' natural field of compassion that we describe as the zone of intimacy…

C: The zone of intimacy[5]

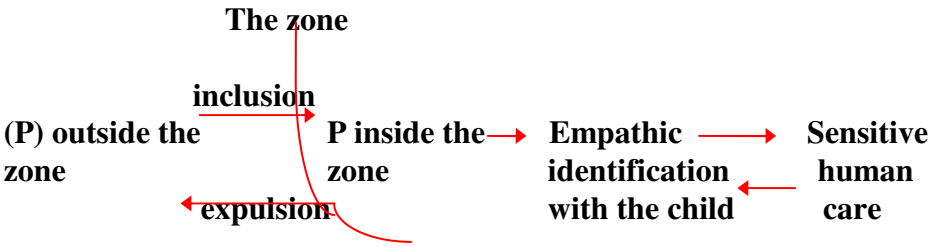
Under conditions of dehumanisation and objectification, a hidden screen seems to be inserted between them and us. "We" who are on the inside of this screen may enjoy empathy, love, human care and companionship from the others, but those who are on the outside may in the best case be treated with indifference, and in the worst case they may dealt with as objects deprived not only of their human rights but also of their human subjectivity – to be understood and seen as human being with capacity to feel, intend and think like human beings... Under

[5] The zone of intimacy has some similarity to Nakano's concept of the zone of the "we", and Stein Braten's concept of "companion space" that can be entered through direct preconceptual participation with the other person's emotional state in "felt immediacy" (Nakano 1996, Braaten 1992,1996).

such circumstances, in order to prevent abuse or neglect, it may be important to help the caregiver to achieve a more human and emotional relationship to their child.

As a metaphor it may be useful to illustrate the sensitive relationship between human beings as inclusion or exclusion in a "zone of intimacy". Through this metaphor it is possible to explicate some of the processes that take place when a person or a victim is included or excluded from the field of intimate human care and understanding. By including a child into the caregiver's zone of intimacy there is the possibility of releasing the caregiver's empathic identification with the child which constitute a deeper and a more sustainable basis for long-term care. **When this mechanism operates, the caregiver is all the time with the child and simple guidance for the child's benefit, in any field from health to education and psycho-social care, is easy because the child's needs are already emotionally available to the caregiver.**

The formulated stated above can be depicted in the following simple way**:**



We obviously do not feel compassion and empathy with everybody who suffers in the world, nor do we join in with everybody's happiness. There is clearly some kind of border between those who are on the inside; those with whom we feel empathy, participation, companionship and compassion, and those who are outside; those towards whom we feel more indifferent. Although we can cognitively recognise the suffering of strangers who are "outside" our zone of intimacy, this experience does not touch in the same way, nor does it have the same immediate emotional quality as when we empathetically share the emotional experiences and purposes of someone close to us - somebody like family or a friend (Hundeide 1996).

But according to the sociologist Bauman (1989), there is more to it than that; seeing the other person's "face" - his or her total expressivity invites me or anybody to feel with him or her, and by feeling that way, we also responsible for the other and, by feeling responsible for the other, we constitute ourselves as subjects, according to Bauman:

> "... ... the primary structure of subjectivity is responsibility for the other... Societal processes start when the structure of morality (or intersubjectivity) is already there... Morality is not the product of society. Morality is something that society manipulates - exploits, re-direct, jams (Bauman 1989, p.183).

This point of view, which constitutes the core of the Bauman's sociological theory of morality, is in fact supported by recent research on early communication between caregiver and child and between child and child (Trevarthen 1989). As we shall see later, it seems as if babies already shortly after birth are able to discern and even imitate human emotional expressions

and later on to engage in emotional-expressive dialogues with sensitive caregivers. This is clearly an inborn disposition that is both pre-representational and pre-societal... Already at the end of the first year, there are clear indications that "moral impulses" are emerging, moral impulses of the nature that Bauman seems to assume. Here is one of many examples that Eisenberg (1992) describes in her book on early care:

> " Jenny (a 14 month old) observed a crying 6-month-old baby. As she watched him; tears welled in her eyes and she began to cry"

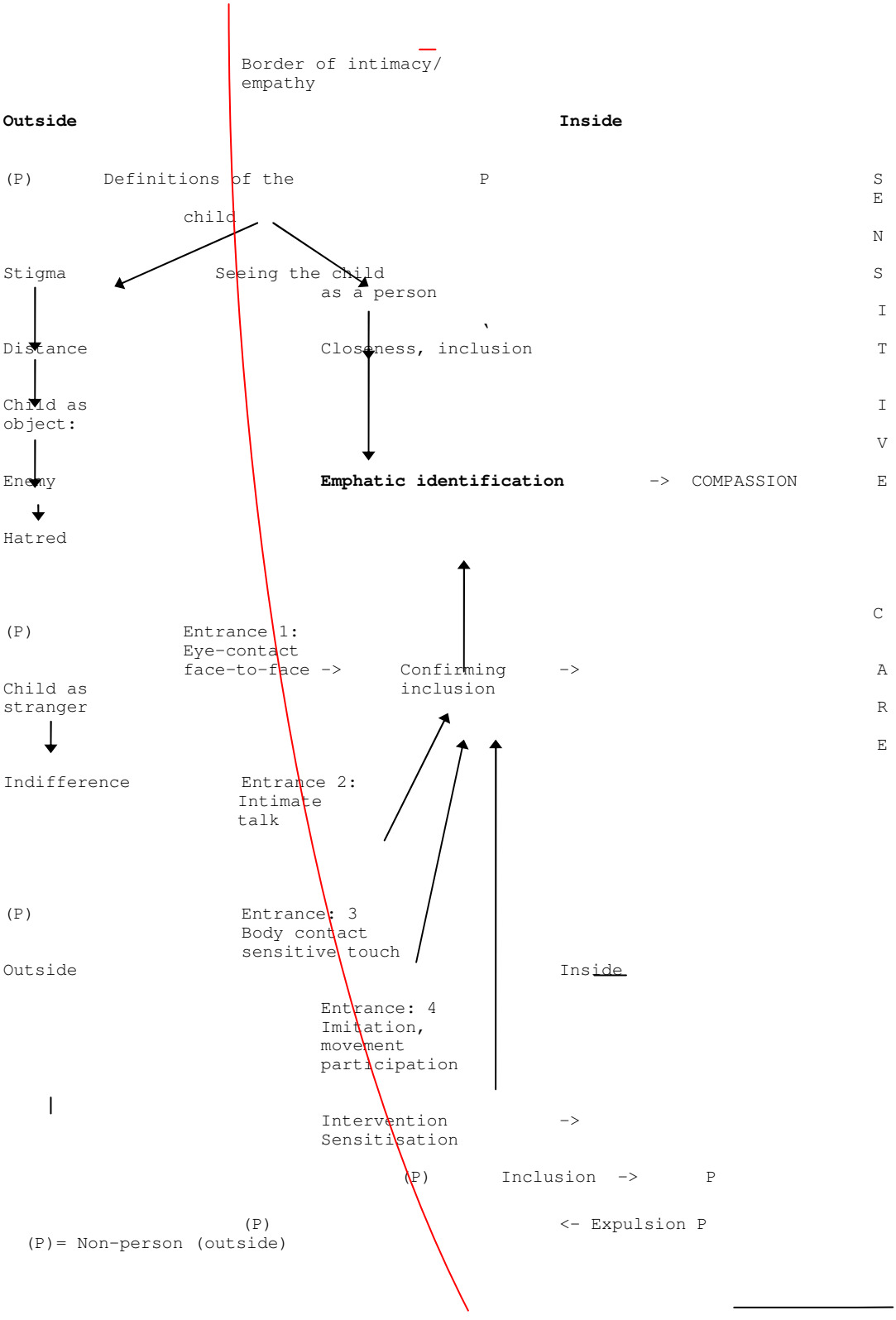
This is what Colwyn Trevarthen aptly describes as "sympathic participation" (Trevarthen 1998, see also Bråten 1999).

A bit more advanced than this is the baby, about 14 months, who sees another baby cry (he sees her "face"), and he immediately turns away and fetches his mother and guides her to the crying baby, obviously to help and console the baby... (Maccoby 1978, Eisenberg 1992). This baby is starting to behave responsibly and thus also to constitute himself as a subject, according to Bauman. So social, moral and altruistic impulses seem to be present very early in a child's life, but so are also aggressive and destructive impulses (Judy Dunn).

In the context of the zone of intimacy and empathic identification, this point of view is interesting because it indicates that the process of inclusion and empathic identification, showing compassion, is not an advanced reflective skills that requires extensive training, but a basic capacity that seems to be present from the start of life, as Bauman suggests, it seems to be pre-societal...[6]

The zone of intimacy can metaphorically be illustrated as a physical border indicating the inside and the outside of the zone of intimacy. In this conceptualisation we can illustrate most of the points mentioned above; the process of empathic identification as opposed to indifference or objectification and the processes of inclusion and expulsion/rejection:

[6] Bråten's point of view on inborn companion space, is very much in line with this argument.



This model needs further clarification:

Seeing a child as a person is the first step in humanisation and inclusion, but in order for us to identify empathetically we would need to be able to identify his expressivity as indication of

mental states, emotional and purposive. This ability to «read» other persons' expressivity seems to be a capacity that all humans possess, according to Colwyn Trevarthen:

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

Another «effective complementary reply» would be to express human care, compassion and consolation in a situation where the Other is expressing suffering and pain. But in order to come into this state of sensitive awareness of the Other that Bråten calls «dialogic closure», the border has to be trespassed and this can be achieved through, metaphorically, different entrance-points, as I have suggested below.

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 **expand our zone of intimacy** so that we can include and identify emphatically with a suffering child outside our intimate network; "it could have been my own child" [7]. But such a story could also easily picture the "enemy" in such a way that we would withdraw from any empathic involvement with him, he would remain outside the zone of intimacy. Finally the zone can also be constricted and narrowed down into petty self-preoccupation and egoism - there is no space for any "Others".

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. This is already described above.

Reversibly it also means that it is possible **to include and bring an outsider into our zone of intimacy** (p) -> p. [8]

The points of entrance

In concrete terms, this means establishing conditions for empathic identifications, and this can be done through at least four entrance-points to the zone of intimacy:

1. **Direct face-to-face perception and exchange of emotional expressions**

"Seeing the other person's face" - his or her expressivity, or being in direct expressive interaction with eye-contact, is clearly one of the conditions that may lead directly to empathic

[7] Provided the child shows expressive features of feelings that we can 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).

identification in a sensitive person: a joyful happy expression invites smile and laughter, while a sad, pitiful expression invites consolation and comforting. Eye contact combined with sensitive intimate talking is part of this mode of interacting.

Also this entrance point can be blocked by distance, by not being directly confronted with a person's emotional expressions in "felt immediacy" (Bråten 1999).[9].

2. Intimate talking

This includes personal disclosure of feelings and secrets, somebody to whom one will listen to intimate confessions and share secrets, happiness and sorrows; this is part of being inside the zone of intimacy. We can see the origins of this in motherese interpretative talking, where the mother is high pitch talks sensitively to the baby and interprets her movements and initiatives as if they are expressions of human intentions and feelings. Sensitive interpretative talking and listening is an important avenue into the zone of intimacy - confirming the others feelings is an important aspect of this. Personal disclosure of secrets is also part of this; we invite persons' into our private sphere by revealing personal secrets - this is a powerful way, or strategy, of signalising that we accept and invite the Other into our zone of intimacy as an confidant insider. Gossiping is also part of this…

Story and narrative presentation of a person's background how he came into his difficult situation, this is another way to evoke empathic identification. This has a more mediate character than the spontaneous reaction seeing a suffering face.

3. Body contact through sensitive touch, embraces and physical closeness

This is another mode of intimate contact, which usually has an immediate impact beyond reflection and mediation. Baby massage is an example of this. As Tiffany Field has shown, premature babies seem to recover more quickly through intimate physical contact with the mother combined with massage.[10]
Sensitive touching and embracing, «hugs» is part of this. This is in fact the prototypical form of expressing love both in relation to babies and young children as well as adults. A consoling embrace or touch is a powerful way of communicating that the other person is sharing his suffering and is willing to help.

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[9] According to Bauman this was one of the things that the Nazis tried to prevent - the face-to-face interaction with "the Jew next door", because that could create a basis compassion and empathic identification that might endanger Hitler's project; namely "the final solution - Holocaust". For that reason the creation of distance was an important part of this strategy. (See also Milgram)

[10] The Australian therapeutical movement "Youth in Search" uses Gestalt techniques like body contact, embracing and intimate confessional talk in groups in order to break the ice and to facilitate empathic identification with each other's situation and experiences.

4. Imitations and participation in body movements and rhythms

Imitating a baby is a way to get in touch. This is a very basic form of communicating - it is like recognising the other part and confirming that he is «seen». But there is more to it than that, in the same mode comes also participation in the child's movement. A sensitive mother not only feeds the baby, but she participates in the feeding by opening the mouth with the baby and takes part in his movements as if she is part of him. This participation is almost a rhythmic thing, it is like joining in with the child both in his actions, feelings and intentions. Imitation is only one manifestation of this «sympathic participation» as Colwyn Trevarthen (1998) calls it. When the child gets older it becomes participation in play, symbolic dramatisations and musical rhythms…

All the modes of interaction mentioned above are direct and spontaneous, not reflective and mediational. But sometimes before this can take place, another condition needs to be fulfilled, namely:

Humanising definitions and stories of the person (child)

As mentioned above it is important that the child is defined as "a person" meaning a human being with similar feelings, reactions, purposes and motivations as us. When a person is seen in this way, not as a monster, then she can easily be included into the zone of intimacy with the possibility of empathic identification when there is a need for it. Therefore how a child is seen or defined, is decisive for whether he or she will be included or expelled from the zone of intimacy.

Sometimes a picture is enough to release a feeling of compassion, but usually when the pictures is combined with a story, a humanising definition, for example of the suffering a child has been through, this may release the feeling: "it could have been me, it could have been my child..." - whatever the mechanism behind such reactions are. And this can also be considered as another entrance point into the zone of intimacy that can be blocked by negative and dehumanising definitions.

Obstruction of inclusion through negative definitions
Stigma

If a child is defined negatively or stigmatised as a monster, a non-human being, as an evil enemy that wants to hurt you, a person possessed etc., then the possibility for inclusion into the zone of intimacy is minimal and so is the possibility of empathic identification. This objectification or dehumanisation of human beings, as monsters, enemies or strangers, or as "Untermenschen", is not something esoteric and unusual, we see it all the time all around us, not necessarily in its most evil and rejective forms, but at least as indifference and fear of strangers, as racism and denominations of minority groups with different cultural background. Its most evil forms, we can observe in the war zones of Bosnia and Rowanda where previous neighbours, suddenly redefine each other as belonging to another category of non-human

enemies threatening each others lives and therefore deserving no human compassion.[11] These are human beings expelling each other's from their zones of intimacy, through fear and dehumanising definitions. They are no longer friends, not even strangers, but dehumanised enemies... The shocking thing about Bosnia and Rwanda is how quickly this transformation may take place even between previous friends and neighbours.[12]

In the context of children, I have seen this in some developing countries where children who are slightly different either through some birth defect, some physical handicap, or some psychological disturbance, how they sometimes are being stigmatised and demonised as "possessed" or bewitched, and under such conditions they are certainly expelled from the zone of intimacy and empathy, and sometimes also physically from the home ending up in the street without any social support.(Hundeide and Mendes: Reports from Angola 96-99)

Defensive withdrawal of emotions and expulsion from the zone through negative definitions

The anthropologist Schepper-Huges (1990), who did field work in poor areas of Recipe in Brazil, describes some interesting cases of expulsion of infants from the zone of intimacy through special definitions of these infants. She discovered that poor mothers under very high survival pressure and high infant mortality sometimes withdrew emotionally from their infants when they understood that their chances of survival were minimal. Under such conditions they withdrew emotionally from these infants as if to protect themselves from the ensuing emotional shocks and mourning.

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

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

[11] As an example one the generals responsible for massacres of Muslims during the Bosnian war, expressed in an interview with international journalist (at an early stage of the war) that " Muslims are not human beings". In another connection he should have expressed: "How many rabbits have you killed to-day?"

[12] Such episodes serve as reminder of Carl Jung's pessimistic statement that "the layer of civilization is frighteningly thin...

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

When infant mortality is high and survival needs are strong, it may not be so easy to sensitise caregivers for children's emotional and psycho-social needs without, at the same time, including other aspects of their survival needs like food, economy and health.

Inclusion into the zone through direct face-to-face contact

As mentioned above, face-to-face contact is one of the bridges to inclusion into the zone of intimacy and to empathic identification with the child. Face-to-face involves eye contact and reciprocal exchange of facial expressions. This can be a very powerful and direct emotional experience when there is sensitivity and an open attitude towards the child or the victim.

The importance of this form of experience was brought home to me through an experience that a close friend of mine told me about his relationship to his son, which has Down syndrome:

> When the doctors told him that his son would be a Down syndrome child, he was deeply shaken - despite the fact that he was in daily contact with handicapped children. When the child was born, he had to begin with great problems in looking at him and touching him. Despite his expressed ideology of acceptance of deviance, there was something deep inside him that could not accept that this was his son. This went on for some time, he could not relate to the child and he discreetly avoided and ignored him... Till some day, his wife asked him to hold the child in such way that he was in direct face-to-face contact with the child. Then he had the following experience: the child looked at him, smiled and stretched out his arms towards him - and that was all that was needed to break the ice; he was deeply moved and started to cry and felt a spontaneous feeling of love and compassion for the child or for his son - which has persisted and grown since...

The deep feeling of "my child needs me" was activated in him through this experience. This is an aspect of what I call empathic identification with the child.

This example also illustrates the powerful impact that direct face-to-face contact with a baby may have on a sensitive caregiver. As this is a two-way process, not only from the caregiver to the child, but also from the child to the caregiver, babies may very often have a humanising effect on adults: Through their emotional expressive signals of positive feelings and innocent helplessness, they invite and bring out compassion and caring feelings in otherwise emotionally frozen adults. This is the deep experience of "my child" that Pnina Klein describes as the dynamic in true human care.

But not all babies, or children, have this immediate emotional appeal, some are quite ugly, some are very passive and without emotional expressive initiatives, especially when they are malnourished, many are not wanted because they represent an emotional and economical burden for a poor family with many children that is already beyond the limit of their caring

capacity - there is no more space inside their zone of intimacy. It is under such conditions that external help is needed.

If we compare the two examples mentioned above, and relate them to the figure of the zone of intimacy, we will see that in the first case of the withdrawal of empathic identification with a sickly child, took place as a consequence of negative definitions. There was a slow process of assessing the vitality of the child and arriving at a "diagnosis" or definition whether the child is an "angel" or not. The other example describes a more direct, unmediated experience (Bråten 1999): through face-to-face contact with the child's expressivity, a spontaneous feeling of love and empathy is released. Both refer to entrance points indicated in the model above. These entrance points also represent important strategies or modes of intervention in order to include a rejected child into the zone of intimacy.

Inclusion into the zone through touch and physical contact

Through the work that we have been doing in Angola I have witnessed the importance of physical contact and loving touch with affectively deprived children. We see these children in institutions for abandoned children. They are the victims of war and poverty. There is one example I would like to mention in this context:

> She is a blind girl in an institution for children with multiple handicaps. When she came to the institution she was so weak and malnourished that she could not walk. After some time with supplementary feeding she started to recover and they then discovered that she was almost blind.
> This made communication with her more difficult and when we met her, she seemed to be neglected with regard to human contact while the physical care seemed appropriate. One of our facilitators, an extremely sensitive woman, approached this girl first by taking her hand, holding it and after some moments she started to caress it slowly. On the video one can see an immediate change in the girls expression; She leans back and relaxes and seems to enjoy the contact, she smiles and her face radiates in contentment. Gradually the caregiver expands the physical contact and starts touching and caressing her cheek in a loving and sensitive way. Finally she embraces her and holds her tightly.
> The girl reciprocates by putting her hands around the caregiver's neck clinging to her as if a deeply felt need is being fulfilled. At the same time the caregiver speaks softly to her, repeating her name and guiding her hands to her face as she repeats her name. She then touches the eyes, the nose, the mouth, and the ears and says their names that she repeats. All the time while this is going on, she is holding her closely and there is content smile on the girls face… The ice is broken and there is an intimate contact and trust between them. Through physical touch she has been included into the zone of intimacy, or more correctly; they had included each other into each other's zone of intimacy. (See Bråten on «the virtual other»).

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

Another simple technique that seems to work quite well is imitating the gestures or activities of the child. This is a way for the caregiver to respond by following the initiative of the child…As long as there are some expressive or purposive initiatives that can be identified there is always the possibility of starting a simple communicative cycle of imitation and turn-taking with the child.

> The most famous examples come from Mc Vickers Hunt's intervention study in an institution for socially neglected babies in Iran. He instructed the nurses to care for the babies in a loving way and in addition he asked them specifically to imitate the gestures and expressions of the babies in order to start a communicative cycle with them. This was a simple and pragmatic instruction that had a remarkable impact compared with the control-group that used «responsive toys» as the techniques of intervention (Mc Vicker Hunt 1980).

In our work in Angola, we used the same technique with an extreme case of neglect that was discovered by one of our facilitators:

> One of our facilitators was approached by the father if a child that had been adopted by another family because the father, who was an alcoholic, could not take care of her. The mother had just died and the girl was then about two years old. She could then speak some words.
> The foster mother was a brutal and insensitive person who accepted the girl in order to make some money. She closed her into a small dark room in the house where she kept her for two years without any human contact beyond the contact she got when the food was thrown into her. There was no toilet and no cleaning neither of her nor of the room in which she lived. She lived like this in her own faeces and dirt like an animal for two years. When this was discovered and she was brought out of her prison, she had wounds all over her body from rats that had bit her. She could not walk but crawled on the floor and made sounds and behaved like an animal.
>
> To begin with it was difficult to establish contact with her. She avoided eye contact and when she looked at a person, her look was expressionless and empty. She moved restlessly around all the time. Only in connection with feeding was it possible to catch her attention for a moment in order for her to get the food.
>
> One of our facilitators in the area started to work with this girl. She was by then four years old. She started to search for some expressive initiatives that she could relate to. She soon noticed that the girl made some special sound in connection with feeding - something like «tchee-tchee». Our facilitator started to imitate these sounds and gestures, and slowly they developed together a simple sign language for signalling feeding, cleaning, playing etc. Gradually she became more confident and her facial expression changed and became more open.
>
> When I saw her at a later date, it was possible to establish eye contact and reciprocity of smiles and expressions with her. She could by then walk almost like a normal child, she was quite confident especially with her brother and used to sit on his lap. A

process of normalisation and humanisation was clearly in progress… This started by establishing communicative contact through imitating her gestures.

Conditions facilitating empathic identification

Beyond the conditions stated above are some other conditions that need to be fulfilled in order for empathic identification to take place. Intuitively there seem to be at least five such conditions. These can be stated as follows:

a. We identify empathetically with persons - with whom we have a **close, intimate relationship,** like our children, relatives and friends (Eisenberg 1990), that is; persons who are defined as inside our zone of intimacy. Psychological or social “distance” seems to be an essential aspect of this. The greater the distance, the less the chance for empathic identification (Bauman 1989).

b. As indicated above, we seem to identify empathetically more easily when we are **directly involved face-to-face interaction and can actively participate** in an imitative manner with the other person's emotional expressions - also through physical touching. Instead of being a detached contemplative observer, we can then more easily join in with the expressivity or the rhythm of the other in hat Braaten describes as "felt immediacy" (Bråten 1999).

c. We identify empathetically more easily with a person who is **responsive and accepting of our expressive invitations for contact and participation.**

d. We tend to identify empathetically more easily when we can **see and recognise the feelings that the other person is expressing.** We do not identify with expressions that are outside our own emotional range of recognition, we have to be able to recognise and define both his expressions and feelings. Therefore a persons with similar background of experiences will most likely be more empathetically responsive and sensitive, than persons with a different experiential background.

e. Finally, we identify empathetically with a person **when our capacity for joining in with the child’s initiatives and activities - for "sympathetic participation" - with others is not exhausted or engaged in other activities**. A mother with a big workload with many children in a crowded stressful family striving for survival, may not have "psychological space" and motivation to participate empathetically with her child's suffering in any situation. It is outside her field of relevance at the moment, although it may not be outside her capacity in a more relaxed situation (Whiting and Edwards 1989).

Appendix:

The dimensions of the zone of intimacy

The dimensions of the zone of intimacy - either outside or inside are too simple. We need a more differentiated conception of the zones inside and outside.

a. **Dehumanised enemies** - these are beings that are not considered worthy of any compassion and care - either because of what they (or their ancestors) have done or what they by nature are - usually evil or mean or something like that… They are stigmatised and defined with subhuman, demonised qualities and for that reason it is considered legitimate and even morally right to direct negative feelings and actions of aggression, rejection and hatred against them. Racial discrimination at its worst falls into this category - the hatred against minority or outcast groups and there seem to be no limit for the cruelty that can be directed towards beings in this category (Holocaust is an example). **Objectification** may be the correct characterisation for this category (Animals can also fall into this category - the wolf is clearly a demonised animal that some considered should be killed).

When children, for some reason, are defined into this category, they are rejected persecuted and killed, as we know from street children in Brazil and elsewhere. Children with some handicap and deviation from the normal are sometimes labelled into this demonised category and rejected or, on a milder scale, considered as legitimate objects for bullying and persecution.[13]

b. **Strangers** - These are beings (not yet «persons») that fall into the more moderate category of being strangers. They can potentially be included into the zone of intimacy as persons and friends, but because we do not know them and **do not have any relationship with them**, they fall outside the limits of our empathy and compassion, although we may react more from principled humanitarian reactions - that persons are being treated badly, but this is amore theoretical reaction. This means that even knowledge of their suffering may not really touch us in a deep emotional sense. They are outsiders and remain in that category till we establish a closer relationship with them.

c. **Friends - momentary and long-term**. Friends are persons with whom we have an interactive relationship and whom we like and define into positive categories - not only because of their personal qualities but because there is a **reciprocal contract** of friendship. This means that we have obligations and rights in relations to them as they have towards us - reciprocal loyalty is the quality that is required.
Inside this category we have also to distinguish between «**momentary expressive friends» with whom we have good momentary emotional-expressive face-to-face contact** and

[13] The evil emotional nature of this category indicates that there is some kind of moral commitment behind the reactions - there is the polarity between the idealized positive pole and the demonised negative pole.

«**friends with whom we have a long-term contract of loyalty».** Our reactions towards persons in the first category can be intimate and emotionally empathic, depending upon the expressive feedback at the moment. We feel with the suffering of the person at the moment, particularly if he responds back. This is how we react when we face suffering children in difficult life-conditions, we respond at the moment to their expressive utterances - as momentary friends. When the moment is passed and the expressive exchange is over, the reaction passes and the friendship is not sustained - it comes and goes with the passing expressive contacts.

Long-term friends are different because do not to the same extent need this emotional-expressive face-to-face feedback in order to be sustained because they are based on a contract of loyalty and reciprocity of rights and duties. When a long-term friend is suffering, empathic reactions can be aroused, but sometimes the reactions are more of a obligatory contractual nature - I need to support and care for him as he would care for me. It does not necessarily have the spontaneous emotional quality that the momentary friendship may have, but it is solid and lasting!

d. **Loved persons** - These are persons with whom we have a strong momentary expressive contact at the same time as we have a deep emotional contract of reciprocity, which goes beyond the friendship contract described above. It involves in addition a contract of emotional concern and care… These are persons with whom there is maximal empathic identification in the sense that their emotional suffering are experienced as if they are our own - therefore emotional care comes naturally when the contact and the relationships is of this nature.

Both the two last categories mentioned above, namely friends and loved ones, are inside the zone of intimacy. But this is not necessarily a permanent position, because there is always the possibility of breaking contracts of friendship and love, which may ruin the relationship and redefine a loved person into the category of a stranger or a friend, and in the worst case also as «enemy»…

The categories mentioned above can be inserted into the general framework of and theory of empathic identification and zone of intimacy.

Sensitive care as communication

As pointed out in the introduction to this article, sensitive care is providing appropriately adjusted human responses or replies to the developing needs expressed by the child. It is basically communicative and dialogical. This means that it is not something fixed that can be prescribed independently of the communicative, cultural and historical context on the one hand, and the and the child's expressivity, on the other. Rather, it is variable and responsive to the child's expressive and communicative signals of varying states, needs and purposes in different contexts and situations.

The caregiver's responsiveness has two opposite poles, one; adjusting to the child by providing sensitively attuned responses to the child's state, needs and purposes. One can describes this as the assimilative pole - helping the child to express itself. The other, the accommodative pole, refers to the caregiver helping the child to adjust to the world by directing and preparing the child for the world, the tasks, challenges and roles, that he or she is going to face and master when she grows up. The balance between these two forces, **the adjusting and tuning in to the child (assimilative) on the one hand, and the directive accommodative on the other,** may vary because care is always inside a cultural normative framework and the normative ideals of a "good child" changes in different historical periods and in different communities, and so will the caregiver's appropriate response vary accordingly (LeVine and White 1985). The social code for how care is expressed in the interaction between caregiver and child in different context and communities may vary.(Ochs and Sheflin 1989).

Beyond this variability, there seem to be some universal features in the spontaneous unreflective interaction between caregiver and child described as «early imitation»,«protoconversation», «motherese» and «intuitive childrearing». These primary biologically based features of early interaction form a basis that can be culturally modulated and channelled into different cultural codes of care or child rearing. Adult members of a community generally know these codes, as they are also reflective of the wider norms, ethos and expressivity of the community.

If that is so, helping a neglective caregiver becomes more a question of sensitising the caregiver for something that is already familiar, something natural, expressive and human rather than teaching new skills. In practice this means helping the caregiver to become more sensitive and empathic to the child's state, expressivity and initiatives and at the same time supporting and reactivating her sense of attuned responsivity in line with the cultural code of appropriate care.

Beyond these general characteristics of care, an essential component of sensitive care, as we see it to-day, is the caregiver's expression of confirmation - that the child is appreciated and loved - that it is included into the zone of intimacy so that the sensitive mechanism of empathic identification becomes operative in the caregiver's interaction with the child.