SENSITISATION, NOT INTERVENTION: A RATIONALE AND DESCRIPTION OF AN EARLY SENSITISATION PROGRAMME

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Sensitisation, not intervention: A rationale and description of an early sensitisation programme[1]

A large number of programmes directed to the child's caregiver have been developed in several countries over the last years (Karnes, Lombard, Badger, Portage, High Scope, Milwaukee, Home Start).

The content of these programmes varies, but they are usually based on the idea that children need activities suited to their level of development (Badger 1981, Hunt, McVicker 1982, Lombard 1981). Several of the programmes have been shown to have a positive long-term effect on children's development (Bereiter 1972, Zigler & Berman 1982, Gaber 1988, Sylva et al 1986, Rye 1993). The general conclusion from evaluations of such programmes is that the more intensively they are implemented and the longer they last, the stronger is the impact (Ramey 1992).

Some objections have been raised against such programmes: The very fact that a mother is presented with a programme in child care, communicates that she is in some way incapable of caring for her own children and therefore needs special instruction in this field. This impression is further strengthened by the presence of experts and manuals giving detailed instructions on how she should proceed in any problem situation. Instead of strengthening the mother's self-confidence as a caregiver, such programmes may have the opposite effect of creating insecurity and dependence on manuals and experts. If, in addition, there is no follow-up of the programme that she has learned to depend on, she may end up in a worse situation than before she started the training - by feeling more powerless, unsure of herself and dependent than when she started (Klein 1990).

This may be the danger of imposive programmes giving detailed behavioural instructions on how to act in any situation.

A further danger of such programmes is that their instruction may draw the caregivers away from their natural ways of child rearing and thus create an alienation from their local traditions and customs of care (Hundeide 1991).

Raising the caregiver's awareness of their existing positive skills and resources.[2]

In the ICDP programme we have tried to avoid these obstacles by 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. The problem is therefore not of acquisition and instruction, but of facilitation and sensitization.

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[1] I am indebted to professors Colwyn trevarthen, Sophie Freud and Stein Braaten for their comments to this paper.

[2] Like the MISC,SPIN and orion method, the icdp programme has been used as 'home training', in institutions and in child guidance clinics.

One of the obstacles that we typically meet, particularly in so called high risk groups of caregivers, is low self-confidence and negative conceptions of the child (Sameroff 1991). For this reason, one of the objectives of this programme, is to raise their self-confidence as caregivers. This is done by pointing out the positive caring skills they already possess and by helping them to refocus or redefine their negative perceptions of their child, so that their natural empathic processes of care and sharing may start to manifest.

The idea of sensitisation and reactivation of existing motives and skills implies, that sensitive and responsive care for children does not normally need particular coaching as it is a natural process that follows from the caregiver's spontaneous participation in the feelings, experiences and purposes of their babies (Winnicot 1965). In this process of empathic participation or identification with i.e. a suffering child, previous experiences or models from the caregiver's own childhood may be reenacted in relation to their own children, in a complementary role (Fraiberg 1975). Similar points of view are held both by Bowlby in his conception of the 'working models', in Daniel Stern's conception of 'proto-narrative envelopes' and Papousek's 'intuitive parenting' (Bowlby 1989, Papousek 1989, Stern 1996).

Sensitisation and reactivation means mobilizing these caring and sharing resources in the everyday care of children.[3] I will return to this later in this paper.

The objectives of the ICDP Programme

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

A. **To influence the caregiver's positive conception and experience of her child**, so that she can identify with and 'feel with the child', sense and know his state and adjust 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.

B **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.

C **To promote enriching (mediational) interaction between the caregiver and the child** which extends and guides the child's experience and activity in relation to the outside world.

D **Reactivation of indigenous child rearing practices**, including the child culture of play, games, songs and collaborative activities.

Points B and C 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 good companionship) which are not prescriptive, but serve more as a framework to reactivate the caregiver's own experience of caregiving in relation to each guideline. (A short version of the

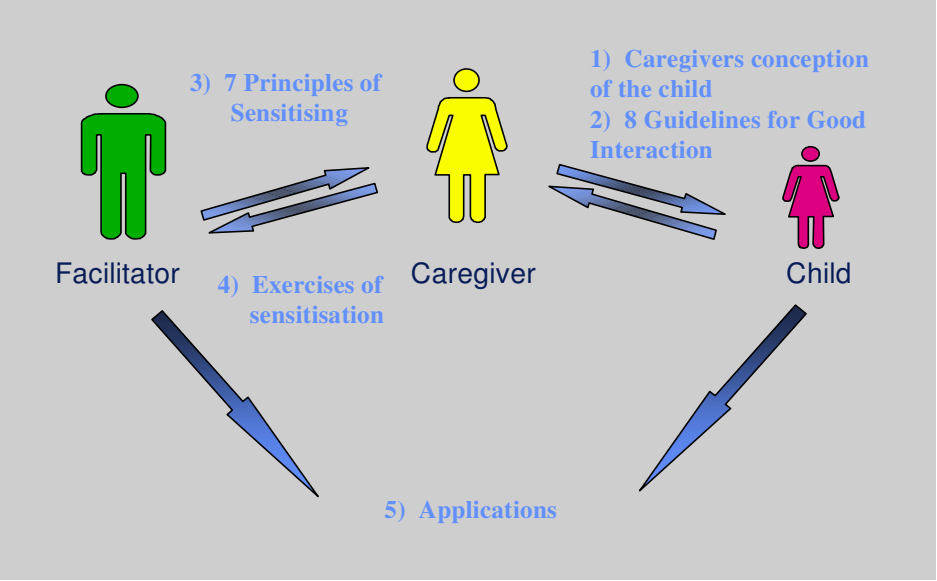
[3] As both Dunn (1992) and Trevarthen (1996) point out, the concept of attachment is too limiting and too much emphasizing the dependency aspects of care; a good relationship is characterized by positive qualities of sharing of companionship, joy and teasing.

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.[4]

In general the construction and conceptualization of this programme is based on an interpretive phenomenological approach where we try to remain as close as possible to the naive motives, conceptions and experiences of the participants. By supporting and expanding their own experiences of care, we also help them to rely on their own common sense experience and traditional knowledge of life with children.
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
3. The principles of sensitization
4. The exercises of sensitization
5. Applications: The curricula for health clinics, institutions and preschools, traumatisation, street children.

Each of these components is indicated in the figure below:



The two first components; the caregiver's conception of the child (1) and the guidelines of good interaction (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 exercises (4) can be both in relation to the child and in relation to the caregiver. The different curricula of application (5) are specifications of the programme directed towards different target groups like health clinics, home-based, institutions, pre-schools.

[4] 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 guidelines on the other hand seem to give the caregivers something concrete to hold onto and they serve as an important tool despite their obvious simplicity and naivity to a scientific audience.

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 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.[5] 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); 'sympathy' (Trevarthen1996), 'dialogic closure in felt immediacy' (Stein Braaten 1996). Peter Fonagy (1996) calls this 'capacity for mentalizing' which he believes should be 'the core of prevention in early childhood".[6]

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

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, 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 on identifying and pointing out the 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).[7]

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[5] 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.

[6] This expression seems to reflect an adherence to 'theories of mind' orientation (Ashington et al. 1988) which tries to explain empathic processes as an expression of some cognitive decentration mechanism. In contrast to this, I believe, like Trevarthen, Braaten and Emde, that this is an inborn capacity or a direct emotional participatory nature that Trevarthen (1996) describes as 'sympathetic appreciation of motives'.

[7] 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).

Empathic identification 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.

Releasing the mechanism of empathic identification

Obviously, we do not identify empathetically with all human beings whom we define as persons even if they express strongly their feelings or experiences, not even when they express feelings of suffering and neglect. There seem to be certain conditions that need to be fulfilled for this mechanism to be released. Intuitively it seems that there are at least five such conditions. These can be stated as follows:

a. We seem to identify empathetically more easily when we **can recognize the feelings that the person is expressing** - we do not identify with expressions that are outside our own emotional range of recognition. In order to respond empathically the expression must be inside the person's 'narrative envelope' or scheme, as Daniel Stern expresses it. We have to be able to recognize both his expressions and feelings. Therefore, a person with similar background of experiences will most likely be more empathically responsive and sensitive, than a person with a different experiential background.

b. More specifically we identify empathically more easily when we **are directly involved face-to-face and can actively participate** in an imitative manner with the other person's emotional expressions. Instead of being in a detached contemplative state, we can then more easily join in with the expressivity or the rhythm of the other. Braaten's concept of 'felt immediacy' is here relevant.

c. We identify empathically more easily with a person who is accepting us as a partner and is **responsive to our intimate expressive invitations and participation.**

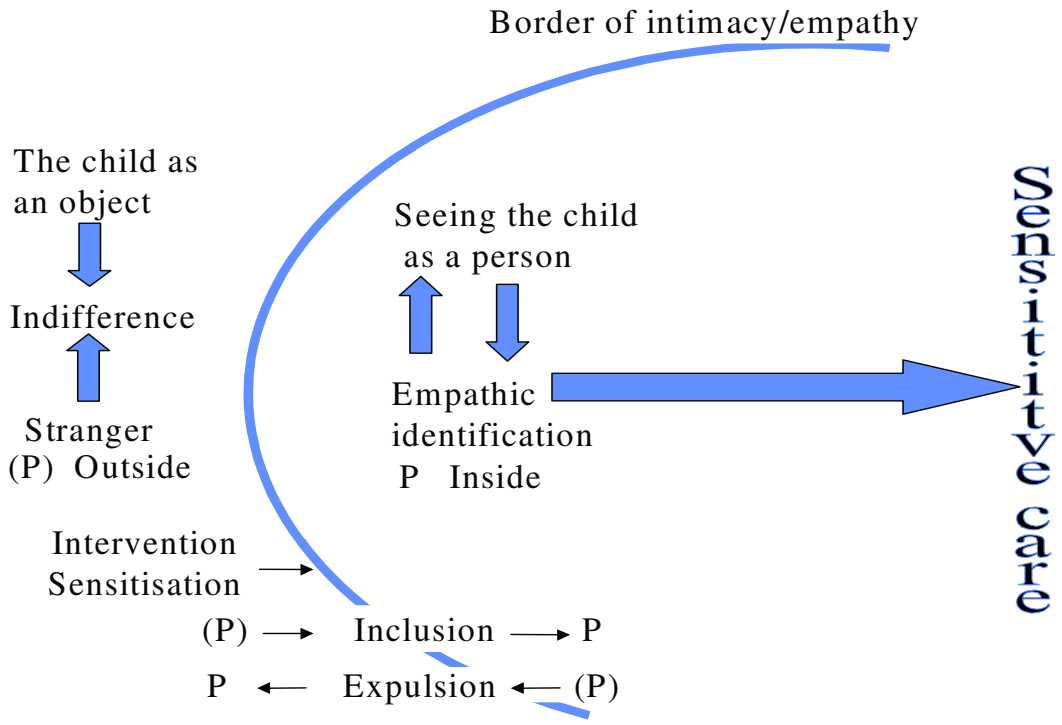
d. We identify empathically with a person when this appears **relevant in the situation** we are in. A mother with a big workload with many children in a crowded stressful family striving for survival, may not have 'psychological space' and motivation to participate empathically with her child's suffering. It is outside her field of relevance at the moment, although it may not be outside her capacity in a more relaxed situation (Schepper-Hughes 1989, Whiting and Edwards 1989).

e. Finally, we identify empathically with persons - with whom we have **a close, intimate relationship**, like our children, relatives and friends (Eisenberg 1990).

The zone of intimacy[8]

It seems as if we have a zone of intimacy around us (Hall 1978) and the conditions stated above are like entrance criteria for this zone: 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 and the processes of inclusion and expulsion/rejection:



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 **expand our zone of intimacy** so that we can include and identify

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

empathically with a suffering child outside our intimate network; 'it could have been my own child'.[9] 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 sensitization 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 a person from the outside involves establishing conditions for empathic identifications (mentioned above) and through intimate dialogue establishes an intimate relationship.[10]

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

If we combine the three components discussed till now:

(a) the conception or definition of the child,
(b) the empathic identification with the child and
(c) the quality of care as expressed in the eight guidelines,

these can all be represented in the zone of intimacy model, as we shall see.

[9] Provided the child shows expressive features of feelings that we an recognize.
[10] 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).

II The eight guidelines (topics) of interaction and empathic identification

As indicated above, the eight guidelines are more like broad issues that can serve as a framework to organize the caregivers' exchange of personal experiences and viewpoints relating to child-care (see appendix). The guidelines are split into two categories: The emotional expressive and the mediational didactic guidelines (Bornstein 1989):

A. The four emotional-expressive guidelines[11]

These refer to the early affectionate 'dialogue' of expressive gestures between infant and caregiver, where the caregiver sensitively 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.[12]

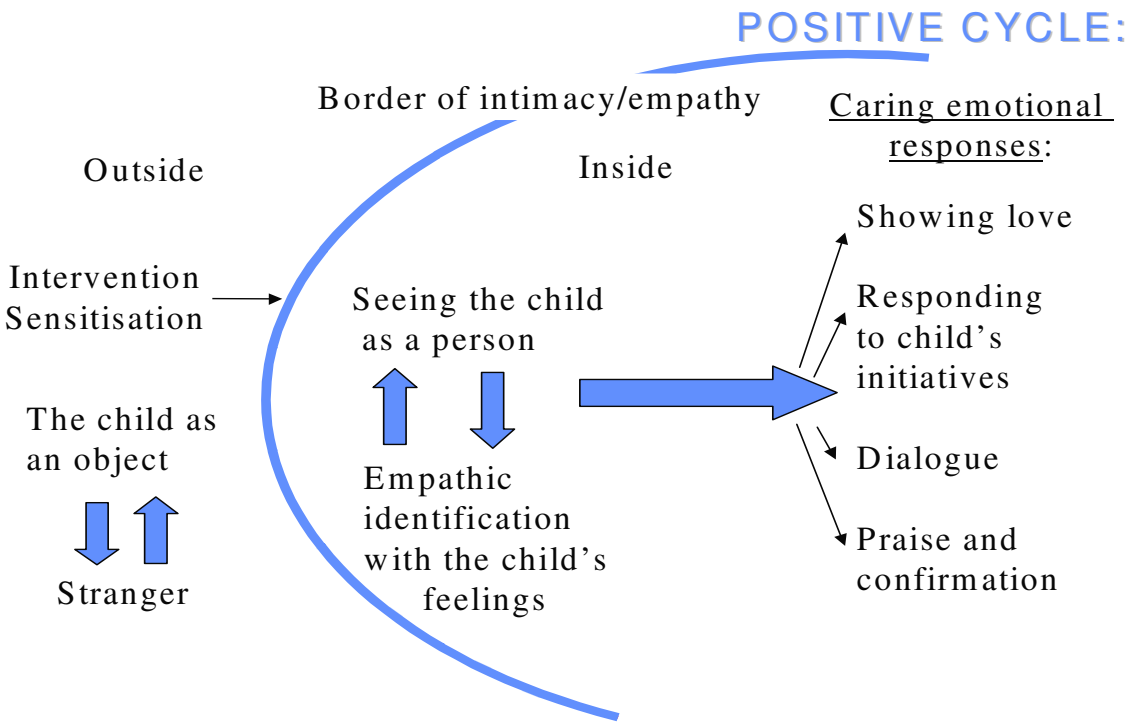
The four guidelines of emotional-expressive communication are the following:

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

[11] 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.
[12] These guidelines are not restricted to infancy, they are just as applicable to any stage in life.



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.

B. The four 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 reciprocaly guided into a shared world of knowledge and values.

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

- Focusing and shared attention (establishing intersubjectivity)
- Mediation of meaning and enthusiasm

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

- Expansion / explanation / comparisons beyond the present situation
- Regulation and limit-setting

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)[14]

As it appears from the quotation above, mediation in Feuerstein's sense is something highly intentional, reflective and didactic; 'the child is taught how to ...'. Still, we know from the research of Papouseks and others, that in engaged interactions between caregiver and child there is a spontaneous, non-reflective guidance or monitoring of the child's actions towards a shared initiative that he describes as 'intuitive parenting' (Papousek 1989): "...Unknowingly, caregivers assess and, if necessary, modify infant alertness and attention stimulate with contingent, simple, slowly displayed and repetitive patterns, encourage and reward coping or matching responses in infants and vary the quality and dosage of stimulation according to feedback cues in infant behaviours..." (Papousek and Papousek 1989). [15]
This is a spontaneous and non-reflective process in response to the caregiver's involvement and perception of the child as an intentional being striving to explore his surrounding world. When the caregiver is engaged with the child in its activities and sees the child's actions as intentional initiatives; as projects, then the most natural thing would be to respond with contingent support, enriching comments and expansion, which is the essence of mediation (Wood 1989, Rogoff 1990, Schaffer 1996).

When mediation is understood in this way, as a spontaneous and contingent response to the child's initiatives in a joint involvement episodes, this can be seen as another aspect 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 also his projects and action-initiatives which are the focus of empathy.[16]

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

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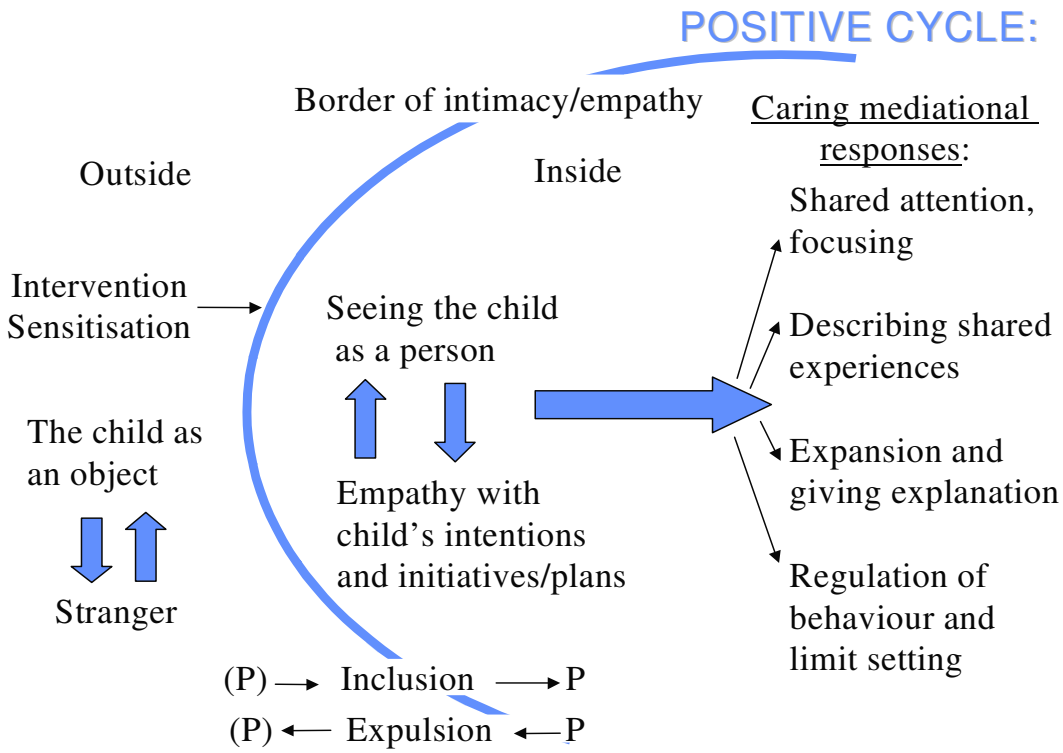
[14] In his description of 'joint involvement episodes' (JIE) Schaffer (1996) comes very close to Feuerstein's description of mediated learning experiences especially when it is applied at an early age:"Establishing a common attentional focus is an essential first step in setting up JIEs, for it is only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

[15] Similarly Braaten suggests in a recent paper (Braaten 1997), that care between babies or young children, does not arise from cognitive decentration in the Meadian or Piagetian sense, but from a more primitive preconceptual process that he calls 'alter-centric participation' where the caregiver is 'moving with' the child 'in the mode of felt immediacy' (Braaten 1997). In adult caregivers, however, the spontaneous unmediated and the reflectively mediated, would probably be more mixed.

[16] 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 for the child and through, c) transfer of responsibility for managing situations.



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As indicated above; a slightly different perception of the child during mediational interaction: In both cases the caregiver needs to see the child as a person with intentions, wishes, human feelings and reactions, but in the case of mediation the focus is more on what the child wants to do, his intentions and 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 from the caregiver. When this assistance is dosaged 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).

III Some principles of sensitization[17]

[17] The word sensitization is used here in order to indicate that the objective of this programme is not to teach or instruct some new caring skills, but rather to mobilize already existing positive skills in the caregiver's repertoire

In line with the theoretical conceptions developed in the previous section, the problem of sensitizing 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. Relabel 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 relabelling 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 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.

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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.

2. How to talk to caregivers[18]

As pointed out by Fonagy (1996), the 'capacity for mentalizing' 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 an 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 sensitize 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, the point is that this type of discourse opens up and legitimizes the child's mental state as a reality that he has to deal with. For some caregivers, even accepting to talk about the child's feelings in this way, is already an important step towards a more humanized and sensitive relationship.

When we combine the points made 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 attitude to 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 has very 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 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

[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.

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 the 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 should 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 exemplify and tell stories about their experience in some field, they have to put their experience into words and into a

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

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 does their importance as guidelines for action appear.

4. Sharing experiences in groups

Sharing experiences through telling each other personal stories about their children makes a strong impact, and it is a very popular exercise that has clearly other more social functions than just to confirm caregivers' understanding of child care. Sharing experiences in group is therefore another way of raising the caregivers' awareness; when they see that other participants, with similar background, 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.

5. Pointing out positive features in her existing practice

As mentioned earlier in this paper, the sensitization 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.

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 correct failures, facilitators need to make considerable adjustments to this different, more positive approach.

In conclusion, the whole idea of sensitization is to raise awareness and bring into practice some qualities of care and interaction that are already available within the caregiver's own repertoire of caring activities. This is basically achieved through 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 own experiences in similar situations and empathic identification with the child.

IV The exercises of sensitization and training

As verbal instruction has limited applicability in our approach, a series of exercises have been developed to activate the new sensitivity for how good child care shall be put into practice. Exercises within the following categories have been developed:

1. Exercises in observation, either observing/coding on-going interaction or watching videotapes, reading facial expressions and body language.

2. Exercises of personal enactment, either through direct contact with the child in practice, through role playing and special exercises in affect attunement and how to communicate empathetically with babies and young children.

3. Exercises of verbalizing, **story telling and sharing** their personal experiences.

4. Exercises in how to sensitize and supervise caregivers and facilitators. This includes theoretical background, how to make curriculum of sensitization and training, how to relate to the caregiver and how to supervise the facilitator and the trainer candidate.

These categories correspond in fact to four different skills, or domains of activity, namely; verbalizing, observing enactment and instruction. These skills seem to be relatively autonomous in the sense that it

is perfectly possible to be skilled in one without the other, i.e. a good verbalizer without being a good observer, instructor or caregiver.

V Domains of practice and applications

Beyond the general sensitization programme, which all participants have to go through, special curricula have been developed for the following target group:

1. Health clinics for babies or home-visits by nurses

2. Preschools and early education[20]

3. Institutions

4. Street children

5. Children traumatized as victims of war

In all these domains of practice the same basic principles of sensitization have been used, and that applies also to the eight guidelines of good interaction - in adapted form.

When we are working in community based way with para-professionals (local resource persons) without much academic background, it is important to have simple common-sensical guidelines that can easily be understood by caregivers, transferred and adapted to new conditions when necessary (Hundeide 1996).[21]

This programme is now in process of being implemented and evaluated in a number of different countries like Norway, Angola, Bosnia, Columbia, Italy, South Africa and Russia.[22]

[20] A curriculum for handicapped children based on the same principles is under preparation by Henning Rye.
[21] It goes beyond the scope of this article to describe the content of these curricula.
[22] The empirical evaluation of this programme is in progress. It goes beyond the intention of this article to review the studies that have been done (Hundeide and Hillestad 1994).

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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.

APENDIX 2

A bipolar dimension

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 projects. Setting limits for what is allowed in a positive way. Giving alternatives for action.	Ignoring the child - the child's actions and laissez faire attitude, letting the child act as he wishes without any interference, support or

limit.[23] Stating what he cannot do only

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