WHEN EMPATHIC CARE IS OBSTRUCTED

Excluding the child from the zone of intimacy

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Abstract.
In this chapter I will try to explicate the conditions that facilitate empathic care and identification with the child on the one hand and those that obstruct this care on the other. In the first part I present empathic care as a component embedded in the normal communication between caregiver and child. This implies that care is not seen as a one-sided contribution from the caregiver to the child, but as a dialogical product where both contribute. In the second part of the chapter, I introduce the concept of a "zone of intimacy" into which a child can be included and cared for through empathic identification and sensitive availability of the caregiver to the child's needs. But a child can also be expelled from the zone of intimacy with subsequent blockage of empathic identification, affective withdrawal leading to neglect and possibly abuse. Through this theoretical metaphor, and offering examples, inter alia from Angola, I try to describe three ways into the zone of intimacy. Finally I relate this perspective on empathic care with the newly emerging field of "ethics of closeness" and Levinas' ideas of the "appeal of the face" (Bauman 1996, Vetlesen 1999).

Introduction.

Recent research within early communication has shown that human care is not a one-way process in which the care-giver provides and the child receives care, independently of the child's initiative and responses. Rather it seems that *sensitive care is a communicative or dialectic process in which the care-giver's actions toward the child is dependent on the expressive appeal of the child's utterances,* and conversely, the child's responses are dependent on the care-giver's actions and on how they are received and apprehended (Bråten 1996,1998, Papousek and Papousek, 1991, Sameroff and Fiese, 1990,Stern 1995, Trevarthen 1995). In this way the *child (in this case) becomes a co-creator of the care it receives* – or more correctly: the care that arises and is created between them. Thus, care cannot be reduced to static recipes for "what one should do when…". Nor can care be attributed to some competence or ability for caring in one person or the other. Rather it is the outcome of a dialogical process that emerges between them (Hundeide, 2002).

In order for such a caring process to take place, empathic sensitivity, and ability to apprehend and recognize the quality and meaning of each other's expressive initiatives and responses is necessary. What do the child's initiatives and utterances express? What are the feelings and intentions behind a caring action?

I. The primary cycle of care.

According to one of the leading researchers in the field, Colwyn Trevarthen, this facility for interpreting the expression of others appears to be a fundamental ability existing in all of us. He writes:

> «…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).

Such an effective complementary reply in an exchange between a committed care-giver and an infant will normally lead to a mutual exchange of smiles and positive expressions. This "proto-conversation" is temporally precisely synchronized to a turn-taking schema, which the infant appears to be able to follow at the age of five weeks, and to which it responds with distress if disrupted (Trevarthen, 1989).

But this disposition may also be apparent when one of the partners responds by expressing human care, empathy and comforting in a situation where the other is experiencing pain and suffering. This does not only apply to adults; one sees the same response in infants of less than a year of age. Eisenberg (1992) mentions as an example that when the father expresses sadness, the thirteen month old infant responds by giving him her favourite doll. There are many such examples (Bråten, 1998).

This demonstrates that what I have called ***the primary cycle of care***[1] is a dialogic response of a fundamental and immediate character, which can be seen both in the committed care-giver's spontaneous caring responses to the infant's utterances and expressive appeals and in the infant's reactions to this response. *This means that there already exists a potential that can be activated and triggered so that already existing communicative patterns (as a disposition) rather than learning a set of new caring actions and communicative skills. This further implies that intervention becomes a question of facilitating and sensitizing something that is natural and that emerges spontaneously. Something the infant invites under normal circumstances through its expressive initiatives* (Hundeide, 2000, 2001).

As an example of this, I had the opportunity some time ago to observe a young sensitive mother's relationship with her first born over a period of time. I was struck by her absolute accessibility at all times, and her participation in everything the child did. When the child was eating, she participated by opening her own mouth when the child did. When I played with the child and made it laugh, the mother participated all along, laughing with the child. When the child tried to attain one goal or other, such as putting something into a box, the mother was attentive and participating, and she made small movements as if to help the child to carry out the activity. She was sensitively accessible throughout, participating in everything the child did. Or to express it in other words; she is *empathically identified* with the child. The care-giver empathises with the child and participates in both its assumed experiences and in its activities as an alternative, supporting self. This is described in more detail in Bråten's concept of "altercentric participation" (See Bråten, 1998a, b, 1999 and 2003 on "the virtual other", Hoffman 2000, Stern 2004)).

In the following sections of this paper, I will return to how this primary cycle of care can be reactivated in cases when there is obstructed and demobilised.

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[1] Not all caring has its basis in the primary care cycle, however. There are forms of caring adapted to older children and adults that naturally require a more reflective approach, mirroring society's varying conventions and values. This *secondary caring* does not have the same immediate and spontaneous qualities as the primary caring cycle, rather it represents the more reflected humanitarian values and principles of human rights that are a part of our culture (Berger and Luckman 1967, Bråten 2003, Skoe 1998).

When empathic care is obstructed.

But not all interaction between care-giver and child has this immediate, empathic and participatory quality. There are accounts of children being abused where this empathic caring mechanism, that I have called *empathic identification with the child*, does not seem to function or has become obstructed (or blocked). For example; when children are placed in traditional institutions (Ryan. & Tomas 1976), when there is extreme poverty and the struggle for survival, when there is brutalisation and demoralization due to wartime violence, when there is high stress and family-conflict involving alcohol and drug abuse, or when the child triggers negative images in the caregiver; images that may be associated with the caregiver's own problematic childhood (Fraiberg, Adelson, & Shapiro 1975, Pelzer 1995). In the following section we will take a closer look at some examples from my work with children in extreme situations also from my social work Angola and relate them to conditions that seem to block empathic identification with the child.

II. When children are negatively defined and stigmatised

In my experience there are two conditions that are particularly conducive to neglect and failure of care, i.e. *negative, stigmatizing definitions of the child and distancing in the relationship between care-giver and child.* These often occur together as part of a general pattern of rejection of the child and withdrawal of empathic identification and care (Scheper-Hughes1992).

Negative definitions in the relationship between parents and children often develop in situations where there is a high level of family stress and where children become a burden, both economically and emotionally. This is visible both in environments with extreme poverty in developing countries, but also in wealthy Western societies, where children may be experienced as a hindrance to the free career development of the parents. Under such circumstances, negative, stigmatizing and objectifying definitions of children, with subsequent emotional withdrawal and distancing in relation to the children, may easily develop.

The anthropologist Scheper-Huges (1992) gives a compelling example of this from her studies in the poorest quarters of Recife in Brazil. In the district where she was

working, infant mortality was exceptionally high, close to fifty percent, she discovered that poor mothers under such high survival pressure and high infant mortality sometimes withdrew emotionally from these infants as if to protect themselves from the ensuing emotional shocks and mourning when they understood that their chances of survival were minimal.

A weak and physically vulnerable child, was labelled and defined by their mother as "a child who wants to die" and a 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 so high that the mother unconsciously tries to protect herself by withdrawing her emotional attachment to the child. It is like an unconscious calculus of risk and emotional investment, and if the conclusion is withdrawal, the whole caring mechanism is at risk and the chances that the negative assessment of the infant will be self-fulfilling, is considerably increased. Under such conditions, a more pragmatic economical survival approach becomes more feasible. As Scheper-Huges expressed it::

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

In this way a self-fulfilling process was initiated on the basis of the mothers' negative diagnosis or apprehension of the child. According to the anthropologist, «there was no expression of great joy nor of sorrow»; at the child's funeral, «the infant was seldom even the focus of the conversation at all ...» (Op.cit, p.418).

It is nonetheless misguiding to interpret this as a general deficiency of empathy and caring ability in these impoverished mothers, because it was at the same time evident

that the same mothers were sensitive and caring towards the other siblings that showed signs of vitality and robustness (Dunn 1994).[2] Such a selective emotional withdrawal can therefore be understood as a strategic reaction of self- protection with the purpose of avoiding repeated experiences of loss and depression following the death of weak and physically vulnerable children to whom they were attached. Such reactions may be interpreted as adaptive strategies that emerge under difficult life circumstances where survival, both physical and psychological, has become a challenge (See also LeVine et al.1989).

In connection with social work directed towards vulnerable children in extreme situations I have witnessed similar examples of the stigmatisation of children in relation to local superstition of possession and bewitchment. In the rural districts of Angola there is a prevailing belief that if a child is divergent for one reason or another - it may be anything from physical defects and impairment, to psychological handicaps following traumatic experiences of war – this deviation is explained as result of bewitchment of the child and possession by demons. An evil spirit is thought to have entered the child and it is this spirit that creates aberrations in appearance or behaviour (Hundeide and Egebjerg, 2003).. As a consequence of this diagnosis/definition (that was very often performed by the local witchdoctor) these children are rejected by their families, both physically and psychologically. In the worst cases they are expelled from their homes and left to beg in the streets for survival.[3]

The most extreme example I have witnessed in this context is a group of impoverished orphans in North-Angola. They had been "diagnosed" (or defined) as being possessed by demons after consultation with the local witch doctor. These children were blamed for most of the local accidents and misfortunes, from deaths of people to crop failure and drought. They became public scapegoats, thus providing an explanation for the adversity experienced by the local society. As a consequence they were usually expelled from their homes, ending up in treatment centres owned by the same witch

[2] Instead of interpreting such behaviour as indications of "deficient caring competence in the mother", the focus is in this paper changed from the mother's capacities to the way she defines her children – and this is to a large extent not only a personal competence, but a situational, interactive and cultural affordance.
[3] In social sense these children serve as scapegoats being held responsible for any negative occurrence within the family or in the local community, thus functioning as a scapegoats for uncontrollable misfortunes in the community – in a similar way as the female witches of the Middle Ages who were burnt on pyres.

doctor that had diagnosed them. Here they were subject to different forms of torture or exorcisms in order to "drive out Satan". For example, they had chilli-pepper applied to their eyes, which then became swollen and red, so that they acquired the look of monsters. They were also subjected to painful cleansing rituals in which they were beaten and tormented. This went on for several months. When we[4] were given the opportunity to visit this «institution» following one such treatment, the children were already totally subdued, subjugated and traumatised. Even after the treatment was over, the stigmas persisted which again led to the unwillingness on the part of their parents to take the children back. Therefore most of them ended up as workers on the farm of the witch doctor who had originally «diagnosed» them.

An interesting point in this context in this context is that the children were themselves convinced of their own possession, and they told the most incredible stories about what they could do at night, all corresponding to the local beliefs about possession. In other words, the children dramatised the expectations, the «diagnosis» and the conceptions they were attributed. It became a part of their understanding of themselves and their behaviour.[4].

More generally, one can say that we approach other people according to our definitions of them. We continuously interpret and attribute characteristics to our fellow human beings, and behave towards them accordingly thus initiating a process that can easily become a self-fulfilling process... [5]

Objectification and abuse

Extreme physical abuse and torture usually involve objectifying and demonising definitions of the victim. «Traitor» is one such definition that appears to legitimize abuse and torture. Working with child and teenage soldiers in Angola, we[6] learned about

[4] This appears like a hidden contract between themselves and the healer about who they are, what their symptoms and powers are, and how they can be healed. (Hundeide, 2003 b and c).

[5] But the definitions that we employ in this process of reciprocal definitions are also part of a cultural repertoire of personality typifications which we appropriate as we are socialized into a community, and this may also include recipes for healing which may not always coincide with Western conceptions of therapy, as the examples above indicate.

[6] "We" implies collaborators inside ICDP, particularly Pedro and Irina Mendes, Milu and Santana

extreme abuse in this category. These youngsters had been kidnapped as children and re-socialised as guerrilla soldiers in the UNITA. The soldiers were trained according to the principle of «the son of a snake is also a snake», and this implied that entire family and all relatives were killed if one of the family members were accused of treason. They were also trained in different torture techniques to be used on alleged traitors. In an area on the border of Namibia a group of teenage soldiers participated in the execution of a group of people accused of treason. This was perpetrated by having the victims themselves collect wood for a pyre on which they were subsequently burned alive. These teenage soldiers were highly regarded among the officers because they were «totally loyal, they carried out orders and killed without hesitation».

An interview with a young female soldier from the war in Sierra Leone gives a certain impression of what they had been through:

- Have you ever killed rebels in this war?
- Yes, many times. When the soldiers came back to camp with the rebels, I was often ordered to «wash» them.
- What does that mean?
- Kill them.
- Did you shoot them with a machine gun?
- No, bullets are expensive. I killed them one by one (with a knife).
- Did you feel that you did something wrong?
- I was defending my country.
- Did you ever feel pity for the rebels you killed?
- In the beginning when I saw their dead bodies I sometimes felt sorry for them, but we had to kill them, otherwise they would have killed us if they had the chance. These rebels killed and cut open the stomachs of pregnant women. They raped all women they could get their hands on (Peters and Richards, 1998, p. 87-89)

These are of course extreme cases, but they contain some of the legitimising components one finds with lesser abuse as well.

- *An objectification, and often a demonising definition of the victim who is seen as morally inferior, non-human, traitors and therefore deserves to be abused.*[7]
- *That they were following orders - and if they did not comply, they would be killed themselves.* [8]
- *That this was in fact a noble and necessary action performed in the service of their country.*
- *These legitimising arguments seem to absolve the perpetrators from a feeling of responsibility, guilt and awareness for their inhuman actions.*

For the child soldiers, these ideological legitimations became an important part of their indoctrination and preparation for their role as "under-aged soldier"[9] (Bracken and Petty, 1998). "We killed traitors because we were fighting for our country"…[10] Many of these youngsters sustained serious psychological problems when they were subsequently to be integrated into civil society after having lived for years in brutalizing war conditions with totally different values (Hundeide, 2003b).

III. The zone of intimacy

It is worth noting that in conditions involving dehumanisation and objectification, *an invisible line appears to be drawn between «them» and «us».* «We» who are on the inside of this line may experience mutual love, empathy and human care and friendship from the others on the inside, while those on the outside are at best treated with indifference,

[7] It is important to note that this type of legitimising and stigmatisation also occurs in violations of human rights an UN conventions in the pursuit of what are called "terrorists" like the abuse of Iraqi prisoners in the Abu Ghraib Prison. One can also find comparable justifications in violence prone racist gangs, such as new Nazis (Bjørgo, 1997; Hundeide 2003a, 2003b).

[8] These experiences were a part of the teenage soldiers' training: in some cases they were instructed to kill prisoners – in some cases members of their own families - while the others were watching. If they were unable to comply with the orders or showed signs of weakness in crying or clutching, they were themselves shot in front of the other recruits. This is the terrorism that led to blind obedience to "the sergeant", who often exploited them with extreme cruelty (Bracken and Petty, 1998; Hundeide, 2003b).

[9] "Under-aged soldiers" is now the politically correct term as child soldiers is starting to have a stigmatising effect due to the violence associated with this term.

[10] When some of these child soldiers were interview individually about their future life aspirations, some them said they would become teachers, and when we asked why, many of them replied "In order to help my country!" This seems to indicate that collective national identifications were dominant even in their personal motivation and self-construction.

and at worst abused as objects deprived not only of their rights, but also of their subjectivity - to be understood and viewed as "persons" and fellow human beings with the same ability to feel and wish, and with the same need for inclusion, love and self-respect as ourselves.

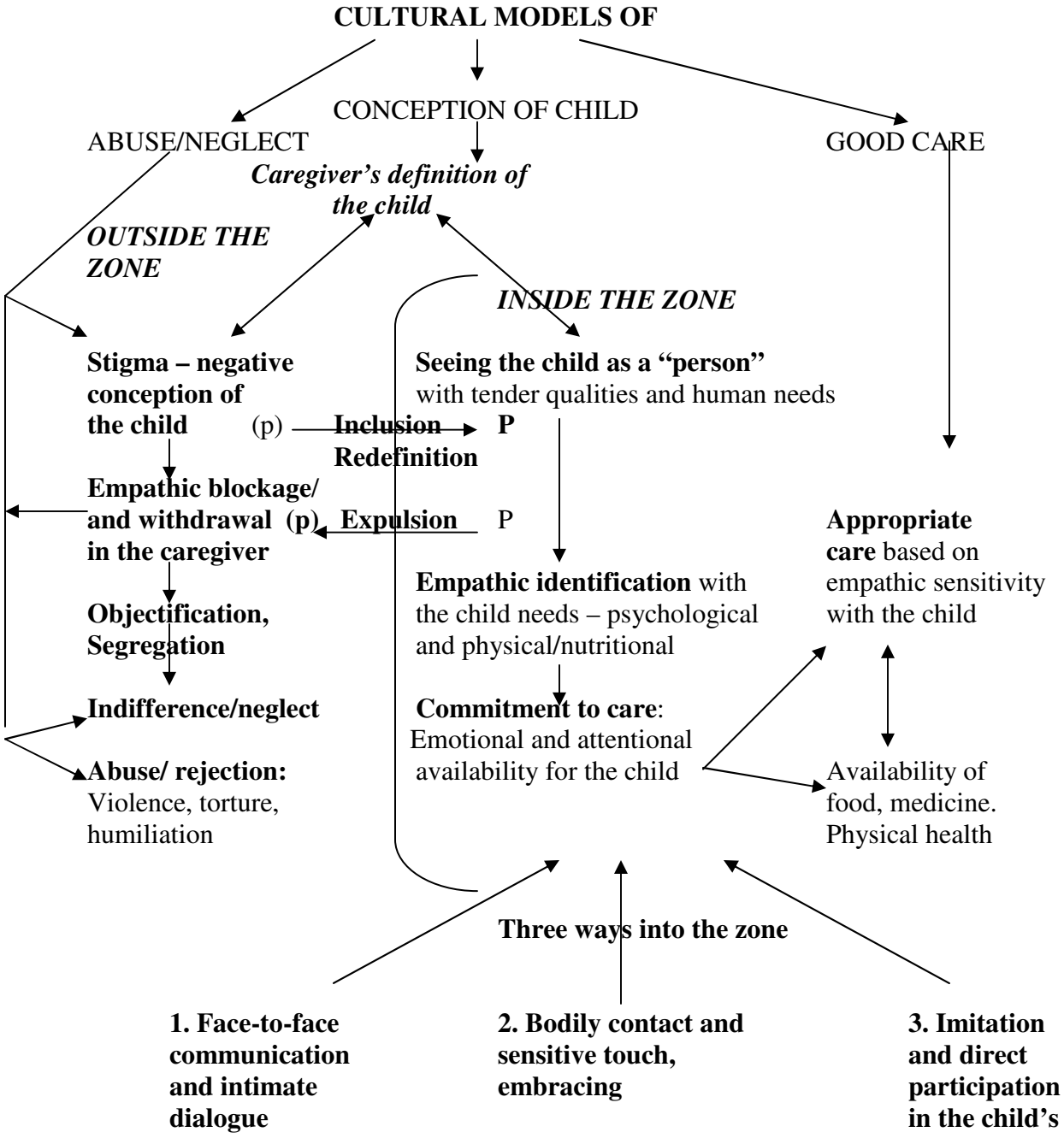
Those who are on the inside of this zone are the people we love and who are close to us - they are a part of our family. With these people we *co-experience* their state and their needs through empathic identification, and we act accordingly. We co-experience their feelings, wishes and intentions for good or bad. In relation to them, it is easy to be caring because it is a natural extension of the relationship we already have with them. The impetus for caring itself is already in existence

Those who are outside of this zone on the other hand, we do not apprehend in the same sensitive and empathic way. These are people we have an external, at worst an objectifying "I-it relation" to, characterized by indifference or rejection. In this situation it is not easy to influence and promote good caring because the relationship does not invite this as a natural extension of the relationship. They are surely human beings, although they are strangers, and as participants within a shared community we understand them according to conventional codes and rights that apply among human beings. However, this tend to be *an outwardly conventional* relation (secondary care), different from the spontaneous co-experiencing we have when someone in our family is exposed to a tragedy or a great joy. In that case *we participate* and *our experience is inward as if it involves ourselves directly and personally.*

Tragedies happening to "strangers" outside of our zones of intimacy affect us to a much lesser extent and less spontaneously. Although we may upon reflection respond in a humanitarian way, still it does not have the quality of direct unmediated emotional participation that characterizes our reactions to those who are on the inside. Of course there are gradations both inside and outside the zone of intimacy, from those whom we love and are part of our family, close friends and persons we like and are friendly with, to those on the outside the zone who are just like strangers, to whom we respond indifferently or show an externalised sympathy, to those whom we dislike or despise ("enemies") and towards whom we respond at best with indifference and neglect; at worst by objectifying stigmatizations that may legitimize abuse and violence.

This metaphor of a zone of intimacy can depicted as a physical barrier indicating those who are on the inside and who are on the outside, as shown in figure below. In this way we may locate spatially our relationship to people – from "persons" with whom we have a close personal relation with empathic identifications within the zone of intimacy, to "strangers" those on the outside with whom we do not spontaneously empathize.

MODEL OF HUMAN CARE IN THE ZONE OF INTIMACY



activity

As indicated in the model, there are cultural conceptions and folk theories that direct both our normative conceptions of a "normal child" (Goodnow 1990), our prescriptions of good care (LeVine, Miller, West 1988) and even of abuse and maltreatment (Rohner 1980). These conceptions become embedded in our taken for granted cultural and institutional practices, which again influences the way individual care-givers relate and interact with their children.

On the positive side, this model shows that *seeing the child as a person*[11] *is the first step towards humanisation and inclusion.* This means that we see the child as a fellow human being with the same needs for security, love, approval, self-respect and human rights as we have ourselves. When this conception of the child is in place, the crucial mechanism, that I have called *empathic identification with the child* , may be released. As shown in the model this again implies *emotional and attentional availability to the child* and sensitivity to its psychological and human needs. In this state of increased sensitivity the care-giver is capable of recognising and reading the child's expression and utterances and refer them to the child's mental state, its emotionality and intentionality. This is what Fogany et al. (1991) calls *"mentalising" – the ability to read the other person's mind* – an essential precondition for sensitive care, and another manifestation of the care-givers empathic identification with the child.[12] *Commitment to care* follows as a natural consequence of this increased sensitivity and engagement, which again makes intervention in the form of facilitation and reactivation of good caring practices easy (Hundeide 2001). By including the child into the caregiver's zone of intimacy, it is possible to elicit her empathic identification with the child, which in turn provides a

[11] The concept of "person" as opposed to a non-person, a thing, has been used in social science to indicate the crucial importance of labelling, stigmatisation and negative definitions when violence, terror, torture, massacres and crimes against humanity are committed (see Buber, Bauman, Bråten, Christie and Smedslund). The concept of "person" is not necessarily limited to human beings; a loved animal, a pet, a dog or a whale, can become the object for person-attributions, which implies that they are perceived as having similar sensitivity to pain. suffering and humiliation and also similar needs for being secure, included, loved and respected – as we ourselves have… They are, in other words, co-human beings. This makes empathic identification possible.

[12] In a similar vein, Daniel Stern talks about the "the intersubjective matrix" which implies that our mental life, our personal feelings and thoughts are "cocreated through dialogues with other minds" (Stern 2003, p. 77)

deeper and more sustainable basis for care. When this mechanism functions, the caregiver is always «with the child», and it is therefore easy to influence the relationship between them in a positive way, whether it concerns the child's physical or its psycho-social health,

On the negative side, when a child is negatively defined and stigmatized in some way, i.e. as possessed, or as a child with bad or evil character, a monster, there is natural withdrawal and distancing from the child. The empathic mechanism of spontaneous identification and participation in the child's feeling and experience is blocked and obstructed. The child is no longer seen as a person and as a co-human being – he is outside of the zone of intimacy, at best as a stranger and worst as a despised and demonized enemy. This objectification is usually combined, not only with expulsion from the psychological zone of intimacy, but also with physical segregation and distancing ("Apartheid") which again prevents direct eye-to-eye and face-to-face contact (see later).

A typical example of this objectification is children in bad institutions and orphanages. As Ryan and Toms (1995) conclude in their analysis of depriving institutions for mentally handicapped persons:

1. The patients are categorised either as normal or abnormal, and there is no option for the abnormal to share any of the psychological characteristics of the normal.

2. There is no possibility for the abnormal to be anything other than what is designated by their social roles and negative definitions, in this case that they are mentally retarded - and nothing else.

3. There is *an unwillingness to accept their subjectivity as persons* - that they have their own subjective consciousness, feelings and thoughts and inner experiences of themselves and others.

In the worst cases these inmates of such institutions live in a dehumanised world in which they are being seen and treated as objects; sometimes referred to as numbers with uniforms to emphasise that they are not unique persons, but outsiders, more like objects. This is dehumanization and de-individualization that invites empathic withdrawal, objectification and abuse. Certainly not all institutions are like this.

IV. Ways in and out of the zone of intimacy: Expulsion and inclusion.

As indicated in the model, the zone of intimacy is both flexible and permeable. It is flexible in the sense that an episode, such as a moving film or story, can temporarily open up and expand our zone of intimacy so that we may include and identify empathically with a suffering child who is normally outside of our intimate network: «it could have been my own child». But it could just as well have been an account of an enemy that makes us withdraw all empathic commitment so that the person (enemy) remains on the outside of the zone of intimacy - remote as an object. In the model this definition (apprehension) of the other as a non-person is indicated with a (p), while the included person is indicated with a P.

The zone of intimacy is permeable in both directions in the sense that it is possible for a person on the inside to be expelled from the zone, i.e. P → (p). He then becomes a stranger or an object with which one no longer feels empathy and sympathy, but rather distance and remoteness.

In the same way, a person on the outside can be included in the zone, "be brought in from the cold" and take part in the human fellowship on the inside, in which one feels closeness and care for one another (p) → P [13]

In order to arrive at this state of emotional sensitivity to the Other, it is necessary to be in close contact. This can occur by way of what I have metaphorically called *the three ways into the zone of intimacy.* These ways are:

- *face-to-face communication and intimate dialogue*
- *bodily contact and touching*
- *imitation and direct participation in the activities of the other*

[13] According to Bauman (1996), this was one of the things the Nazis tried to prevent. Face-to-face contact with "the Jew next door" could be the basis of inclusion into the zone with sympathy and empathic identification.

I will deal with each of this ways through some case studies from our work in Angola.

Inclusion into the zone through face-to- face and gaze contact (p) → P

Face-to-face contact is one of the ways into the zone of intimacy and empathic identification with the child. Face-to-face contact will also provide eye contact and the reciprocal exchange of facial expressions and speech. A strong and direct emotional experience can create sensitivity and openness to the child's attitude, or the «victim's». «the appeal of the face» is brought to bear, as Levinas and the ethics of closeness has described it (Vetlesen, 1998). There is a body of literature on the importance of the face and gaze in the establishment of emotional contact that I am unable discuss here (Ekman and Friesen, 1975; Vanderberg, 1999; Oppenheim et. al., 2003).

The impact of face-to-face contact and gaze contact became clear to me through an experience recounted to me by a close friend. It was about his relationship with his son who had Down's syndrome:

When after scanning, the doctors told him that they would have a child with Down syndrome, he became very agitated and depressed, despite his daily contact with handicapped children at work. In the beginning after his son was born, he had great problems in looking at him, touching and holding him. Despite his explicit ideology about the acceptance of deviations there was something in him that was unable to accept that this was his own son. This continued for some time. He was unable to relate to the child, and he avoided and ignored him. But one day his wife asked him to hold the child - who was then an infant - in such a way as to gain direct eye contact with it. He then experienced that the child looked him in the eye, smiled at him and reached out for him - and this was what it took to break the ice. It gave him an emotional shock. For the first time he could see his son as a smiling, but vulnerable and helpless person who turned to him. This was a breakthrough in his relationship with his son.

Experiences such as these, where there has been emotional rejection of a child, are not unusual. It is as if the profound feeling of emotional contact and acceptance of the child breaks through when it is experienced as a helpless being, combined with a feeling

of «my child needs me». This appears to be a fundamental aspect of all empathic care and a precondition for what I have called empathic identification with the child. [14]

This example also demonstrates the strong effect which direct face-to-face encounter and gaze contact can have on the relationship between the care-giver and the child. Since this is a two-way dialogical process and not confined to care-giver-to-child but also from child-to-care-giver, it is apparent that expressive children can have a humanising effect on adults: through their emotional expressive signals, usually experienced as expressions of innocence, vulnerability and helplessness, they invite care and empathy in most people - even people who rarely express such feelings themselves

However, not all infants or children have this immediate emotional appeal. Some are unattractive, even ugly to look at. Others are passive and not very expressive, they give weak or ambiguous emotional signals. In such cases it may be important to help the care-giver to establish contact with the child by identifying the signals that are there, gradually supporting a positive re-definition of the child as a person needing care (see the ICDP programme, Hundeide, 2000).

Let us compare two of the examples we have mentioned and relate them to model of the zone of intimacy. In the example of the «children who wishes to die» mentioned at page 5,we see a mother who withdraws emotionally from the child because it was defined as an «angel who wished to die». A withdrawal of emotional identification occurs as a consequence of the negative definition, and the child is expelled from the zone of intimacy.(P ->(p)). In the example with the father who could not accept his child, but who experienced an emotional breakthrough in contact, we see the opposite. Through gaze and the experience of the infant's expressive appeal, the father gained a spontaneous emotional contact with the child, which in turn initiated empathic identification with the child - «my child». From being ignored and overlooked, the child was included in the zone of intimacy and care ((p) ->P). From being a non-person, the child has become a person for whom the father feels protective, i.e. there has been a movement from (p) to P.

[14] In his recent book " The Present Moment" Daniel Stern (2004) points out the significance of short moments of intense contact "... in which both partners create and undergo a joint experience…This resonant experience enlarges the intersubjective field between them and opens up new possibilities for exploration…" This is exactly what happened in the example described above about the father and his Down Syndrome child. The intense moment of eye-to-eye contact became a turning point in their relationship.

Furthermore, these two examples illustrate two important ways into the zone of intimacy, i.e. the importance of positive definitions of the child, and the importance of expressive exchange through face-to-face contact and gaze contact. Body contact is also an important way into the zone of intimacy as we shall see in the next section.

Inclusion in the zone of intimacy through sensitive touch and bodily contact

In the ICDP's work with orphans and neglected children in different parts of the world, we have observed the importance of bodily contact and affectionate touching when treating children who have been subject to affective deprivation and traumatisation (Field, 1990). I will discuss two examples from Angola.

We observed a blind girl in an institution for children with multiple handicaps. When she arrived at the institution she was so weak and undernourished that she could hardly walk. After a period of time with supplementary feeding and care her condition improved, and this was when we discovered that she was almost blind. This made communication with her very difficult (the signals for mutuality were ambiguous), and when we met her, she appeared to ignore human contact while the physical care was seen to. Through sensitive physical communication it was possible to achieve contact with her again. We have video recordings of the emerging interaction between the girl and one of our female "facilitators", who first approaches the girl by taking her hand, holding it and gently caressing the hand with sensitive touch. We can see how this leads to a change in the girl's expression: she leans back, relaxes, smiles contentedly and appears to enjoy this intimate contact. The facilitator gradually expands the physical contact by first touching the girl's lips and then her cheeks with affectionate stroking. Finally, she puts her arms around the girl and holds her closely. The girl responds by putting her hands around the supervisor's neck and clinging to her as if a crucial need in her is satisfied. While the supervisor holds her like this, she speaks into the girl's ear, repeating her name and guiding her hands towards her eyes, nose, mouth and ears while repeating the girl's name and the names of the body parts she is touching. In this way they come to understand one another and by speaking about the same things, a space for inter-subjective sharing was created between them ... All the time the facilitator holds the girl tightly to herself, and

there is a contented smile on the girl's lips. The ice has been broken and an intimate contact is in the process of developing between them.

Through sensitive physical contact, touching and intimate dialogue it was possible to bring the girl into the zone of intimacy - or more aptly; they included each other mutually in their own zones of intimacy.

Sensitive, affectionate touching that leads to close embracing is the prototype of closeness and mutual love, whether in relation to an infant or a partner in an adult love relationship. In a situation of sorrow, loss, neglect and despair, such contact can often release repressed feelings and tears, which may relieve pressure and provide a considerable sense of comfort and security. Nonetheless, this is a powerful form of intervention and contact, and it must be applied with sensitivity and respect for the other person's limits - more as a spontaneous response to the other's expression and appeal. Because the danger of infringement is of course great in such situations and in relation to persons with strong dependency needs. Therefore, this method must be used with prudence and follow-up in order to prevent new disappointments and new betrayals.

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

Another way into the zone is by first establishing contact by imitating the child's gestures and initiatives, and then gradually developing this into communication and participation in the child's activities. This is a way of responding by following the child's initiative. As long as a child produces expressive or goal oriented initiatives and actions, it is always possible to start a simple communicative cycle by imitating and complementing the child's actions, following the child's initiative and thus initiate a cycle of turn-taking.

The most well known example in this regard comes from Hunt's intervention study in Iran. In addition to instructing the care-givers to express an affectionate attitude towards the children, he particularly asked them to imitate the children's gestures and expressions so that a simple communicative cycle could begin. It was this simple, pragmatic instruction that turned out to have a very strong positive effect on the orphans subsequent development when they were compared with a control group only receiving

so-called responsive toys, in line with Piaget's theory on the important role of self initiated actions (Hunt, 1982).

In our work in Angola, the ICDP-team has occasionally employed the same technique, particularly in cases where there have been contact difficulties. In one case, one of our facilitators was contacted by a father who was an alcoholic and unable to take care of his two and a half year old daughter after his wife died. At that time the girl functioned apparently normally for age and she was able to say a few words. Due to her father's condition she was placed in a very poor foster home with a foster mother who was only interested in the financial benefits of keeping the child, thus subjecting her to extreme neglect.

The child was placed in a small room where she spent the next two years without any form of human contact. There was a little window high up on one wall, but no toilet. The room was never cleaned, food was thrown in once a day, and the girl lived in her own dirt for two years. When this state of affairs was discovered, one of our facilitators intervened and got the child out of the prison. At this time, the child could no longer walk properly, but crawled about on the floor making sounds like an animal. She had rat bites all over her body. It was impossible to establish eye-contact with her or gain contact through face-to-face expressive exchange. She did not respond to normal communicative expressive signals, and her face was closed and devoid of expression. She avoided eye contact and she constantly moved restlessly around in the room. The only thing that caught her attention was when she was given food, at which she produced a specific sound - something like «tchee-tchee». While this went on it was possible to focus her attention on the food for a short time.

When one of our facilitators started working with this girl she was more than four years old. The facilitators was deeply committed to help this girl and in line with the ICDP approach she started by looking for expressive signals, initiatives and actions that she could relate to and imitate in order to start a communicative cycle (Hundeide 1991). In the beginning, these signals were the same sounds that she made in connection with feeding. After a period of time, she was able to distinguish more signals from the child, and began to use them systematically in relation to food, washing, visits to the toilet and play. Little by little, *a rudimentary communicative system based on imitative signs and*

sounds began to develop between them that seemed to work well in their practical daily lives. The girl also began to show signs of emotional attachment to the supervisor, showing joy when she visited her, and distress when she left. Gradually, her facial expression also changed, becoming more lively and expressive and it as also possible to obtain eye contact with her. Slowly she began to reciprocate the facilitator's expressive initiatives with similar expressive utterances, such as smiles and bodily contact, for example tickling. In time she was also able to focus her attention on one activity over a somewhat longer period of time.

When I saw her at a later point in time it was possible to establish eye contact and exchange mutual expressive utterances; smiles and sounds, in the same way as one would communicate with an infant. She could walk, albeit a little unsteadily, and she showed a particular trust in her brother, and liked to sit on his lap. Evidently, there was a normalisation and humanisation process under way. This process started through sensitive communicative contact with another person, a facilitator, who managed to establish contact and communication with her through imitation of her *accessible gestures and expressive utterances.* This is where the development begins. At this level, one must begin where the child is, with the utterances and expressive initiative that are accessible.

V. The ethics of closeness and the primary cycle of care.

In this account I have placed the main emphasis on what I have called the primary care cycle. This implies an assumption that caring has its roots in a pre-verbal and pre-theoretical disposition that is apparent in the infant immediately after birth. In more general terms, one can say with Trevarthen that there appears to be a «dynamic 'together-with-the-other-consciousness" that comes first and that is sustained throughout our lives in our deepest moral core». He further elaborates this in the following quote:

> "The human consciousness seems to emerge from a completely non-rational, non-verbal, concept-less and totally non-theoretical potential for participation and communication with other persons that one can see first in infants."(Trevarthen 1996, p. 8)

This is a radical claim that goes against the traditional view of how the human consciousness (the mind) is formed as a result of linguistic socialisation. According to the new perspective, it is rather a primary inter-subjectivity, formed before language, that constitutes the basis for how further socialisation evolves (Bråten 1998, Stern 1985, Trevarthen 1989).

Quite surprisingly, this radical viewpoint appears to accord with French philosopher Levinas and his idea about the «first philosophy» in which ethical responsibility for the other through the direct "appeal of the face" itself comprises the basis for our subjectivity. In Levinas' words:

> «When the other looks at me, I am responsible for him without expecting reciprocity on his part ... responsibility for the other is the crucial, primary and fundamental structure in our subjectivity» (quotes from Bauman, 1996, p. 180).

Bauman further concludes with the claim:

> «Morality is not a product of society, it rather it is the moral relation that is primary, something that society manipulates, edits and confuses ..." (quotes op.cit. p. 182-183).

In a review of the relationship between the new communicative developmental psychology and the ethics of closeness, Vanderberg (1999) points out that the new findings in early communication appear to support the basic perspective of the ethics of closeness, He mentions the following converges between the two positions:

- The view on the primary moral relation as «the first philosophy».
- The significance of the appeal of the face and expressive closeness as fundamental to the development of responsibility for fellow human beings.
- The dangers of remote relationships which deprive human beings of the direct experience of the other's face and thus the feeling of direct responsibility.
- The dangers inherent in the abstracted and "totalizing gaze" of the bureaucrat - the glance from a distant and abstract position

- The dangers of negative definitions that can legitimise dehumanisation and infringement, freeing the perpetrator from the feeling of responsibility for fellow human beings.

In line with this viewpoint, the care of others is not only something we do for others, but something we do in order to recreate our own human subjectivity - our deepest moral core.

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