The minimum ICDP material for international use

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Content

Preface

The minimum requirement for a project to call itself an ICDP project

Over the years the ICDP program has gradually been spreading in different countries all over the world. The local teams have in some countries prepared adapted versions of the ICDP materials, and in doing so they had occasionally departed too far from the original ICDP manual, either by over complicating the simple ICDP messages or by omitting important concepts.

It is possible to make adaptations to the ICDP program materials but the question is how to accomplish such adaptations without losing the hallmark of ICDP?

"The ICDP material for international use" is a booklet designed in relation to this question and it contains an outline of key concepts of the ICDP program. The content of the booklet is extracted from the "Facilitator's Manual for the ICDP Program", where full explanation of these key concepts and principles is to be found.

The "Facilitator's Manual for the ICDP Program" was produced for the purpose of training and applying the ICDP program in practice; it is issued by ICDP International in connection with ICDP training workshops. However, in cases where a local ICDP team decides to make their own ICDP materials, we would expect their materials to include the "ICDP material for international use". By including this booklet as part of locally adapted ICDP materials, we hope to ensure the application of its content in the practical work with caregivers.

The hallmark and flexibility of the ICDP program lies in the nature of its underlying philosophy which does not recommend instruction, but instead encourages individual and group reflection and sharing of practical experiences concerning each of the ICDP themes and principles contained in "The ICDP materials for international use". It is in that spirit that we present this booklet to our colleagues working in different ICDP projects wishing them success in their international endeavors carried out for the benefit of children and their caregivers.

ICDP International

Part 1 - The interaction between caregiver and child

1. The ICDP Program – an interaction-oriented and empathy based program

About the ICDP Program

ICDP[1] is a simple community oriented program with the objective of supporting and promoting psychosocial care competence in the persons responsible for children's care-giving. The program is based on universally accepted humanitarian values about the significance of activating human empathy and compassion as a basis for care for children in need. The ICDP Program is another expression of the same humanitarian spirit as it is encoded in the convention of children' rights.

The program is "community based" or "community focused" and preventive. This means that the program is generally carried out in a local community without a specific focus on individual clients, such as clinical consultant services have. In this way, we expect to reach further and thereby add to the specialized clinical consultant services.

When this program is to be carried out in practice, we mainly use local resource persons who have respect and influence, so that in this way we may get access to local communities and influence and deal with local attitudes, perceptions, customs, and conducts – without appearing intruding or offending.

These local resource persons are then trained to be facilitators in the ICDP Program, and these facilitators will lead groups of caregivers when the program is set out in practice. Participants in the facilitator training can be parents, kindergarten staff, teachers, nurses, or staff from the child welfare authorities etc.[2]

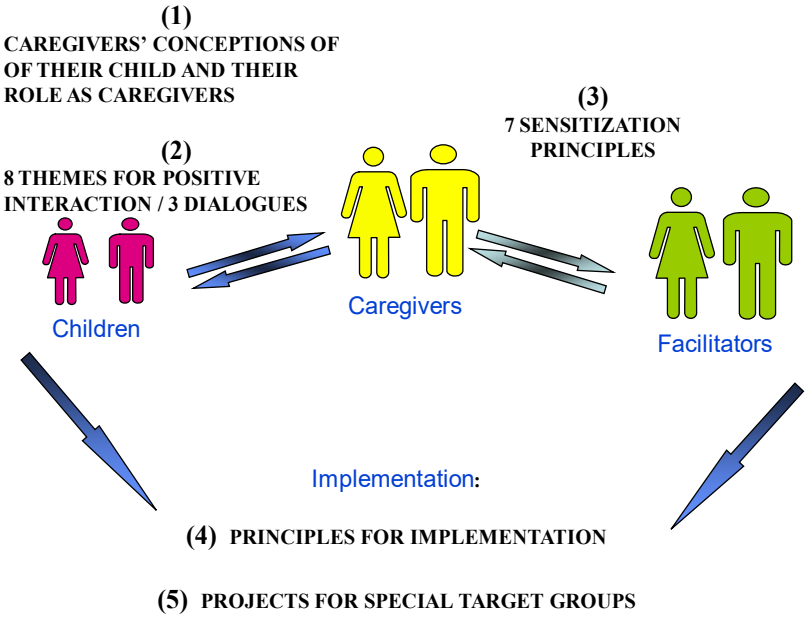
The most important components of the ICDP program are the following:

1. The caregiver's conception of the child (the child as a person)
2. The three dialogues and eight themes on positive interaction
3. The principles for sensitization
4. The principles for implementation
5. Projects for special target groups

These components are illustrated in the figure below:

[1] "ICDP" stands for "International Child Development Programs". Confusion can easily arise here as the abbreviation ICDP is used both for the ICDP program described in this manual, and for the ICDP institution. This is a Norwegian institution working as an NGO with projects in different countries.

[2] In culture-oriented developmental psychology emphasis is on the interaction between the child and the central caregivers because research shows that if children's development is to progress in the best possible way, there is a need for sensitive assistance from close caregivers who can both create emotional confidence and direct the child to understand and manage the challenges it will encounter growing up. The central components in the ICDP program have broad scientific coverage in developmental psychology.



The objective of the ICDP program is primarily to influence and improve the quality of contact and interaction/relation between the caregivers, usually parents, and children, and for this purpose we have developed eight themes on positive interaction, which we also have abbreviated "three dialogues between caregiver and children" (2).
However, in order to develop a positive interaction, it is necessary that caregivers have a positive conception of the child; he or she has to perceive the child as a person with potential for development, a person whom she cares about and whom he/she can "identify with emphatically"(1).
If she has a negative conception of the child, it is hard to encourage a positive interaction and care between the two. Therefore, we strongly emphasize encouraging a positive conception of the child in cases where this is negative and limited, and we have developed methods for this purpose.

In order to encourage the caregiver's relation with the child, it is also important how the facilitator behaves when assisting the caregivers (parents) to improve their interaction and relationship with the child. Traditional imposition and instruction are of little use, and we have therefore *developed seven principles for sensitization which emphasize supporting caregiver's own activities and self-awareness,* as opposed to implementation and imposition of "behavioral recipes" unfamiliar to caregivers' own understanding and practice (3).

However, it is of little help to sensitize caregivers for example in an institution if the key persons are against changes. In other words, there have to be certain external conditions in place in order for the program to be carried out in practice in an efficient way, which influences the children, and which is sustainable. Therefore, we have developed *the principles for implementation (4)*.

Finally, as we are working with *different target groups, we have developed different agendas adjusted according to these groups, but still based on the same ICDP principles.* This concerns children in kindergartens and institutions, in schools, children with war-traumas in camps, street children, children with special needs, child welfare etc. (5).

2. Caregiver's conception[3] of the child

Unconsciously, we all carry with us conceptions about how the ideal child should be, how we wish our child should be, which qualities it should have, about what is a good way to bring children up etc. These are conceptions we normally taken for granted because they are of course part of our background. When we meet people with different conceptions, for example ethnic minority parents, we become aware of our own conceptions. These are values that have been shown to change in accordance with history and culture. It is important to be aware of this because we cannot expect everybody to have the same conceptions about childrearing goals and care.

Therefore, in relation to childrearing, treatment (intervention) and diagnosis of children, it is important to be aware which values we assume and which qualities we wish our children to develop. People from different cultural backgrounds may have other values from us in that they for example, emphasize obedience, respect, loyalty, and "dependency" more than we do, and as result such qualities may be perceived as deviation and pathology. *It is therefore important, within a multicultural society, that there is tolerance for variation so that cultural differences are not perceived as deviation and pathology as it can easily happen*.

Perceiving the child as a "person"

Perceiving a child as a person means that we expect that infant to have the *same need to be loved, included, respected, and understood as we have. Furthermore, this means that we, as persons and social beings feel committed to treat her or him accordingly. This also implies the opposite, that we do not underestimate, humiliate, exclude and ignore, misinterpret and misjudge, but instead make an effort to look for the positive – in the same way as we would like to be considered and perceived by others* (see Vetlesen 1996). This is the humanistic basic point for the ICDP Program.

Empathic identification with the state of the child

[3] Alternatively we could also use the terms perception or definition.

This is basic because it allows us to recognize in the child the same need, pleasure or suffering that we experience ourselves in similar situations. It is what makes empathic understanding possible; that one empathizes with the child, shares its suffering or pleasure. I have called this the *"empathic identification"* with the child. We can then activate our own experiences from similar situations… (Hundeide 2000). It is this ability for empathic identification which renders possible empathy and shared experience, which are the preconditions for sensitive care-giving, sensitive interaction, and sensitive pedagogy (Bråten 2000, Stern 1995, Hoffman 2000).[4] On the other hand it is obvious that this is an ideal condition considering all the suffering and lack of care-giving experienced by children all over the world.

Seeing and interpreting the child's expressions and signals

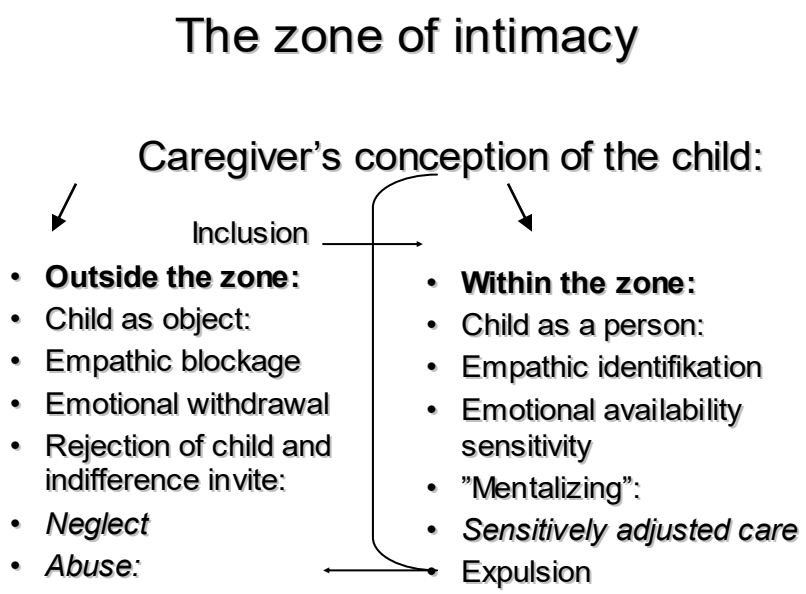
When we refer to the ICDP Program as a sensitization program, this implies that we also train ourselves in seeing and interpreting facial expressions, gestures and body language, quality of voice, etc. This sensitivity is a condition for us to be able to communicate with children's feelings and intentions before children can express themselves verbally. "Following the child's initiative" presupposes that one can "see" and "read" the child's initiative and expressivity, which is an ability that is often lacking in caregivers (Stern 1995).

The zone of intimacy – inclusion and exclusion

Without thinking about it, it is like having a zone around us, which we have called the "zone of intimacy". The people inside this "zone" are the people close to us, those we perceive to be our family and closest friends. These are the people with whom we have such a close relationship that when they experience pain or sorrow, or success and happiness, it affects us so that one can talk about "shared experience" and "empathy". This is a spontaneous and un-reflected reaction (Bråten 2001).
We do not have a corresponding sensitive empathic relationship with the people outside this zone – they are strangers, and as people inside a community we relate to them, at best in a polite and friendly way, in line with conventional codes and rights for treating other people. This is an **external relationship,** different from the spontaneous "shared experience" we have when somebody in our family experiences a tragedy or a great pleasure, which we experience as an **internal part of ourselves.** The tragedies hitting people outside our zone of intimacy affect us to a much lesser degree and less spontaneously. People who find themselves outside our zone of intimacy may be strangers to whom we are indifferent, or for whom we may hold external regard and respect, or in the worst case scenario they may be enemies with whom we have a

[4] Recent care-giving ethics inspired by the philosophers Levinas and Løgstrup argue that these are basic qualities of being human. This point of view is also supported by recent communicative research about the infant's ability to empathic or 'altercentric' participation (see Bråten 2003, Trevarthen 1999).

dismissive or hate/revenge relationship. To illustrate this, we can imagine a picture of a physical barrier which we identify as the *boundary of intimacy* as figure below shows:



The zone of intimacy[5]

As we see from the figure (one arrow pointing outwards from the zone and another arrow further down pointing inwards), both *inclusion and exclusion* can occur from the zone of intimacy. Inclusion is already mentioned, but exclusion happens when a child is for example, emotionally rejected by the family, stigmatized and at best neglected – in the worst case abused, as was the case with the child called "it".

In some cases neglect may go so far that the Child Protection social workers have to intervene and the child has to be removed from his home and parents in order to be protected. Even in cases where the child is not physically excluded, the life in the family may be characterized by neglect and brutality to such an extent that the child in reality feels "outside". *Being excluded – outside the zone of intimacy - does not necessary mean that one leaves the scene or the "home" physically. Rejection and inclusion refer to the relationship between people.*

Sometimes this exclusion is a two-way process, in the sense that the rejected also contribute to their rejection and exclusion by dismissing contact and by isolating from others; or it may be that they reject certain people in their environment. In this context it is important that the person approaching the child respects his or her vulnerability, private

[5] The zone of intimacy is a metaphor which in a simple way indicates the difference between being included or expelled from close intimate contact. But there are intermediate states where people are neither inside as "persons" or outside as "objects", they are "Others" or "strangers" with whom we relate in a normal conventional way. Thus most people fall in-between the two extremes in the model above.

boundaries and fear of re-opening. New confidence can only be built step by step from both sides.

When children are defined positively

There are examples all over the world of children who are perceived as objects without value, and who are treated accordingly, with disregard and neglect, or in the worst cases as things that can be sold and abused in the most grotesque ways (see UNICEF reports on sale of children as slaves). In these circumstances it is obvious that children are not perceived and treated as "people" and social beings.

How the child is perceived (defined), is decisive for the care it receives

When a child or a pupil is perceived (defined) negatively, it usually means that the likelihood of support and care from his closest people will be reduced.

Typical categories of "folk-stigmatization"

1. *Stigmas related to school failure* – this may invade a child's self-perception and reduce his confidence and ability to cope and take challenges in other situations.
2. *Family stigmas* within the local community. These may be transferred to the child so that s/he is prejudged as belonging to "that family"…
3. *Cultural stigmas* against particular ethnic or social group. This is usually called "racism" – colour of the skin etc.
4. *Children with deviant appearance* - they may have some physical defect or it may even be their way of dressing. They are expelled from the in-group of "cool" children.
5. *Children with a professional diagnosis*. Sometimes a diagnosis (like ADHD) may have a negative effect both on the child's self-perception and on the caregivers/teachers' expectations of that child…
6. *Stigmas in a family with high stress* and disturbance, where the child becomes the *family scapegoat*…
7. *Disturbed parents with negative models of care that stem from their own childhoods* who project these models on their own children.

This shows that the same processes of inclusion and exclusion which are normally connected to more extreme situations with harassment and violence can also happen in relationships between ordinary people at work, home and in school. Some children and adults are defined negatively and pushed out from the intimate fellowship, and are exposed to bullying and abuse, often related to a negative definition (or conception) so

that one can say that he or she deserves it. These are normal processes we all experience in our daily interaction with others[6].

When children are perceived as "objects"

There are examples all over the world of children who are perceived as objects without value, and who are treated accordingly, with disregard and neglect, or in the worst cases as things that can be sold and abused in the most grotesque ways (see UNICEF reports on sale of children as slaves). In these circumstances it is obvious that children are not perceived and treated as "people" and social beings.

When a child is perceived as a "monster", as "evil" or "possessed" [7] then most of the child's actions (utterances) are interpreted negatively and the chances are that such a child is expelled from the zone of intimacy, neglected and at worst mistreated and bullied. The box below shows how important it is to help such parents to "see" and define the child in a new and more positive way:

Physical abuse and caregiver's interpretation of the child's signals

It has been shown that one of the most promising approaches to treating parents, who physically abuse their children, is to try *helping them redefine their conception of the child's signals when problems arise* (Siegler, Deloache and Eisenberg 2006). *When problems arise, abusive parents tend to almost always ascribe evil intentions to the child, directed towards them as parents; the child wants revenge and wants to hurt and undermine their authority.* Parents then react with violence and abuse in order to maintain respect and "to defend themselves" against the child. In such a situation, parents need help to redefine the child's behavior and see that there may be other reasons for the child's reaction than evil intentions directed towards them. In an investigation where such redefinition techniques were used on abusive parents, there was a considerable reduction in physical abuse compared to the control group (Bugental and colleagues 2002).

[6] Negative definitions can often serve as a reason for neglect and abuse (Bauman 1997). We see this in extreme forms in war situations where the enemy is almost always described as a monster with only negative qualities, which justifies treating him brutally and with violence - he deserves it.

[7] Psychological diagnoses also belong here because they can easily have a stigmatizing effect, although this is not intended. Still, such diagnosis may pursue the child in an unfortunate manner (Hundeide 2003, Pihl 2006).

What can be done when children are defined negatively and excluded from the zone of intimacy?

- ***Point out positive qualities of the child***

The easiest way is for an important person in the caregiver's environment to *point out positive qualities of the child.* We have used this simple technique in child health centers, schools and kindergartens where the parents have been developing a negative relationship and conception of the child. In such a situation, we used a person of authority for example, a kindergarten teacher, to establish contact with parents and give them positive feedback about their child when they arrive to collect him or her from school, by telling a story about something their child had done or achieved.

- ***Use pictures to release positive stories about the child***

This is a technique which easily activates caregivers' conception and empathic identification with their child. When parents look at pictures and start to talk about the positive experiences with their child or children, their feelings are easily moved as they talk. It is easy for them to continue talking about their child's special qualities and strengths, as well as areas where he or she is more vulnerable and needs the parents' support. When this happens in a group with other caregivers a positive atmosphere is created that focuses on the positive aspects of the child.

- ***Share positive memories from the child's past***

This is important in cases where the relationship between parents and children may have been locked in a negative cycle of communication where empathic identification with the child is blocked. Here also pictures can be used to bring back positive memories from shared experiences between parents and children, e.g. when they were on holidays or during the time after the birth. When a caregiver talks about such events, the feelings from that time usually return; happiness, the feelings of love, the vulnerable sides of the small child… These are positive moments from the past which can have a healing effect on a frozen relationship. When such positive feelings are activated, positive changes in the relationship may occur – especially when this is supported by others (Stern 2003). This may then become an important step in changing the direction of the relationship and reaching reconciliation.

- ***Redefinition: Point out the positive aspects***

When we attribute to the child negative qualities, it is often a biased description of the child. Most of us have many and partially incompatible qualities which are expressed in different circumstances. We are not always the same person in all situations. This also applies to children who are perceived negatively. One often disregards the fact that the same qualities which are described as negative, may also, in a different connection have positive sides. For example, when a child is described as "aggressive, dominating and outrageous", the negative description may have its positive counterpart and the same child could be described as having "a strong personality" or to "have leadership qualities…" An "apprehensive, shy, and withdrawn" child could be seen from the opposite pole as "an extremely sensitive person, a talented artistic type…" etc.

In this way most negative characteristics can become positive, which helps the caregivers to redefine their conception. So the caregivers need support and assistance to notice to a higher degree the positive aspects of their child's personality. With some training this can become a natural way to refer to children with problems, which may have a considerable effect on insecure parents.

- ***Use a positive and authoritative way of speaking***

The way that we talk about children, i.e. our way of speaking ("discourse"), influences both our own and other people's attitudes towards the child and its care. The way we talk about children can create space for a more sensitive and loving care or it may close such attitudes by using a negative, cynical and stigmatizing way of speaking.

Exercises and questions for all participants must answer:

- *Which qualities do you wish your child to develop? How would you describe a "good child"?*
- *What constitutes good upbringing of children? What constitutes bad upbringing of children?*
- *Please give examples of a child that is negatively defined by parents of teachers.*
- *Please give examples of the consequences when a child is being negatively defined (stigmatized).*
- *Go through the above mentioned techniques for positive redefinition and provide personal examples showing how these techniques impacted either yourself or the people close to you.*
- *If you are a care-giver, either caring for your own or other people's children, try out these techniques and write down how they work according to your experience.*
- *Terminology: What does the following mean:*
  - *The child as a "person"*
  - *The child as an "object"*
  - *Negative and positive definition of the child*
  - *Empathic identification with the child*
  - *Emotional availability*
  - *The zone of intimacy*
  - *Inclusion or ejection from the zone for intimacy*
  - *Objectification and demonization of children*

3. The three dialogues and the eight themes on positive interaction:

The quality of interaction is decisive for children's development

One of the most important conclusions from recent developmental psychology is that the quality of interaction between caregivers and children plays a decisive role in children's development (Schaffer 1996).

It was previously assumed that the infant was born rather asocial and only gradually developed socially. However, now we know from intensive research in this area, that *the infant is born with strong predisposition and initiative to establish contact and communication with people;* that it recognizes the mother's voice immediately after birth, and that it shortly after birth prefers manlike pictures. Shortly after birth, babies can imitate simple facial expressions and after some weeks, it is possible to start a mutual exchange of sounds and expressions which resembles a conversation, hence the name proto-conversation (Bråten 2002, Trevarthen 1992).
Furthermore, this means that the child is an active agent in producing the care that it receives. It is not only the caregiver who contributes in this interaction, the child is also an important contributor to his or her own care, in the sense that it is the child's signals and initiatives which "drive" the caregiver's caring actions. In other words caregiver's caring actions happen in response to the child's *communicative "requests" and initiative.* This can be seen as a dialogue where the child makes a request to which the caregiver gives a response in accordance with the way he/she perceives the child's "request". This also means that if the children's requests/initiatives are weak or unclear due to illness or malnutrition, they may easily be neglected and exposed to inadequate care because the "drive" for care, namely the child's utterances and initiatives, are too weak, which makes them difficult for the caregiver to interpret.
In other words, infants are born as social beings that are biologically adjusted to enter into interaction and contact with other people. If one stretches this a bit further, one can say that humans are born as natural "cultural apprentices" who, through contact and interaction with others, will be guided into the cultural community characterizing humans as species (Tomasello 1999).
This is in line with the Russian psychologist Vygotsky's argument that "what is in the mind as mental operations has previously been interaction between people." In other words, our mind has its origin in previous interactions – especially in interaction between the child and its most important caregivers. This conception underlies most central theories in recent developmental psychology (Vygotsky 1978, Stern 1985, Klein 1992, Schaffer 1996, Nelson 1996, Tomasello 1996, Bråten 2000, Rogoff 2003).

During the last decade, the recent communicative infant research has strongly supported Vygotsky's view and this has led to intensive research about guided interaction between caregiver and children – about how the child, through communicative contact with its caregivers, is gradually led into the cultural community (Carew 1980, Wertsch 1985, Rogoff 1990, Klein 1992, Schaffer 1996, Nelson 1996, and Saljø 2000). According to this research, development is no longer seen as a *spontaneous process* unfolding through

child's biology and its adaptation to the physical environment, but as a *humanly assisted process where the child is, consciously or unconsciously, led to acquire the skills needed to participate in the cultural community. (Papousek 1991, Hundeide 1989). In other words, caregivers do not merely have a caring role consisting of creating physical and emotional safety for the child; they also have a pedagogic, guiding role that has often been disregarded. In addition to emotional care and safety, a child needs to be accompanied by a stable facilitator and receive guidance about ways to master his or her social reality in order to become a participant of a cultural community. This means that care for children goes beyond emotional safety and trust, and in addition to that, a child needs guidance which promotes understanding and knowledge about the surrounding world. This also calls for support in mastering the required skills to adapt to other people and to accomplish expected goals as a participant of our society. In addition to safety and secure attachment, guidance for children*[8] *constitutes a vital part of care, and if this fails, it may have serious consequences for the child's future development (Klein 2000 Hundeide 2003).*

The model below summarizes some of the conditions that seem vital for the quality of interaction between caregivers and children, and thus also for the child's future development:

The three dialogues and the eight themes for positive interaction

Another important aspect of the ICDP Program is represented by the three dialogues and the eight themes for positive interaction. In short, these eight themes summarize in a simple way the qualities of interaction considered to be vital for the child's development in a broad sense. The themes can be divided into three main categories corresponding to the three dialogues:

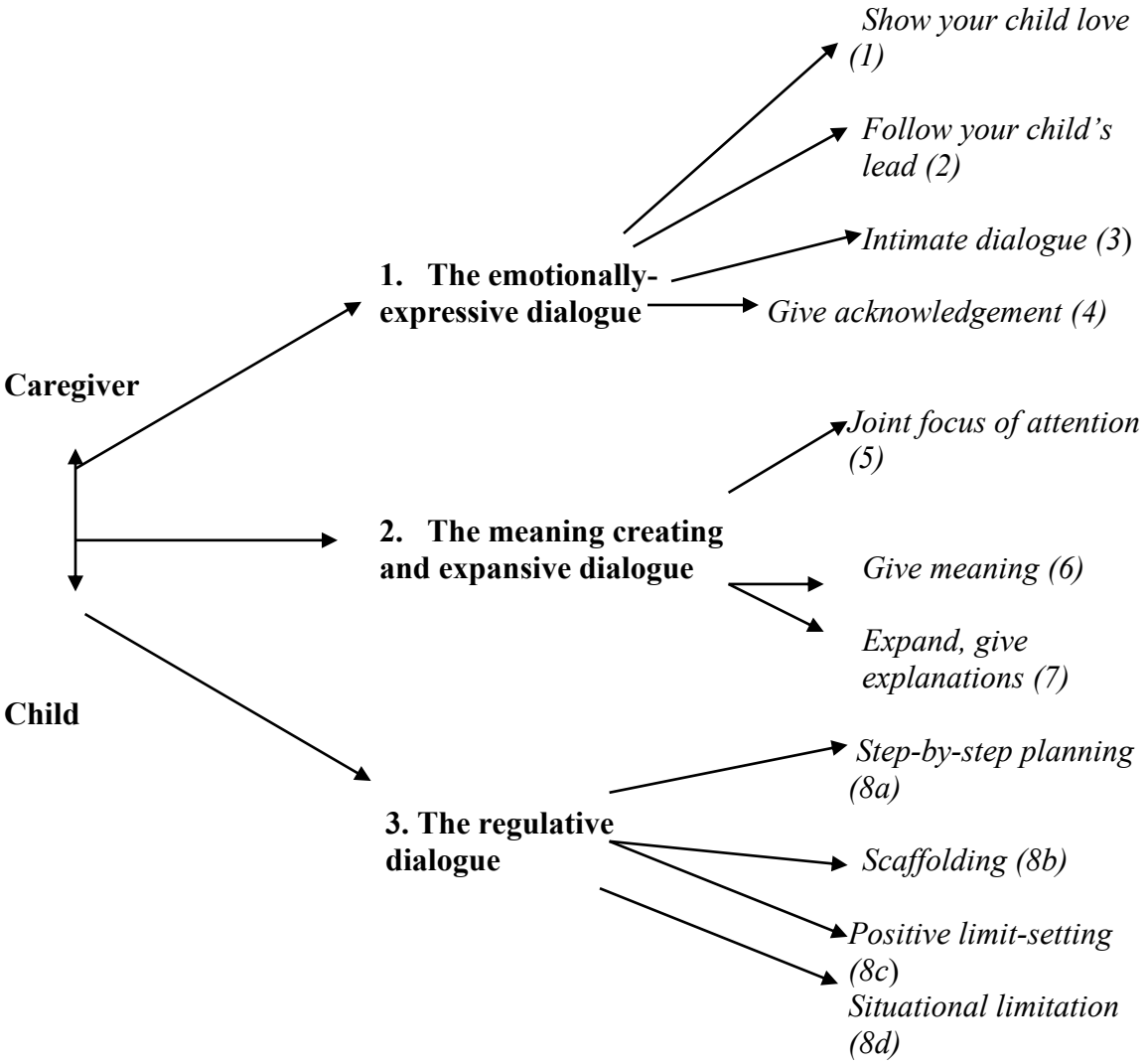
> ***The emotional dialogue*** with the child presupposes that the caregiver adjusts to the child's condition and state, sees and follows its initiative, expresses positive feelings, praises and acknowledges the child, and establishes an intimate and loving dialogue.
>
> ***The meaning dialogue*** where the caregiver shares a joint focus of attention on common experiences with the child, expands on these experiences and gives them meaning, explains and tells stories so that they appear interesting and are bound to the rest of the child's experiential world. In this way the child is led towards shared understanding and view of reality, which is a precondition for normal development and participation in a community.
>
> ***The regulative and limit-setting dialogue*** where the caregiver/teacher helps the child to accomplish tasks and challenges i.e. develop strategies for goal oriented actions which require planning and self-control. These may vary from simple tasks like helping the child to get dressed and feed him/herself, to problem solving

[8] In order to emphasize this point, the book about the ICDP program is called "*Guided* interaction from infant to school age (Hundeide 2000)".

strategies related to different subjects, for example mathematics. In both cases, the child is assisted step-by-step to plan and reflect on the consequences of its actions. This applies also for ***limit-setting*** which is a part of regulation. The point of limit-setting based on the ICDP Program, is that it should ***be positive and consistent,*** not aggressive and power assertive, negatively depreciative, and contradicting. As opposed to negative regulation, positive regulation is accomplished through "limit-setting" in a friendly atmosphere with mutual respect and with clear rules for cooperation.

The ICDP Program has become known for its eight themes for positive interaction. This is not in contrast to what I have called the three dialogues. Rather, the three dialogues are a simpler way of addressing the same. The figure below shows how the three dialogues include the different themes: The emotional dialogue includes the first four themes; the meaning dialogue includes themes 5, 6, and 7, and the regulative dialogue consists of theme 8 with several sub-points and specifications, as illustrated in the figure below:

The three dialogues and the eight themes for positive interaction



As the figure shows, the three dialogues can be divided into the eight themes for positive interaction. This is a more detailed description than the three dialogues. The eight themes can also be used for a more balanced analysis of interaction.

The eight themes are starting points to talk about, share and activate our natural ways of showing love for example, or about how we establish meaning and expand on the experiences shared with our children, or how we regulate and set limits in a positive way. The actual content of the eight themes are experiences accessible to all of us. There may not be anything new; nevertheless, these experiences are the real keys for quality care.

Although the content of the themes may seem well known to most people, the question remains to what degree they are actually practiced? These themes refer to experiences which are at the core of any good caring practice - at any level[9], and it is therefore important that they are activated and brought to practice. This is the goal of the ICDP Program.

The themes for positive interaction are not commands

> ***The themes for positive interaction are not meant as commands which*** *have to be followed, but as reminders and starting points for reactivating experiences most of us already have, but that nevertheless, are disregarded due to the stress of everyday life. These 8 themes are topics for personal exploration in typical interactive situations with children that occur in everyday life.*

By working with these themes in different cultural contexts in Africa, Latin America, and South East Asia, as well as in different European countries, we could see that they express common lessons most people recognize and experience as important in their care for different age children. However, the 8 themes may still have their particular articulation in each different community.

[9] The themes for good quality interaction apply to infants, young children and children of school age, but also to adult relationships, and with the elderly who may experience psychologically inadequate care.

The eight themes for interaction as contrasts

This table can be used both as an overview and as an observation-form, where a five-parted scale is applied from very positive (5) to neutral (3) to very negative (1).

Table 1: Eight themes as contrasts:

1. Showing loving feelings	5	4	3	2	1	Neglecting and rejecting the child
2. Following the child's lead	5	4	3	2	1	Dominating and pushing own initiatives
3. Having good personal dialogue with the child	5	4	3	2	1	Having no communication with the child
4. Praising and acknowledging the child	5	4	3	2	1	Depreciating and undervaluing the child
5. Helping the child to focus its attention	5	4	3	2	1	Distracting and confusing the child with conflicting stimuli
6. Giving meaning to and enthusiasm for the child's experiences	5	4	3	2	1	Not talking and being indifferent to the child's experiences
7. Expanding and enriching the child's experiences with comparisons, explanations and stories	5	4	3	2	1	Talking little, only what is necessary at the moment. Not giving the child explanations.

8. Regulating the child's actions step-by-step. Setting limits for what is allowed in a positive way by pointing out alternatives.	5	4	3	2	1	Permissive attitude. Leaving the child to itself. No guidance for the child's actions. Negative setting of limits "no, no" without explanations.

This table may also be used as an observation-form where the answers to the right of the shaded area imply lack of good care giving.

Emotional dialogue - Exercises and questions for all participants:

- *Why is the emotional dialogue so important in the child's development? Please provide examples of what happens when this is absent.*

- *Explain the four emotional themes with concrete examples:*
  Show positive feelings towards the child
  See and follow the child's initiative and expression
  Establish an intimate dialogue
  Acknowledge and praise

- *Role-play or demonstrate caregiver-child interaction where each of the four emotional themes is used.*

- *Give examples of interaction where "showing positive feelings" (1) and "acknowledgement" (4) are present but where the caregiver does not "follow the child's initiative" (2). Thereafter, provide examples where the caregiver follows the child's initiative.*

- *Give examples of the emotional themes in interaction between adults.*

- *What does the following mean:*
  "The child's expressive communication"
  "The mother's emotional attunement to the child"
  "Being emotionally available"

Meaning dialogue - Exercises and questions for all participants:

Please provide a short explanation of the difference between a) the emotional, b) the meaning and c) the regulative dialogue

Explain the three themes:
Focusing
Providing meaning
Expanding
What is the difference between them?

Why is expansion so important in interaction between caregiver and children?

Give concrete examples of interaction between caregiver and children where each of the three themes are used.

Give an example of a situation where there is focus and meaning, but where expansion is lacking.

Regulative dialogue: Exercises and questions for all participants:

Please give a short explanation of the difference between the emotional, the meaning- and the regulative dialogue.

Explain the three different ways regulation can be done:
1. Step-by step planning
2. Scaffolding
3. Situational regulation
4. Positive limit setting

Create an interactive situation with a goal oriented activity where you use Step-by-step planning and Scaffolding.

Create a situation of interaction in which the child acts outrageously and where you use Situational regulation and Positive limit setting.

What is the difference between positive and negative limit-setting?

Why are explanations important in connection to limit-setting?

Part II - Implementation of the ICDP Program

4. Seven principles for sensitization

The table below summarizes the most important principles for sensitization and can also be used as a check-list for sensitization:

Summary of sensitization of caregivers and the 7 pedagogic principles applied

Pedagogic principle	Operational description	Basic principle
1 Establish a confident relationship and contract of trust	a. By positive expressive contact b. By being willing to listen c. Show loving attitudes with respect d. Clear agreement about what will happen during the training	Influence through emotional attachment and contact is more efficient than without emotional contact
2. Positive redefinition of the child	a. Point out the positive qualities of a child b. Positive redefinition of negative aspects c. Reactivating earlier positive relations d. Remove signals that encourage negative concepts towards the child: child's un-cleanliness, strange clothes, smells and so on.	See possibilities and resources in the child and not only negative features and failure – "the zone of proximal development"
3. Activating caregivers with regards to the 8 themes	a. Observational tasks; observe children and one's own interaction b. Testing c. Find examples from own practice d. Make own manual	Self-activation and discovery has a stronger effect on practice than instruction alone
4. Point out positive features in caregivers' practice	This can happen through: a. Pointing out when one observes the interaction, or b. through video-feedback	Positive feedback and focus on resources also strengthens the caregiver's self-confidence and motivation to develop further in the same direction
5. Verbalizing; using directed awareness-raising	a. Using the theme booklet and making self-evaluations about the extent these themes are practiced b. Verbalizing and giving personal examples for the themes	Expressing oneself about the themes will focus the attention and help observation and awareness-raising. Concretization through the "booklet" is important for many people
6. Share experiences in groups	a. Goal-oriented group; aiming to exchange experiences and about the interaction themes b. Turn taking and participation of all	Sharing experiences in a group gives a social confirmation which may be decisive for insecure

	participants c. Positive confirmation	participants' self-confidence. In addition, this strengthens the belief and commitment to the main ideas.
7. Personalized and interpretive communication about the child	a. Talking from one's own personal experiences with examples b. Talking interpretively about what the child experiences and feels	When principles are put in form of concrete experienced stories it creates more interest. Explanations based on the child's experiences and feelings legitimize that this is an important theme, also for the caregiver.

A minimum format of exercises/tasks in sensitization of caregivers:

- Tasks related to positive definition of the child
- Explain the guidelines (themes) to each other with own examples and demonstrations
- Identification tasks; identifying the themes of interaction on photos and videos
- Exemplification and role-playing of themes
- Activation and "test-report cycle" with home tasks (Sensitization principles 3)
- Making one's own manual with personal examples and pictures
- Application of the sensitization principles

5. Implementation and sustainability

Checklist of implementation

Principles of implementation	Evaluation 1-5
1. Support from relevant authorities.	
2. ”Space” for the project:	
a. Time	
b. Organizationally	
c. Economically	
3. Willingness and commitment of the receiver (caregiver)	
4. Plan of action and plan of implementation	
5. Quality and intensity of the implementation (including number of intervention-meetings)	
6. Using everyday-routines to facilitate implementation	
7. Plan for follow-up, self-evaluation and internal reward-system	

These principles of implementation are important also in connection with evaluation, because they specify the conditions under which the program should ideally be implemented. If the program is implemented under unfortunate conditions, it then becomes difficult to separate whether the mediocre effect of the program is due to the program itself or to the conditions under which it has been implemented. For this reason any intervention should have some indicators that record the quality and intensity of the implementation. That is the whole point of having principles and indicators of implementation.

There are five modes of intervention in the ICDP Program these are summarized in the table below:

Summary of five ICDP modes of intervention

ICDP Modes of intervention:	*Level of interaction Family-care*	*Local community*	*National policy*
1.Redefinitions and focusing on the positive resources	*To counteract a negative conception/ image of the child and stigmatization*	Mobilization to counter-act stigmatization and prejudice, facilitate hope	Raise awareness mobilization to counter-act stigmatization media, radio, TV
2.The emotional-expressive dialogue (4 guidelines)	*To promote love and affectionate care, trust and self-esteem*	Raise awareness for the need for affectionate care for vulnerable children	Raise awareness for the need for affection and care – media, radio, TV
3.The meaning/ expansion dialogue (with 3 guidelines)	*To expand the child's understanding of his or her world and situation (narratives, memory work also)*	Raise awareness for the need to talk, share experiences and communicate with children about their experiences	Raise awareness for the child's need to share experiences – time together. Explanations & proving stimulating environment, also the role of media
4.The regulative dialogue/ limit-setting	*To help the child organize, plan and regulate his life, develop self-control*	Create settings and opportunities where children can act in collaborative and organized ways …	Setting national guidelines/ norms for appropriate care for children against abuse – children's rights
5. Principles of sensitization – how to train/sensitize facilitators and caregivers	*Sensitize primary caregivers in how to use the principles above in everyday life through personal activation*	How to train and sensitize community facilitators who train primary caregivers – through personal activation.	Setting national criteria and standards for education of caregivers

As the table shows, these modes of intervention can be applied at the caregiver-child interactive level (2), at the level of community (3) and at the national level of policy, advocacy and human/children's rights (4), although *the focus and emphasis in the ICDP Program will be on the interactive level.*

Example of a typical agenda of group meetings with caregivers

(Can be from 8 to12 or more meetings according to need)

Meetings	Main message	Sensitization-method	Homework - examples
1. Meeting	ICDP and what you can do for your child's development and health	Explain Show video Show poster	1. Tell me two happy stories about your child. 2. What makes your child happy, sad, angry?
2. Meeting	The "positive child" – The importance of having a positive conception of the child	Share the stories If they have a picture of their child to share… Bring expressive pictures of children's faces – what does it express? Distribute the guidelines in local language	1. How do you show love your child? 2. Do you sometimes praise your child? How? Give examples at next meeting
3. Meeting	The emotional expressive dialogue – of love and appreciation of the child	Share homework. Role-playing. Explain and demonstrate the emotional expressive dialogue and its guidelines	1. How does your child react when you follow his/her initiative? 2. How does s/he react when you express your feeling of love through touch or speech?
4. Meeting	Continuation of previous topic: Emotional expressive dialogue	Share homework Explain, discuss, role play. Analyze filmed interactions, photos	1.Give examples of how you explain things to the child so that s/he understands his surroundings better
5. Meeting	The meaning dialogue of understanding – the importance of talking and explaining to the child about what he sees and experiences	Share homework of talking to your child giving meaning and understanding. Role-play meaning interactions with explanations from everyday life. Use pictures to release interactions…	1. Do you and your child have moments of joint attention where you talk and share things or tasks together? Example 2. What is you child's field of interest? Do you join in? Example 3. What kind of stories does your child like/need to

			hear? Example
6. Meeting	Continuation of previous topic	Share homework Discuss Role play Observe on film, photos	1. Tell what kind of naughty things your child does? How do you react when he does naughty things? 2. What is the best way for you to react when the child does things that are not allowed?.
7. Meeting	About limit-setting, the importance of reducing violence and aggression and instead take time to explain to the child	Share homework Role-play episodes of disobedience and parental reactions. Discuss the best way.	1 How does your child react if you explain why things are not allowed instead of punishing and scolding? Example. 2. How do you teach and help your child to do things in the house and in his surroundings and at school
8. Meeting	Topic of particular relevance – for example: About HIV and AIDS about physical health and prevention	Share the most important thing to keep your child healthy? How does HIV spread and how to protect? Sum up…	Give them praise for their participation
9. Meeting	Celebration with distribution of diploma	Show video-recording of them, taken from earlier sessions	Ask them to spread the message of good interaction and ICDP

These meetings are carried out in a participatory way where the caregivers share their experiences, examples and stories. This usually releases an intimate feeling of sharing and enthusiasm. The outcome is very often that new friendships and networks are established.

The agenda described above is a short draft which only contains the most important elements in the sensitization of caregivers in relationship with the child (caregivers' conception and the three dialogues). Special issues related to different groups are usually added to these elements. This is normally included gradually in the same project so that it is expanded.

Regarding the intervention with vulnerable target groups, we usually use a project with 12 meetings (for example project for ethnic minorities). Originally, there were ten meetings, but after conducting an evaluation we found that there was a need for extending to twelve meetings. Yet, this is not much time compared to the time spent in

other similar programs (Klein 1990). Due to the short time, it is important to keep an agenda, as shown below:

Standard agenda for each meeting:

Regarding the *agenda for each meeting* it has the following form:

1. Summary of the main points from last meeting
2. Go through the home task for this meeting. This should be done in a way so that most participants get to talk (testing - and reporting cycle)
3. Group leader presents the main message and theme for this meeting with explanation
4. The theme (main theme) is activated in group-work through different techniques such as communication with exemplification, showing of video, role-play, use of picture (See methods described above)
5. Summary of group-work regarding main message is written on the blackboard.
6. Go through home tasks for next meeting.
7. Time: the meetings usually take about 2 hours. It is very important that the facilitator of the meeting keeps track of the time to make sure that there is enough time for all the planned themes.

As will be seen, the participants are the active part in this project because they will report their observations and testing.
Usually, we use two facilitators for each sensitization meeting – especially in the beginning.

Facilitators' tasks in connection to the project and meetings:

Show up on time, prepare and go through the plan for each meeting in line with the manual.

The following is required:

Practical information
Name of the facilitators
Workplace and address
Descriptions of the participants - number, language, gender, number of children etc.

Selection of participants
Reasons for choice of participants

How were participants informed and motivated
Attach invitation to the information meeting, plan for meeting etc.

A log-book has to be written after each meeting

- The facilitator writes the log book together with the person leading the group
- It is important to hold an evaluation after each meeting connected to observation and reflection

The log-book should contain the following:

- To what extent was the meeting conducted according to the agenda? Were there any changes? Which?
- How did the participants react to the different themes in the agenda?
- What engaged them most - what engaged them less?
- Were some points not understood or disliked?
- How was the homework received? Did everybody do all the homework?
- How was the group's activity and engagement? Who was active - who was passive?
- Was this a successful, average, or an unsuccessful session? Why?
- Was everybody present or some did not show up?
- When did the meeting start - when did it end?
- How do you evaluate your role as a facilitator? (checklist)

Attach stories, and examples from the meetings!

Evaluation and summary

Participants:
Your impression of how the participants experienced the course?
How did the participants answer the five questions?

Your role:
What have you learnt about yourself as a facilitator?
What would you do differently next time?

The six questions of evaluation after the course according to the participants

These questions are asked at the last meeting:

1. Tell me how was it for you to participate in these meetings about child care?
2. Did you benefit from participating – in which way?
3. Has this influenced your relationship to your children – in which way?
4. What did you learn during these meetings?
5. Was there something in this course that you did not understand and that you found difficult?
6. After having been through this course, is there anything that you feel should be improved or changed?

Continuation
How do you imagine continuing the work at your workplace?

What do you need in the future to maintain your engagement and your enthusiasm as a facilitator in ICDP?

The log-book should be kept so that the quality of the implementation can be evaluated at a later stage.

The facilitator concludes with a summary of the implementation, with information about important experiences, case-stories, and suggestion for how the program can be adjusted if this is brought up during the meetings. Group-meetings are the most common way of implementation, but it is also possible to switch between group and individual meetings. In this context, we chose to conduct group meetings. *More precise projects for different target groups are described in the different additional manuals which are prepared for the different target groups.*