



REPSSI

Psychosocial Wellbeing For All Children

Psychosocial care and support for young children and infants in the time of HIV and Aids:

A resource for programming





REPSI

Psychosocial Wellbeing For All Children

REPSI is a regional capacity building organization working in Southern and Eastern Africa to enhance the psychosocial wellbeing of all children affected by HIV and AIDS, poverty and conflict.

In the field of psychosocial support and while trying to address the psychosocial well-being of families and communities affected by HIV and Aids, poverty and conflict, it is all too easy to forget about infants and young children. This gap is reflected in the literature and across many programmes. It is my sincere hope that this publication goes some way towards addressing this gap.

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November, 2007

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ISBN: 978-0-620-40186-9

Novartis Foundation
for Sustainable Development



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Acknowledgement

This publication has been made possible thanks to the financial contribution of the Bernard van Leer Foundation.

The opinions expressed herein do not necessarily reflect the views and policies of the Foundation.

The story and the people behind this publication

In 2004, the Bernard van Leer Foundation commissioned Jim Smale to lead a process in which several stakeholders, including Masiye Camp and REPSSI (Regional Psychosocial Support Initiative), met and 'talk-shopped' the contents of a resource that would address Early Childhood Development (ECD) from a psychosocial care and support (PSS) perspective.

The basis for the development of this resource was a REPSSI–Masiye Camp working document entitled PSS for under 5s for which Ncazelo Ncube, Marian Mlupi and Isabel Mavengano were key contributors.

Jim Smale assisted by Jo Stein wrote the first few drafts of the resource but this project was never taken to final publication. In early 2007, REPSSI and the Bernard van Leer Foundation committed themselves to its publication by December 2007.

Jonathan Morgan, REPSSI Knowledge Development Manager, took responsibility for co-ordinating the project, and with the help of André Viviers from UNICEF, enlisted the support of seven regional ECD and PSS experts to edit the document content. Chapters were assigned to André Viviers, Margaret Irvine, Carol Smith, Juliana Seleti, Mary Clark, Snoeks Desmond, Jonathan Morgan and Judy Morgan.

André Viviers, Brighton Gwezera and Alex Tigere then reviewed the entire manuscript in its early stages.

After the editors had each submitted and signed off their chapters, a smaller editorial committee, comprising Jonathan Morgan, Jill Sachs, Mary Clark and Gill van Wyk, was formed. This committee met for three days in Cape Town to finalise the publication.

This entire draft was then edited and proof read by Gill van Wyk and Richard Rufus-Ellis.

Candice Turvey of The Projector Room did the layout of the publication.

For the biographies of all the contributors see page 75.

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Introduction

Introduction: Context for this publication

This publication is titled 'Psychosocial Care and Support for young children and infants in the time of HIV and Aids'. However, the material will benefit *all children affected by HIV and Aids, poverty and conflict*.

The triple effects of HIV and Aids, poverty and conflict mutually reinforce one another and have created an unprecedented crisis in the eastern and southern Africa (ESA) region. As a result, a growing number of babies and young children have lost traditional child-protection mechanisms. Millions of babies and young children who have been adversely affected by this loss are now more vulnerable to neglect and various forms of abuse.

HIV and Aids

HIV was detected in ESA in the early 1980s. Today the region has one of the greatest rates of HIV infections in the world. By the end of 2005, it was estimated that approximately 14 803 100 people were infected with HIV (UNAIDS, 2006). A staggering nine of the ten most-severely affected countries in the world are in ESA, namely Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. AIDS-related illnesses are the leading cause of mortality among adults in ESA. UNAIDS (2006) estimates that Aids accounts for approximately seven out of ten deaths among adults aged 25 to 49 in the region.

These deaths have resulted in a growing number of orphans and vulnerable children in the ESA region. The region now has the unenviable highest proportion of orphaned children in the world – with the best available estimates from UNICEF (2006) suggesting that between 13 and 15 percent of children may be single- or double-orphans. UNAIDS (2006) estimated that by the end of

2005, there were approximately 16 285 000 AIDS-orphans in the 13 countries in which REPSSI currently operates.

Conflict

REPSSI operates in three countries in which conflict is occurring or has recently ended: Angola, Mozambique and northern Uganda. More than two decades of conflict in these three countries has displaced hundreds and thousands of children and has been greatly harmful to their psychosocial wellbeing.

In northern Uganda, the Lord's Resistance Army (LRA) abducted over 20 000 children and forced them to be soldiers and sex slaves. UNITA rebels in Angola also used child soldiers and these children have been severely traumatised by their experiences of killing and maiming people from the communities in which they originate.

Sexual violence against young girls and women was rampant in northern Uganda and used as a weapon of war by LRA forces. Human Rights Watch (2005) estimated that more than 30 000 young children were raped and left traumatised by this experience. Babies and young children who witnessed violence being inflicted on their mothers, sisters and other women in their communities have also been traumatised.

A significant majority of children who have survived conflict in northern Uganda and Angola have been negatively affected by acts of vandalism and barbarity perpetuated by armed groups. It is estimated that at least 66 percent of children in Angola have witnessed someone being murdered and 67 percent have witnessed someone being tortured, beaten or hurt. The statistics for northern Uganda are similar: Ugandans have witnessed horrendous scenes in which their own families and friends were killed, sometimes

being hacked to death.

In addition, many young children have lost years of schooling and are raised in communities with eroded family and societal structures – in camps for displaced people, on the streets and in active duty with armed groups and in other dangerous situations.

The conflict has had severe psychosocial repercussions for Angolan children and adolescents. Many young children exhibit symptoms of trauma such as fright and insecurity, thoughts about war, and disturbed sleep. Moreover, studies indicate that exposure to violence puts young children at greater risk of future involvement in violence. Immediate and persistent attention to the needs of Angolan children and adolescents is necessary to end the cycle of conflict and move towards a lasting peace.

Evidence from situational analyses undertaken by REPSSI in Uganda and Angola indicates that significant numbers of young children who have experienced conflict have problems such as nightmares, loss of concentration, and social isolation. The overall impact of conflict on young children has been severe disruption of their normal development, so threatening their security and trust in humankind, and undermining their sense of hope for the future.

Poverty

The 13 countries in which REPSSI operates are some of the poorest in the world. In all 13 countries an average of 65 percent of children live in poor households. Research on the effects of poverty on the psychosocial wellbeing of babies and young children has convincingly demonstrated that conditions of poverty – including lack of access to services, poor environmental conditions, inadequate material supplies, social instability, and overworked and demoralised parents and caregivers – negatively affect their development. When this happens, babies and young children fail to grow to their expected levels, are more vulnerable to severe illness, and lack the capacity and energy to engage with their environment and to actively learn about the world. They are insecure and clinging, and their physical and psychological development may be delayed. When such conditions persist, unchanged for most of the child's early years, they have permanent effects on that child's cognitive and social capacities.

In spite of the severity of the triple crises of HIV and Aids, poverty and conflict, there are degrees to which specific young children are affected as follows:

- A small number of children are severely affected and, based on clinically verifiable symptoms, require specialised mental health interventions, for example psychiatry/clinical psychology.
- An intermediate number are more severely affected and require focused, non-specialist group interventions, for example structured group therapy.
- The large majority of young children are affected by HIV and Aids, poverty and conflict, but through their own resilience and the family, household and community support that they receive, require no extra or specialised psychosocial care and support (PSS).

Key messages of this publication

1. In this publication, we will attempt to communicate the belief that the most sustainable, powerful and important form of PSS is everyday care and support provided by families, households, friends, teachers and community members. Specialised mental health services are necessary, and possible, for only a small percentage of highly affected young children.
2. In each issue-based chapter, (for example Chapter 6 on abuse) we will present guidelines to addressing these issues at family-, community- and household-levels for babies and young children, as an early intervention and a preventative measure, as well as at a specialised mental-health level for severely affected babies and young children.
3. We will describe what can be done without excessive reliance on outside financial assistance, professionals or para-professionals. We will highlight possible support by family and community members that relies on their natural, caring instincts and builds on what they are already doing (which, in most cases, is a tremendous amount).
4. We will also argue that many severely affected children are less likely to develop serious symptoms that require specialised PSS – if they are given family-based and community-based care and support, and helped to maintain or resume a sense of normality in their lives.
5. We will emphasise that the natural resilience in babies and young children can be harnessed to help them to cope with and move on from despair, to regain hope and to thrive.
6. Finally we will convey the message that referrals to specialised services should be based on clinical symptoms and not because a child belongs to a particular category

(for example orphans, formerly abducted children, Orphan and Vulnerable Children (OVC), etc.).

Rationale for this publication

This publication is offered for a number of reasons.

1. Firstly, many of the interventions and guidelines pertain to children aged seven and older. Comparatively little material exists to guide the PSS of younger children (six years and younger).
2. Secondly, even in the field of Early Childhood Development (ECD), much of the material has focused on cognitive and physical development, while disregarding psychosocial awareness. In South Africa, Education White Paper 5 defines ECD as an umbrella term that applies to the processes by which children from birth to at least nine years grow and thrive, physically, mentally, spiritually, morally and socially.
3. Thirdly, much of the material in this field is either very basic, or highly academic. This publication seeks to bridge that gap.
4. Fourthly, the material in this publication provides practical ideas and ways to identify and support vulnerable babies and young children, their parents and caregivers, and communities, building on their natural resilience.

How to use this publication

- This publication is offered as a resource for programme staff in organisations that work with babies and young children, or their parents or caregivers, in the context of HIV and Aids, poverty and conflict. It is not intended for direct presentation to grassroots community workers, parents or caregivers.
- It can be used to develop programmes, training or action sheets for local needs.
- The material contained in this publication can be used as a set of principles or guidelines.
- The reflections contained in this publication are useful for both staff themselves, and for their work with parents, caregivers, families and their communities.
- The reader can read the entire document or use it as a reference for specialised topics, listed in the index. Those who choose to read it from cover to cover will find that a logical sequence has been followed.
- Different editors have worked on different chapters, therefore the reader will encounter different styles of presentation.

REPSSI vision

The REPSSI vision is that *all* children affected by HIV and Aids, poverty and conflict benefit from stable, affectionate care and support. This publication is therefore offered to organisations working in the frontline of HIV and Aids, poverty and conflict in the ESA region, to mitigate the effects of the triple crises, and focuses primarily on younger children in the age range of birth to nine.

References and resources

- Christian Children's Fund, 2005, Annual Report
<https://www.christianchildrensfund.org>
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2

Psychosocial care and support (PSS), and babies and young children

Different models of PSS

There are five models of PSS, each of which describes PSS from a slightly different perspective. By examining all of these the underlying concept and fullest meaning of PSS can be reached.

Model 1: The 'head–heart–social' model

PURPOSE

The purpose of this model is to explore how PSS involves both psychological and social dimensions.

DISCUSSION

You will have noticed that PSS contains one letter P and two letters S. The P represents **psycho**, which is an abbreviation for **psychological**. Psychological includes all the feelings (emotions) and thoughts, as well as how people act or behave because of those thoughts and feelings. In Figure 2.1 you will see that the letter P has been placed *inside* the person's head (but it can also be placed inside his heart or body.)

The first S represents the word **social**. This word refers to people's relationships with one another. It is something *between* people rather than *inside* them. The second S represents the word **support**, which we will discuss later on, using another model.

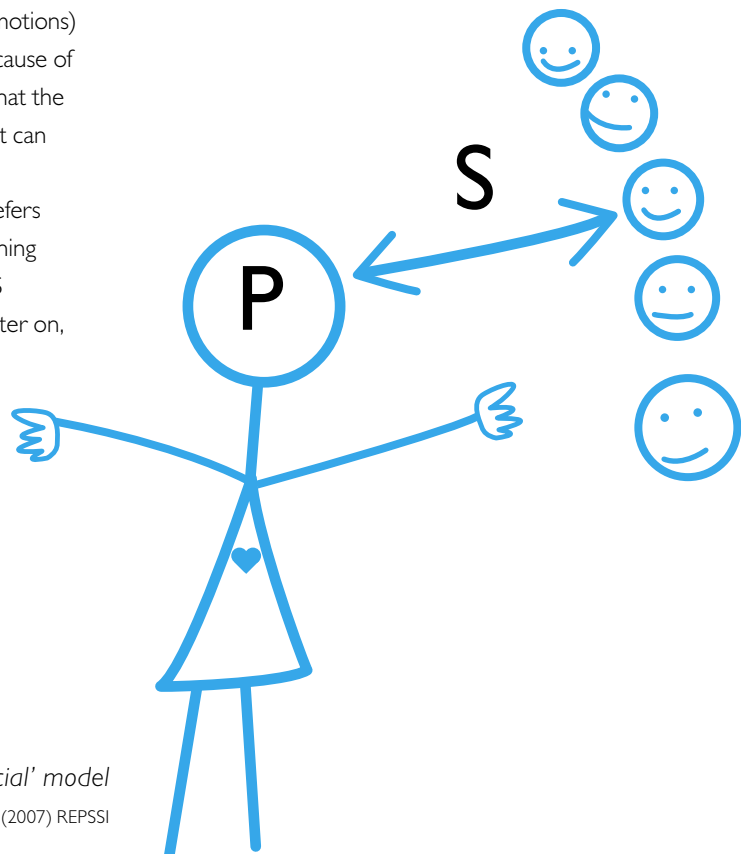


Figure 2.1: The 'head–heart–social' model

Source: Jonathan Morgan (2007) REPSSI

Model 2: The wellbeing model

PURPOSE

The purpose of this model is to explore:

- how psychosocial wellbeing is part of holistic or total wellbeing
- how different aspects of wellbeing overlap
- how difficult it is to separate out these different aspects, both for understanding and for programming.

DISCUSSION

With regard to young children, psychosocial wellbeing is the positive age-appropriate and stage-appropriate outcome of their development. It is an interdependent aspect of several other overlapping aspects of total or holistic wellbeing. These aspects have been described as biological, material, social, cultural and spiritual aspects. The focus of psychosocial wellbeing is not only on the individual, but also on larger social units such as households, families and communities.

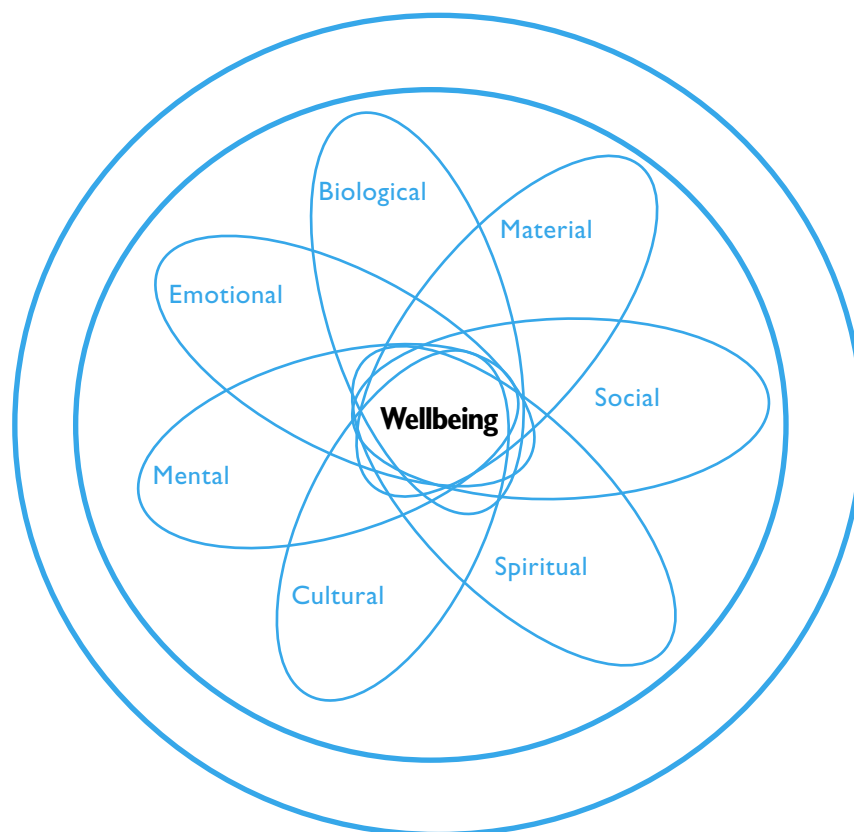


Figure 2.2: The wellbeing model

Source: Williamson, J. & Robinson, M. (2005) *Psychosocial Interventions, or Integrated Programming for Wellbeing* International Journal of Mental Health, Volume 4, Number 1, March 2006)

Model 3: The resilience model

PURPOSE

The purpose of this model is to better explain the psycho and social aspects of the term wellbeing. Resilience means the ability to 'take strain but not break'. In difficult times, resilience is a very good thing to have. It means that some babies and young children will be as happy as they possibly can. Without resilience, they will suffer psychologically.

There are four aspects to developing resilience in babies and young children.

1. Reducing stressors:

- reducing the impact of present stressors (making the effects of problems lighter or less painful)
- unloading accumulated problems (taking some problems away from babies and young children and making them feel less responsible for solving these problems alone)
- assisting babies and young children in making peace with the past (helping them to heal emotional wounds).

2. Strengthening their use of existing protective factors (things that protect babies and young children from suffering):

- within children (for instance, the ability to identify and name obstacles that stand in the way of their goals)
- within the remaining family (See Model 4.)
- within the wider social environment such as friends and neighbours (See Model 4.)

3. Broadening the coping alternatives:

- facilitating the use of existing coping strategies (finding out what babies and young children are already doing to overcome their problems and then reinforcing these actions)
- assisting babies and young children to look for new coping skills (including training, life skills and beliefs).

4. Strengthening and opening future perspectives:

- supporting the search for future possibilities and visions (building hope and a sense of a future to look forward to).

Source: Bala, J. (1996) *Strengthening the Protective Umbrella: The Refugee Child and the Family*

Model 4: The circles-of-support model

PURPOSE

The purpose of this model is to explain the support and care aspects in PSS, and to emphasise that external programmes are best used to help communities to support families, who are in the best position to provide for the psychosocial needs of babies and young children.

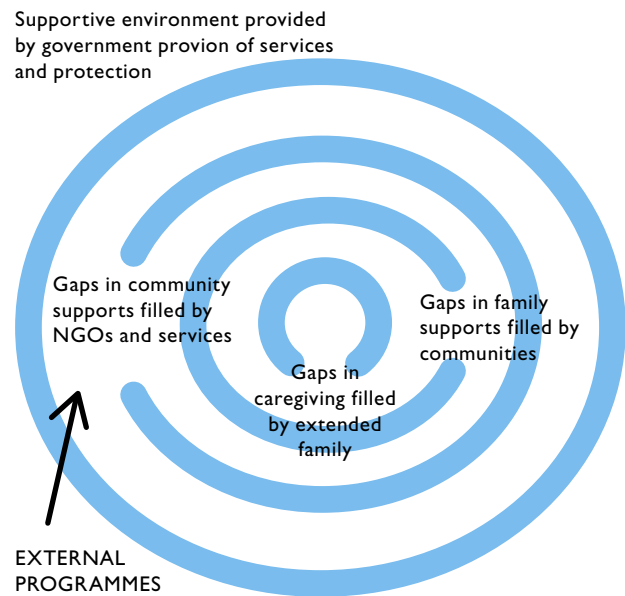


Figure 2.3: The circles-of-support model

Source: Richter, L., Foster, G. & Sherr, L. (2006) *Where the Heart is: meeting the psychosocial needs of young children in the context of HIV/AIDS*.

The best way to support the wellbeing of babies and young children affected by HIV and Aids is to strengthen and reinforce the circles of support and care that surround them. (See Figure 2.3.)

Babies and young children are best cared for by committed and affectionate adults. When the immediate care-giving circle is broken, extended families need to fill the gap. If this cannot be done, community initiatives need to provide the necessary care. And if this community circle of care is broken, external agencies need to take over. A strong and continuous circle of support provided by government and legislation should embrace all efforts.

External programmes are best used to support communities to support families, who are in the best position to provide for the psychosocial needs of babies and young children.

Model 5: The pyramid model

PURPOSE

The purpose of this model is to consider:

- PSS in terms of all possible expressions of support
- the potential reach of different kinds of support and interventions
- how to identify which type of support is required and should be offered to which babies and young children.

The pyramid in Figure 2.4 reflects multi-layered support, all layers of which should be in place at any time with a high degree of referral and coordination between them.

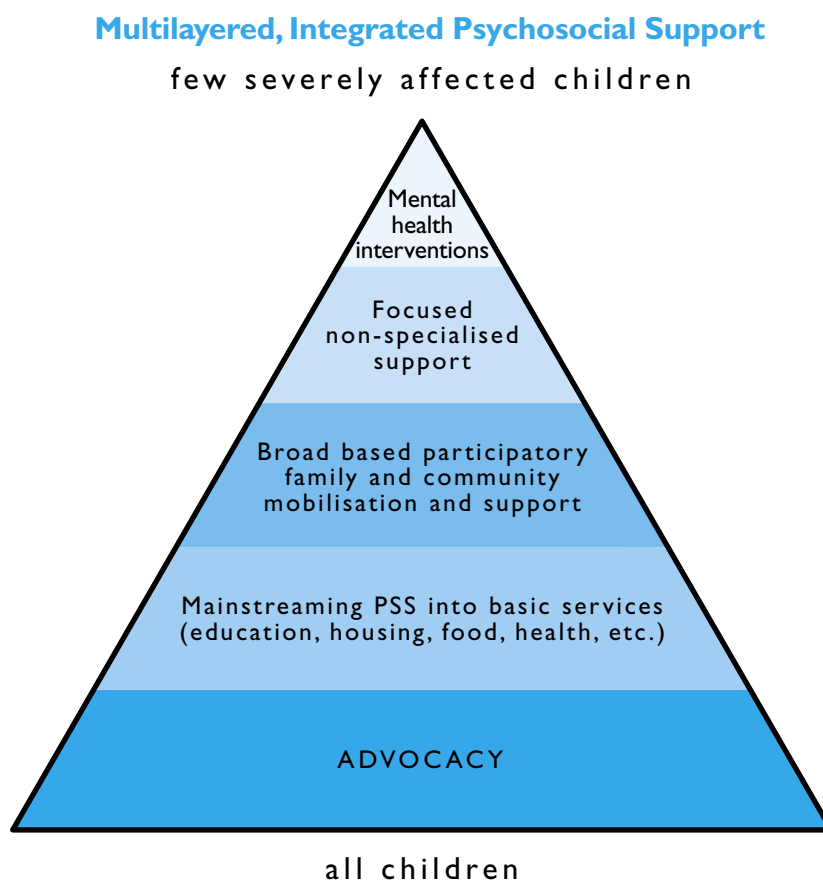


Figure 2.4: The pyramid model

Sources: Morgan, J. (2007) *Making a Hero (Active Citizen) Book – A guide for facilitators*; IASC (2007) *Guidelines of Mental Health and Psychosocial Support in Emergency Settings*

LEVELS OF PSS:

5. SPECIALISED MENTAL

HEALTH SERVICES: psychiatric, clinical psychological, and specialised traditional healer services, for children with clinical mental health diagnoses (potential to benefit only small numbers of the most severely affected children at any time)

4. FOCUSED NON-SPECIALIST SUPPORTS

for special needs of children who are not coping, and who are exhibiting symptoms of distress (potential to affect and benefit hundreds but probably not thousands of more severely affected children at any time)

3. FAMILY AND COMMUNITY

SUPPORT: everyday care and support provided by caregivers, friends, community members (potential to affect and benefit thousands of children at any time, the most powerful and sustainable form of PSS)

2. PROVISION OF BASIC

SERVICES: food, shelter; education, housing, health etc into which PSS needs to be mainstreamed (potential to affect and benefit millions of children at any time)

1. ADVOCACY to influence policy and direct change to the social conditions that directly affect wellbeing (potential to affect and benefit millions of children)

What the different models can and cannot achieve

Table 2.1 shows the strengths and limitations of the five models.

Table 2.1: Strengths and limitations of the five models

Criterion	Head–heart–social model	Wellbeing model	Resilience model	Circles-of-support model	Pyramid model
Distinguishes between psycho and social	Yes, because the model explains what is 'inside' (psychological) and what is 'outside' (social) a person.	No, because different aspects of well-being overlap.	No, because different aspects overlap.	No, because the model focuses on support rather than the effects of the support. (Psychological refers to thoughts, emotions and behaviours which are all effects.)	No, because different aspects overlap and the model focuses on different kinds of support and not their effects.
Examines total well-being (of which psychosocial well-being is a part).	No	Yes	Yes, but not as clearly as the well-being model.	No, because the model focuses on the support rather than the effects.	No, because the model focuses on the support rather than the effects.
Focuses mainly on the most important qualities of psychosocial health or well-being (and not on total well-being) and provides clues to important life skills to develop in young people	No	No, because the model is quite general.	Yes	No, because the model looks at the support rather than the effects.	No, because the model looks at the support rather than the effects.
Is a child-centred model that focuses on the different circles of support surrounding children, drawing attention to what the role of external agencies might be	No	No	No	Yes	Yes, to some extent, but is more focused on what the specific support might look like.
Looks at all possible expressions of support, with a focus on reach, and begins to explore what these kind of supports might look like	No	No	No	No	Yes

Things to think about and reflect on: models of PSS

1. Is it helpful to develop separate psycho and social programmes and interventions?
2. With reference to the well-being model, is it advisable to develop separate programmes that address, for instance, psychological needs and spiritual needs, and even more separate programmes that address, for instance, nutritional needs and cultural needs? Or do you think that the programmes should be integrated or mainstreamed, because the aspects of well-being overlap?
3. How have the different models contributed to your thinking differently about your actions and what PSS is?

What do we mean by PSS?

The following aspects of PSS are important.

- PSS embodies values, principles, actions, hopes and dreams that people have for themselves and for the wellbeing of one another, including vulnerable babies, young children and groups such as families and communities.
- PSS is expressed through caring and nurturing relationships that communicate understanding, unconditional love, tolerance and acceptance.
- PSS is about day-by-day, consistent nurturing care and support that is expressed through family and community interactions that occur in everyday life.

What do we mean by psychosocial wellbeing?

In babies and young children, psychosocial wellbeing is dependent on the positive, holistic and appropriate development of the individual, within the context of a caring and supporting family, household and community. The psychosocial wellbeing of individuals and of the larger social units is affected by three key issues: human capacity, social ecology and culture and values.

- **Human capacity** includes the physical and mental health of a person, as well as his or her knowledge and skills.
- **Social ecology** refers to the social connections and support that people share, and that form an important part of psychosocial wellbeing.
- **Culture and values** point to the specific contexts and cultures of communities that influence how people experience, understand and respond to events.

These three areas are all inter-related. Changes in one area will affect the other areas, as well as the overall wellbeing of people.

What do we mean by psychosocial interventions?

The term psychosocial intervention refers to any programme that aims to improve the psychosocial wellbeing of people. Activities within these programmes must be focused on facilitating the provision of psychosocial care and support. However, if these activities remain stand-alone, without links to family and community interaction, they have limited potential to effectively contribute to the psychosocial wellbeing of the individual and the group.

The question is: Does the intervention promote human

capacity or the social ecology of a community, or contribute to people's efforts to re-establish culture and values in some way? If the answer is yes, then the intervention can be described as contributing to the psychosocial wellbeing of communities.

What do we mean by psychosocial care and support for babies and young children?

Ideally the psychosocial development of babies and young children should be a natural part of their early childhood development. It should happen as they grow, develop and learn within their families and communities and shouldn't be separated out as something to focus on in isolation. However, with babies and young children in difficult circumstances, such as settings that are seriously impacted on by HIV and Aids, we need to provide extra care and support for their general early childhood development. Furthermore, we may also have to respond to special needs associated with their psychosocial functioning and growth.

In the early childhood field, PSS is a relatively **new term** that covers many important areas of child development. Analysing the concept in its parts helps us to understand what it means.

THE PSYCHOLOGICAL ASPECT

The term psycho is short for psychological. The word psychological relates to the human mind, its nature and how it works. Early childhood is a vital time for development of the mind, as the greatest part of brain development happens in the first three years of life. It's the time when babies and young children learn most rapidly from their experiences and opportunities.

The mental foundations are laid in the early years, either for life-long strengths or for life-long problems. During early childhood the minds of babies and young children begin to develop important characteristics such as emotional wellbeing, intellectual capacity, self-confidence, self-esteem, the ability to cope with challenges and setbacks (resilience), and so on.

For many young children, much of this healthy development occurs naturally in their family environments. The family environment creates a natural place where most young children know love and security. Within this context most of their important early developmental experiences occur. This is also where they have the support of their parents and other family members.

However, babies and children in families that are severely

affected by HIV and Aids may not enjoy such an environment. For example, one or both parents may have died and this may reduce the ability of the family to provide for all the needs of their children. Parents who are unwell may not have the psychological and physical stamina to deal with the ordinary daily activities and routines which babies and young children require. In such contexts this primary role of parenting may be undertaken by others.

The social aspect

The social part of the term psychosocial refers to our relationships with others. To be socially successful, an individual must be balanced, capable, able to empathise with others, understand and share rules, common moral values and acceptable ways of relating to others. The foundations for this are laid in early childhood.

Babies and young children rapidly become social beings, who are not just focused on themselves but begin to understand social relations within the family, household and community. This is part of their natural human need to belong and to feel loved and accepted by their carers and siblings, friends and significant members of their community. Again, youngsters growing up in an environment afflicted by HIV and Aids may find that their families and communities lack the capacity to support their social development, because they are struggling to cope with daily life.

Care and support

Everyone needs care and support, especially when faced with problems and difficulties in life. But for children – and especially babies and young children – it is critically important that they have the protection, encouragement and guidance that they need as they grow and develop. Ideally, this would be part of their early childhood experience – they would naturally have advice, help and love from family and community members as they grow to be healthy and strong, and acquire the skills and abilities to deal with life's challenges. Again, the impact of HIV and Aids on families and communities can make this difficult to guarantee.

Babies and young children as unique individuals

Babies and young children are individuals. They will react to situations and circumstances in different ways; sometimes predictably, sometimes very unpredictably. It is important, therefore, to be aware of and work with each baby or young

child as a unique individual, to accurately determine his or her precise psychosocial needs. A very important part of providing psychosocial care and support is to discover the unique experiences, opinions, thoughts, feelings, behaviours, attitudes and values of the baby or young child.

The relationship between PSS and culture

Although the term PSS was first used in the English language context, and the words psycho and social draw on Eurocentric ideas, PSS has always existed in all human cultures. It preceded western civilisation and is certainly not a western invention that needs to be taught or introduced to non-western cultures.

It is very important to recognise the value and significance of the local culture (local norms, beliefs, practices and behaviours) as you develop your own understanding of PSS for ECD and your response to local conditions.

Reflecting on such topics can ensure an understanding of all the factors involved in PSS, and discovery of appropriate local ways to respond to needs. Using local words that relate to PSS is important; it's not enough to simply translate English definitions and concepts. By considering the local culture, your attitudes and approaches to ensuring PSS to babies and young children will be more relevant.

Definitions of PSS

A broad definition of PSS is useful as a starting point: '(PSS is) the ongoing support of babies and young children to meet their age-appropriate and identified emotional, spiritual, cognitive, social and physical needs, through interactions with their surroundings and the people who care for them.' Table 2.2 provides some examples of definitions of PSS in a range of local African languages. It is interesting to compare the different definitions. Although there are a lot of commonalities, many small differences reflect the local understandings of PSS and have implications for responding appropriately to needs. Such local definitions also reflect the culture of each community.

Things to think about and reflect on: terminology

1. Think about each part of the terms, psychosocial care and support, namely psycho; social; support and care.
2. Find the words to express these terms in your own language.
3. From this, write your own definition of PSS.
4. Compare your definition with the English examples and/or with any of the definitions in Table 2.2.
5. Can you add anything from any other definitions that you can understand in Table 2.2?
6. Describe how HIV and Aids impact on the psychosocial well-being of babies, young children, their families and caregivers.
7. Think about the value and importance of PSS for long-term development and well-being of babies and young children.

Language Definition(s)

Table 2.2: List of definitions of PSS in local languages

Language	Definition(s)
Dhopadhola	Tororo uganda Ngeyo gimatimere iyi paro kodi - Nyangith pa nyathi makere kodi miyo go gikipiny mago nyalo ora - Kony ma makere kodi gima timere - iyi adundo, nyeri ma go nyalo - dongo kanyachiel gi wadi kanyo - iluwo gima tho gi chik maadhumi pesa ma nintye iyi Adechno kodi. Timi ma'pa jono ma jokuro nyathi.
English	<ol style="list-style-type: none"> 1. All the processes through which babies and young children are nurtured to grow and develop. 2. Psychosocial care and support is the continuous care and support provided for children to meet their emotional, physical, spiritual, social and cognitive needs through their interaction with their surroundings and people helping them. 3. Psychosocial care and support is the process of meeting the physical, intellectual emotional, social and spiritual needs of the child depending on the cultural, political and economic situation of the community.
Luo	<ol style="list-style-type: none"> 1. En kong mosiko ma imiya wahia moho olo dwachigi mag ringruok, chunyi, pachgi ka okalo kuom jogo ma otudoregodo e aluora mar dak gi kod jogo ma knoyo gi kanyakta. 2. En kony mapile pile ma imiyo myithindo mondo okony dwaro mar chuygi, dendgi, yie margi gigo mag ringruok kod pachgi dwaro etudruokgi makinde kakinde e aluora kama gi dakie kod ji magi dakgo. 3. En kony ma nyithindo yudo e ndamo ka ko ndamo. Ka konyo dwaro mar chunyi, ringre gi, bedo gi e kanyakla, kaluwoza kod timbe gi, siasa, kod yuto mar oganda gi.
Hausa	<ol style="list-style-type: none"> 1. Tamako ne da ake bada wa ma yara don duba/a same konchiya hankali, abotowa gane, ban gskiya zuchiya da zama du hadiwa chinkin mutane ta harduwa da mutane masu bada tameko a ugwa ku a famako na, nu ugaba ne ba we za'a fara se a siya ba. 2. Tamako ne de ake bada wa ma yara don duba konchiya hankali aboboa gane, ban gaskiya, zuchiya da zama haduw chikim mutane ta haduwa da mutane masu bada taimako a ungwa, kuma taimabu ne ha chinga ba ne, ba wai za'a fara a seya ba.
Swahili	<ol style="list-style-type: none"> 1. Ni huduma endelevu ilitotewayo kwa watoto ili kuwasa idia kimaono, kimwili kiroho kijamii na kiakili/ kimawazo kwa kuandaa mazingira yanayowafaa. Kwa ukuasi wao. 2. Namna ya kumsaidia mtoto kimwili kihisia,kijamii na kiimani katika mazingiva yake kulingana na hali ya utamaduni, siasa na uchumi wa jamii. 3. Ni mbinu zote zinatunika ambazo mtoto hupewa ili kukuwa na kuendelea ipasavyo.
Luganda	Okubudabuala kwekukya musa obwago bwan abana gatu yitira mmubantu ne loyeteronde omwana gatumu yamba mu byo mubiri ekoragana nabolala okutyakafonda nedowooza
Dholuo	Kony duto mimio nyathi mondo odongi e ngima makare.
Samburu	Nkoito na keibungakini nkerai pe eret te lbulunye e akunoto enye.
isiZulu	Ukunakekelwa nokubhekela kwabantwana nezingane ukuhlangabezana nazo zonke izidingo zabo, lokhu kwenziwa ngokusebenzisana ngokubambisana nendawo abakuyo, kanye nalabobantu ababasizayo.

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3

Holistic child development, including psychosocial development

Instruction in youth is like engraving on stone.

THE BERBER OF NORTH AFRICA

The way you bring up your child is the way it grows up.

THE SWAHILI OF EAST AFRICA

Introduction: What is holistic child development?

Holistic child development is the ongoing process of growth that starts from the moment children are conceived and continues until they reach adulthood. It includes the intellectual, emotional, spiritual, social and physical development of children, and is concerned with helping them to reach their greatest possible potential. The aspects of emotional, intellectual and social development are the most significant for psychosocial wellbeing.

The stages model

A general view is that the development of babies and young children occurs in fairly predictable stages as they grow. (See Table 3.1.) Each child is unique. The rate, nature and quality of his or her development are influenced by a number of factors including the children themselves (who they are), their caregivers, their environment, and their culture. In addition, their development is not necessarily linear; although all children will pass through the same stages of development, they may not do this in a similar order. In addition, many areas of growth and development are inter-connected, happening at the same time and these can affect one another positively or negatively. During these stages the holistic development of babies and young children is often adversely affected by HIV and Aids.

While babies and young children will naturally progress through stages of development on their own, their progress will be hugely enriched by the loving and involved support of adults, their siblings and other people whom they know and trust. In the earliest days, it is the mother who is likely to be closest to the baby and she therefore has a special responsibility – which is almost always natural to her. Fathers also play an important role and the active involvement of fathers in the care and development of their children from birth should always be encouraged. Other family members can play their part too by showing love, talking to babies, offering them safe objects to explore and initiating simple play activities. In all of this, they should be guided by the babies' responses and should be aware of their rapid development and stimulation must evolve to match the babies' evolving abilities and needs.

As babies and young children's needs become more sophisticated, those nearest to them must find ways to support them. Generally, this means understanding that babies and young children need opportunities and the resources to explore, be creative, and reflect on what they are doing. They need support to move on to more complex operations and be positively challenged by them; to have new experiences, solve problems and puzzles. As a key part of their development, babies and young children need

opportunities, in line with local norms, to develop their social lives by enlarging the group of people they encounter and inter-relate with, and by being assisted to develop strong and healthy ties with them.

STAGES OF DEVELOPMENT OF BABIES AND YOUNG CHILDREN

The first weeks

During the first few weeks, babies:

- are totally dependent on others for their wellbeing and safety
- need to have all their physical and emotional needs met
- quickly become highly responsive to the efforts of caregivers who engage with them and play with them to support their development.

Things to think about and reflect on: the initial development of babies

1. What would you say are the essentials in supporting the development of babies?
2. How would you advise monitoring the development of each baby in a programme?
3. How would you decide if additional support for a particular baby is necessary?
4. How would you ensure that each baby receives essential support?

The first two years

During their first two years, babies:

- develop physical skills including control such as sitting up, feeding themselves, crawling, perhaps walking, hand/eye coordination, manual dexterity, and so on
- develop bonds with their parents or caregivers by recognising them and becoming close to them
- develop trust for those who care for them
- start to develop other emotions, including anxiety, if their needs are not met
- begin to understand that they are separate beings from others
- become more independent – do more things for themselves
- play on their own more, for example by becoming engrossed in a project involving manipulating found objects and materials

- come to understand what is being said to them and to respond appropriately
- develop communication skills beyond facial expressions, sounds, chuckling, body posture and gestures
- begin to talk, and participate in and initiate dialogue with others
- begin to widen their vision and understanding of the world as they are offered opportunities to explore it through play and through carers introducing them to it and talking with them about it – even if they don't understand the words
- learn the names of familiar objects (from adults and siblings) and are able to ask for them
- understand how some things work, for example if a plate is dropped, it will break
- begin to understand cause-and-effect, for example if they wave something too energetically, they may bang and hurt themselves
- recognise that objects still exist even when they can't see them – this can happen during games where adults hide an object from view then shows it again, and through 'peek-a-boo' games
- understand concepts such as warmth or bedtime
- investigate and experiment more, and need opportunities and resources for this
- initiate more complex activities such as systematically exploring objects to establish what they do and how they work.

Things to think about and reflect on: the first two years

1. Ideally, what do babies and young children need from adults and others to support their development?
2. What kinds of actions and attitudes by parents, caregivers and others close to babies would support their development?
3. What kinds of action and attitude would not help to support babies' development?
4. Would any of those carers closest to babies appreciate help and advice? If so, how could you supply that?
5. What easily accessible local resources could be helpful?

The period two to five years

During this period, young children:

- consolidate, refine and build on the skills they have

acquired so far, for example physical skills, analytical abilities, social skills, language and communication skills

- gain more understanding of who they are as individuals, and as family and community members – although they remain largely ego-centric (self-centred)
- develop their concept of others, become more sociable and begin to understand what it means to interact with others
- investigate and come to understand more advanced concepts such as family, community, or religion
- understand more about the consequences of their actions
- know about acceptable and unacceptable behaviour,
- learn more about the rules of their families and communities and learn to adapt to these, often by testing them
- find and create their (evolving) roles in their families, for example by helping with chores or by pretend play that mimics what they see
- find and create their (evolving) roles in their communities, for example by exploring what they are allowed and expected to do
- gain confidence in what they can do, especially if they receive praise for previous efforts and achievements
- are generally unable to differentiate between real and imaginary
- think and plan in the immediate short term only
- develop their understanding of the past and future, but this often remains a general understanding rather than a precise one, for example last week can mean any time before a few minutes ago, and tomorrow may mean anytime after their next sleep.

Things to think about and reflect on: the period two to five years

1. Who should be the primary support giver for this age group?
2. How can parents, caregivers, families and others be supported in meeting the developmental needs of these young children?
3. What kinds of attitudes and actions would not help to support young children's development?
4. Other than enrolling children in pre-schools, what opportunities exist or could be created in communities to support the development of these children?

The period five to nine years

During this period, children:

- continue to develop their physical skills and have great control and considerable confidence in what they can do
- continue to develop their roles in their families – perhaps by taking on quite sophisticated responsibilities, or caring for a younger sibling
- continue to develop their roles in their communities – perhaps by joining sports teams, forming wider friendships, or by participating in activities organised by schools and churches
- understand that other people have points of view that may be different from their own, and they may understand that this is acceptable and not necessarily a cause for dispute
- are verbally more able to negotiate and resolve conflicts
- understand more about the emotions of others and can express their understanding
- refine their abilities to understand concepts such as the future, and cause-and-effect
- develop their abilities in logical thinking and can see that if something is true then something else necessarily follows
- are better at solving complex problems
- are able to learn to read and write.

Things to think about and reflect on: the period five to nine years

1. How can parents, caregivers, families and others be supported to meet the increasingly sophisticated needs of children of this age range?
2. Other than enrolling children in schools, what opportunities exist, or could be created in communities to support the development of these children?
3. Would it be appropriate to have activity centres in communities that offered opportunities and resources designed to support their development?

Psychosocial development

The previous section dealt with holistic development. Psychosocial development is an integral part of children's holistic development with emphasis on intellectual, social and emotional development.

The stages model suggests that, in the earliest days and months of life, babies come to recognise their parents or

principal caregivers and can initiate social contact through smiling at people in their surroundings. By the age of three, young children can be playing with others, exploring the boundaries of what is right and wrong socially, and may be learning about the needs of others. By the age of six, they may be able to share and take turns, and they may be aware

of gender and difference in people. Thereafter they may go on to participate in community activities, work and play with others, and begin to compete.

Table 3.1 offers an overview of this and also of the roles that caregivers have in helping to ensure healthy psychosocial development.

Table 3.1: Psychosocial development of young children

Age	Normal psychosocial characteristics	Role of parent/caregiver/support worker
0–1	<p>Babies begin to develop basic trust for caregiver(s) on whom they are dependent and will show mistrust of strangers.</p> <p>If basic trust is strong, they may develop a hopeful and trusting attitude. Usually, at this stage, a baby's strongest bond is with its mother, who is breastfeeding. Babies are capable of forming strong bonds and attachment.</p> <p>Communication involves crying, babbling, eye-contact and smiling, touching, wriggling and holding.</p> <p>Babies respond to pain, hunger, anger and discomfort by crying, and to familiar faces, joy and entertainment by smiling. Infants experience fear and distress, for example in the absence of their parent or caregiver or if they experience a loss of support. They may also experience hostility and anger towards others. This is expressed by kicking, hitting or struggling.</p>	<p>Be reliable and consistent about feeding, bathing and changing, so that the baby develops trust in others.</p> <p>Be loving and accepting.</p> <p>Engage with the baby actively – talk, smile, play and cuddle.</p>
1–3	<p>Young children begin to become separate and independent individuals as they learn physical coordination and to walk and talk.</p> <p>Young children need praise and support.</p> <p>They understand their need for the caregiver.</p> <p>They 'test' behaviour, emotions and socialisation in the home and with the caregiver.</p>	<p>Encourage very young children's efforts to walk and talk.</p> <p>Support the development of their self-esteem by praising what they do.</p> <p>Gently lead them away from inappropriate behaviour.</p>
3–5	<p>Young children begin to explore, try out new activities and ask lots of questions. It is normal for children this age to be quite selfish and to fight a lot as they learn to relate to other people.</p> <p>Temper tantrums are still common, and normal.</p> <p>Young children are open to magical ideas and may have imaginary friends.</p>	<p>Allow young children to explore their surroundings within set limits.</p> <p>Give praise rather than criticism.</p> <p>Give honest answers to questions.</p> <p>Encourage creativity and openness and the expression of feeling, including negative feelings like anger and disappointment – but in an acceptable way.</p>
5–9	<p>Young children begin to compare themselves to their friends and peers.</p> <p>Failure to achieve a task may make them feel inferior and unhappy.</p>	<p>Encourage children to keep trying and praise their efforts.</p> <p>Give support and help them to consider other ways of achieving what they want.</p> <p>Make sure that young children do not feel inferior to friends of their own age.</p>

Table 3.1 shows some of the ways in which parents and caregivers can support babies and young children in their psychosocial growth. This is part of the bigger picture of ensuring that children get the care and support they need, particularly vulnerable children affected by HIV and Aids. In their holistic development, those babies and young children depend on the people nearest to them such as family members and extended family members, community members (as their social horizons widen) and then, eventually, members of their wider societies. One way of looking at this is to see three circles of care and support for babies and young children: the first circle stands for the family; the second circle represents the community; and the third circle stands for society. The significance of these circles in providing psychosocial care and support is discussed later. (See Chapter 4 on psychosocial care and support.)

**Things to think about and reflect on:
healthy psychosocial development**

1. How can you make sure that babies and young children affected by HIV and Aids have the best opportunities to develop their full potential?
2. Emotional distress is frequent among babies and young children affected by HIV and Aids. How could a caregiver help to relieve this?
3. Babies and young children may experience anxiety and grief when their parents are sick and/or die. How could a caregiver help? What kinds of support could they need and how could that be provided?
4. Sometimes babies and young children experience neglect and abuse, especially when they have become members of substitute families. What role could you suggest for monitoring this and ensuring that they are protected?

Psychosocial development and childcare beliefs

Childcare beliefs affect how people understand children, especially babies and young children, as well as what they need and what they can do. These beliefs help to define people’s understanding of childhood and how babies and young children should experience it. For example, the belief that young children should not participate in discussions about them can have several adverse effects. They may feel demeaned by not being allowed to contribute because it

seems that others don’t feel they have anything to offer. They may not comply with decisions that emerge from discussions either by being rebellious or because they don’t really understand what is expected of them. In the long-term, they may come to believe that they are inferior to others.

Think about your own culture. You may find many wise and helpful beliefs about childcare and child development. However, every culture has beliefs that can be negative and harmful to child development. Sometimes these potentially harmful beliefs are called myths. Such myths are passed from generation to generation, and are often embedded in local cultures. Trying to change them can be difficult. However, when they hinder the healthy psychosocial development of babies and young children, or increase their vulnerabilities and burdens now or in the future, it may be essential to find ways to make those changes.

Myths relating to gender inequality (and what is and is not appropriate behaviour for girls and for boys) are especially resistant to change. Apart from discriminating unfairly against them, such inequality can be dangerous to young girls in HIV and Aids settings. For example, certain myths about how girls should behave can make young girls vulnerable to sexual abuse, and, later in life, can make it difficult for them to look after their own wellbeing, especially in matters of sexual health. This includes making decisions about matters such as when to have sex or whether or not to use condoms. The HIV and Aids pandemic, makes it imperative to stop female children being treated as inferior beings, or as passive participants in families, communities and relationships. The Swahili of eastern Africa say *You cannot turn the wind, so turn the sail*. If HIV and Aids is represented by the wind, then we must accept that we cannot just ignore it and that we need to teach our young children new sexual behaviours.

In some societies, childcare myths often relate to the following key areas in general child development:

- breastfeeding and nutrition – how babies and young children should be fed
- behaviour – how babies and young children should behave
- gender – how boys and girls differ
- health and development – what makes babies and young children grow up healthy and strong.

In each of these areas, myths can impact negatively on holistic child development; and sometimes they can have specific consequences for the psychosocial development of babies and young children. Table 3.2 offers some examples.

Table 3.2: Some local myths and how they affect children negatively

Myths about...	Myths	How the myth may affect babies and young children negatively
nutrition	<p>Pregnant women should not eat bananas, eggs, mangos or their babies will get jaundice.</p> <p>Children who eat eggs will not learn to speak or will become cowards.</p> <p>Children who eat certain parts of a chicken will become greedy.</p> <p>If a female child sleeps without eating dinner, she must not be woken up. (Boys, on the other hand, must be woken up and must eat well.)</p>	<p>All these myths deny essential healthy food and therefore negatively affect nutrition. Inadequate nutrition directly impacts negatively on health and healthy development.</p>
behaviour	<p>Babies and young children do not understand things or have no feelings.</p> <p>Young children should not talk when adults are present.</p> <p>Young children should not talk about sexuality or say the names of sexual organs.</p> <p>Babies and young children must be protected from death. They should not go to funerals or places of grieving or they will be haunted by spirits.</p> <p>Disabled babies and young children should be kept in, away from others.</p>	<p>Babies and young children obviously think and feel. If people don't recognise their thoughts and feelings, or don't allow them to express themselves, they will not develop into secure and confident adults.</p> <p>Self-expression and communication are hindered by these myths. Young children need to learn how to communicate with adults appropriately. They are curious and they notice what is happening around them.</p> <p>If people don't tell them about sexuality in an appropriate way, they may learn the wrong things from the wrong people; or they may get a very unbalanced view of sexuality. Young children should not be made to feel guilty or secretive about their own sexual organs. They need to be told what is appropriate behaviour in a gentle and loving way by their caregivers.</p> <p>Young children need to understand that all people will eventually die and when someone close to them dies, they need to know that they too can feel sad and grieve their loss. Shielding them from the realities of, and rituals around, death can hinder them from accepting what has happened, and deny them the opportunity to express their grief rather than to hurt in silence.</p> <p>If disabled babies and young children are shunned and kept away from others, they will be deprived of social experiences and stimulation, and possibly held back in their psychosocial development. In addition, they will never have the opportunity to show that they have valuable contributions to make to their families and communities.</p>
gender	<p>Boys should not work in a kitchen.</p> <p>Girl children do not count as much as boys.</p> <p>Girls cannot plant trees.</p> <p>Girls do not need as much education as boys.</p> <p>Boys are not allowed to cry.</p> <p>Girls should not climb tall objects, for example if girls play in trees they may lose their virginity.</p> <p>Girls must be circumcised.</p>	<p>Treating girls as less important than boys means that they may be regarded with less respect, may be paid less attention, may have fewer privileges, and may have fewer developmental, educational and employment opportunities. If girls do not feel that they have equal rights to boys they may not learn to value themselves and may not develop the self-confidence to have and express their own views. They may be more at risk of unwanted pregnancies and sexually transmitted diseases, including HIV and Aids.</p>

Addressing beliefs and myths about child development

Arguing that myths are harmful to children should be done in sensitive ways that are not disrespectful to the culture. All cultures change and evolve. This is reflected in the following African proverb, which suggests that changes in cultural tradition are normal, and sometimes necessary: *When the music changes, so must the dance* (the Hausa of Nigeria).

In settings where myths could hinder the development of young children, there is a need to find practical ways of helping families and communities to challenge their beliefs. Change is most easily achieved and maintained when it happens from within, when all stakeholders are involved in investigating the need for change and together reflect on what changes are necessary, and then agree to make the changes. These are the lessons of community development. In practical terms, they involve:

- facilitating discussion, creating awareness, sensitising family and community members about babies and young children's rights, needs and potential roles
- sensitising family and community members to how babies and young children develop
- promoting positive ways of disciplining babies and young children
- ensuring that everyone is engaged in encouraging and supporting babies and young children develop to their full potential, and in preparing children for active roles in family and community life.

Sensitive and respectful discussions, where people talk about their beliefs, work best. Together, people can decide for themselves *whether* changes are necessary and *why*, *what* changes are necessary, and *how* to make the changes.

An alternative is to work around potentially damaging beliefs. But to do so raises questions about the consequences of such an approach: How to deal with those consequences? What actions will be necessary? Who will take those actions? What resources will be needed?

Things to reflect on and think about: childcare beliefs and myths

1. Think about the beliefs concerning babies and young children in a community and try to identify which beliefs are wise and helpful, and which are negative and harmful.
2. Are you able to build on the wise and helpful beliefs in your community?
3. Why do you think myths are potentially harmful?
4. What are some practical ways to get families and communities to change beliefs?
 - a. What actions will be necessary?
 - b. Who will take these actions?
 - c. What resources will be necessary?
 - d. What are the consequences of trying to make changes?
5. Who has the right to discuss these beliefs and myths?
6. How could a caregiver start such discussions?
7. What evidence would you need to help people to change their thinking?
8. What objections may a caregiver have to overcome?
9. How well are children's rights and needs understood locally?

References and resources

Children's Rights Centre (CRC)
<http://childrensrighscentre.co.za>
(Accessed November 2007)

The Centre for Conflict Resolution. University of Cape Town, South Africa. <http://ccrweb.ccr.uct.ac.za>

4

Being part of psychosocial care and support

Introduction

Human beings help one another. Here is an African expression about Ubuntu that reflects this: *I am a person because of other people. (Mntu ngumtu ngabantu.)* Giving psychosocial care and support to young children requires firstly an understanding of ourselves. When we have grappled with (and, of course, continue to grapple with) our understanding of what it means to be human, we are more able to understand babies and young children and how they experience the realities around them. In other words, we are able to empathise with them. We also need an understanding of how to work with those realities in which babies and young children and their families live. Whether supporting psychosocial development as part of overall development, or giving psychosocial care and support in cases where specific kinds of extra support is needed, we must have an understanding of how to work with those realities. Only then can we decide upon a strategic vision, clear objectives and the resources needed.

Human beings are social creatures; we generally cannot live alone with ease; we need other human beings to remain human ourselves. This is the basis for the African philosophy of Ubuntu.

What is the African philosophy of Ubuntu?

The philosophy of Ubuntu is linked to the Western philosophy of *Agape*, a Greek word for the unconditional and non-discriminating love of our brother and sister human beings. Ubuntu, like *Agape*, means that our own humanity is caught up in the humanity of all others. We are human because we belong to groups of humans. Archbishop Tutu said that we are made for community, for togetherness, for family, to exist in a delicate network of interdependence.

He said, '...ultimately goodness and laughter and peace and compassion and gentleness and forgiveness and reconciliation will have the last word and prevail over their ghastly counterparts.' (1999)

We always seem to be living in times where our life philosophies are being challenged. At present our philosophies of Ubuntu and of *Agape* are being challenged in Africa by poverty and its effects on extended family networks, regional wars and HIV and Aids.

Knowing clearly our philosophy of life is helpful to us. It especially helps to be clear on our attitudes to one another, not only in our own families and neighbourhoods, but in the wider family of human beings whom we do not even know and may never know.

Things to think about and to reflect on: philosophy of life

1. What is your own family's philosophy of life? What do you think is good about it? What do you think is perhaps a challenge to you? How did you 'inherit' aspects of this philosophy from family members?
2. What is your own philosophy of life? What has changed and how? What has made it change? Can you give your philosophy a name?
3. Does Ubuntu or *Agape* work for you in your own life? What is difficult about living according to this philosophy?
4. What behaviours do you show to others with whom you come in contact, which reflect your own philosophy of life?

Seven basic principles in supporting humans psychosocially

In this section we will examine seven principles.

1. Work ethically

Working ethically means respecting the dignity and rights of every child – and other family members – to:

- privacy and confidentiality
- be heard
- participate in decisions affecting them.

It also means respecting the responsibilities of children (depending on their ages and abilities, of course) and of their families (depending on their circumstances and abilities, neighbourhoods and communities). When we do *not* respect the responsibilities of people, we may end up dysfunctionally rescuing them. This refers to rescuing people in such a way that we disable their own confidence in themselves and their own powers and competence.

The Igbo (of west Africa) have a proverb that explains it like this: *At whatever age a child gets a problem, at the same age she has to shoulder the responsibility of solving it.*

2. Be aware of developmental environmental factors

A second basic principle of PSS in an HIV- and Aids-affected context is the need to be aware of the development environment that babies and children really have, compared with what would be normal (even ideal) in that setting, and to find practical ways of improving it. Young children need to be nurtured by care-giving adults (or significant older children, in some cases) who provide:

- love and protection, food and shelter
- stimulation, opportunities for exploring, playing and learning.

The family is the first circle of support for children and is especially important in situations where young children are affected by HIV and Aids, such as when their parents are sick and/or dying. Babies and young children need normality as they develop physically, intellectually, emotionally and socially.

For them, this means:

- being in familiar surroundings with the people they are closest to
- having routines
- doing things that they know
- moving smoothly on to new things
- knowing what to expect each day, and so on.

In some circumstances, that normality can be lost, and should be restored or an adequate substitute developed.

3. Regard each baby or young child as a unique individual

Especially important are the baby's or child's:

- views and ideas
- perceptions of the realities of life
- ability to cope
- actual psychosocial state
- needs
- ability to participate in determining and meeting those needs.

It is important to develop an understanding of what an individual is, in the neighbourhood in which you are working. The Swahili proverb explains it thus: *A person becomes what she wants to become.*

4. Discover and develop the actual and potential resources that exist in babies and young children, in families, in communities and in society generally

Babies and young children are resilient and can be helped to cope with what they are facing. The groupings they regard as their families can be helped to contribute more to their wellbeing and to sustaining the viability of the family unit. Communities can also yield resources to support both children and families. They can also reflect on their collective beliefs, attitudes and behaviours to counter the stigma, discrimination and marginalisation that young children and their families so often face.

Similarly at the wider level of society, you can encourage supportive attitudes to those living with HIV. There's a need to ensure that resources, such as health care and education, are in place and available to all, irrespective of their HIV status.

5. Establish approaches and objectives by working closely with babies and young children, their families and communities

A fifth basic principle is to decide *together* what should be achieved. Joint planning and decision making is not just a matter of respecting rights; it also involves practicality. When people are fully involved, the right ways forward can emerge, and the people themselves will be more committed to them because they own the ideas.

6. Work within local norms and practices

Make sure that harmful beliefs, myths and proverbs are discussed and changes are agreed with all stakeholders. It is important to discuss what they meant in the past and what they can mean now.

7. Evaluate the effectiveness of the plan or work

Ask yourself:

- Is the plan having a positive effect?
- If so, how?
- What isn't working?
- How can I correct this?
- What plans do I have for future work to sustain the achievements so far?

Who can give psychosocial care and support to babies and young children?

Everyone can! We are all born with a natural ability to look after our young. This is true of children, adolescents and adults. We see this even in very young children who look after one another, show concern when another child cries, and comfort children by putting their arms round them. We see this with women who traditionally take the primary role of caring for babies and very young children. We see this with men who in very many societies traditionally share in this role because not only is it expected of them, but also because it is one of the greatest joys of our lives.

We are socialised in our families first of all, and then within our neighbourhoods and wider communities. Through socialisation, people sometimes think that childcare is only for women. People are sometimes taught that a boy or man who takes care of family members and who nurtures others is not 'a man'. They are sometimes taught that 'a man' is a person who is aggressive, violent, controlling and without emotions for others. This is not true. It is a myth.

All over the world, boys and men are looking after babies and young children, bringing them up, caring for them and teaching them skills for life. Boys and men can be as attached to their families as girls and women can.

In addition to the qualities which we all share, we are living within an HIV and Aids pandemic. Many women are dying in this pandemic. If women are seen as the sole caregivers of babies and young children within families and communities, who then can take care of the children when their mothers are ill and dying?

It is time for all to reconsider firstly our attitudes and behaviours towards caregiving and nurturing, and our own roles and responsibilities as caregivers and nurturers of children. It is also time we considered what knowledge and skills we already have as natural nurturers.

Things to think about and to reflect on: attitudes and behaviours towards caring for babies and young children

1. What attitudes were you raised to have about babies and young children? Who influenced you in developing these attitudes and behaviours?
2. Should men care for their babies and young children? Why or why not?
3. What qualities do you have that would help you to give psychosocial care to adults, to babies and to young children? Think about your existing knowledge and skills in giving psychosocial care. Also think about the attitudes and behaviours that you already practise.

Who are the babies and young children who need our psychosocial care and support?

Some people think that:

- It is not only babies and young children who need support, but all human beings with whom we come in contact.
- It is only those young children who are orphaned by Aids who need support.
- Offering support is none of their business; it is only the business of the family.
- Every child is their business.

Some people think that we should be sympathetic and empathetic towards people who are struggling to live their lives. **Sympathy** is a mixture of compassion and pity for others. When you are being sympathetic it means that you have an understanding of the lives and views of others, and you are showing pity and compassion from your own point of view. **Empathy** refers to understanding people's lives and views from 'inside their shoes', that is understanding them from their own points of view, and not from your own. When you are being empathetic, you do not so much show pity or compassion, but rather live the experience with the person. This helps you to view the situation from the person's own point of view.

Whether you are sympathetic or empathetic, it is very important to be respectful to everyone. Being respectful means that you are not only acting upon your own rights, but also upon the rights of everyone with whom you come in contact, including the young and the old, the rich and the poor, the healthy and suffering. Being respectful also means

acting upon your own responsibilities in accordance with your own abilities, and equally upon the responsibilities of others in accordance with their own abilities. This is reflected by the following Zulu proverb, *Respect must be paid on both sides*. It is interesting to compare different translations of empathy and sympathy in different cultures. Although there is a lot of common ground, many small differences in meanings reflect the local understandings of the concepts and can have implications for responding appropriately to needs. Such local definitions will also reflect the culture of each community.

Things to think about and to reflect on: understandings of concepts

1. What do you understand about the concepts of sympathy and empathy? How can you show these in your own behaviour?
2. What do you understand about the concepts of respect, rights and responsibility? How can you show these in your own behaviour?
3. What do you think is the meaning of these proverbs:
 - a. The African proverb, *It takes a village to raise a child?*
 - b. The Ganda proverb, *What happens in the family is not for outsiders?*
 - c. Can these two sayings 'fit together' in any way?
4. What effects will an understanding of these proverbs have on the ways in which you interact with adults, babies and young children?

Working from what is already there

In addition to developing empathy, there is also a need to work with the realities that babies and young children are facing. This means having clear objectives and the ability to discover and develop resources that will help achieve the objectives. This is true whether supporting babies and young children's psychosocial development as part of their overall development, or whether delivering support in cases where specific kinds of extra support are needed.

To do this, it can be useful to have a view of the situation of babies and young children in relation to the people around them. One such view, as discussed in the circles-of-support model (see Chapter 2, Model 4), views the three circles of support as being made up of significant people and resources.

Young children depend on these layers of support to

provide not just love, protection, shelter, food, education and health services, but also an appropriate development environment. They depend on the people who generate that environment to offer rich opportunities to aid their exploration and learning, and they also depend on those people to meet any special needs they may have, for example psychosocial needs that arise out of the impact of HIV and Aids. These three layers are closely inter-related, and become more so as babies and young children develop closer contacts with people and children outside of their immediate families. They are also dynamic; what happens to one layer can impact on what happens in the others. For example, a young child might return from school with the idea that she must have special shoes because everyone else has them. This will impact not only on the child herself (she may feel like an outsider at school if she is different from the others); this will impact on the family too. Can they afford the shoes? Do they want the child to have that type of shoe?

The relative importance of each layer or circle to babies and young children may also change. For example, the formal education received at school may become the dominant educational force in a young child's life and call for the family to switch to new supportive roles that replace their previous ones as prime agents in a child's education.

The first circle of support: the family, especially the mother and her role

If relatives help one another, what evil can hurt them?

AFRICAN PROVERB

Kinship cannot be washed with water and removed.

SHONA PROVERB

The first and most important of circle of support for babies and young children comprises their family members. Generally young children will thrive best within their families if they find the support they need to help them cope with adversity. In terms of PSS, family members can support them simply by doing what all functional families naturally do. For example, family members can:

- love them unconditionally
- ensure that they feel they belong to the family
- hear them and take their views seriously
- encourage, praise, motivate and appreciate their activities
- help them to learn about their origins
- involve them in decision-making
- provide them with rich opportunities for play

- train them in life skills
- be good role models as adults or siblings
- give them enough room to develop as individuals
- help them as they begin to identify their roles in the community
- guide and counsel them on sexuality.

The importance of the family in the lives of babies, and of young children supporting families (so they can keep going), is well-proven for responding to threats to the development of babies and young children in HIV and Aids situations. However, this can be challenging, for the reasons discussed below.

COUNTERING MOTHER-TO-CHILD TRANSMISSION (MTCT)

Obviously, the welfare of mothers and their babies is the primary consideration. Two especially vulnerable times for possible mother-to-child transmission of HIV are during pregnancy, labour and delivery, and during breast feeding. Mothers therefore need information and education about their options, and the implications for their health and that of their babies.

Families in some communities have been seriously affected by poverty, conflict and the HIV and Aids pandemic. In many cases, parents are sick and may be dying or already dead. Because HIV and Aids can spread through whole communities, many members of the wider family (who would naturally take over the functions of parents) may also be sick or dead.

An alternative to the biological family (including parents, sisters and brothers) is the extended family network that includes grandparents, cousins, aunts and uncles. Grandmothers are often the first resort but they may struggle to care for their grandchildren on their own, having led demanding lives themselves. Sometimes, the eldest child or children take responsibility for their siblings and this may mean that they have to leave school early; and they may have to find work to support the family. Sometimes, it may not be possible for a family to remain viable.

Things to think about and reflect on: identifying family strengths and weaknesses

1. Think about a family functioning in normal circumstances. How would such a family normally meet the psychosocial development needs of its babies and young children?
2. What strengths might that family have?
3. What kinds of weaknesses might that family have?
4. What kinds of problems could a family affected by HIV and Aids have that would weaken its ability to support its babies and young children?
5. What strengths would that family have?
6. What kinds of support could keep that family viable?
7. Who could provide that support?
8. What kinds of challenge would there be in finding and providing that support?
9. How could a caregiver overcome those challenges?

The second circle of support: the neighbourhood and community

When a spider's webs unite, they can tie up a lion.

ETHIOPIAN PROVERB

Different communities may be significant for the development of babies and young children, for example, the community formed by the family's immediate neighbourhood, the wider village, community of their religion, the work community that a parents may be involved in, and so on.

Each of these communities can and should play a role. The roles of school and religious communities are obvious, while a work community might be able to ensure that parents get enough time with their children and pay high enough wages to ensure that families are viable. Perhaps the most useful understanding here is that families constitute the core of a village: no families—no communities; no children—no future community. Family members— including babies and young children— collectively give life and coherence to their communities and jointly contribute to its wellbeing and sustainability. In return, a viable community helps to meet many basic needs that its members may have, for example mutual support; and education and health provision, and generates a rich variety of social environments for its inhabitants. As babies and young children grow, they become more obviously members of their communities, both in contributing to them and benefiting from them.

It is therefore natural for a community to be regarded as a significant resource for babies and young children—

a second circle of support.

This circle is made up of people and organisations and includes:

- classmates and friends and their families
- neighbours
- religious leaders
- teachers
- nurses and social workers
- community leaders
- community chiefs and ward councillors; and so on.

In addition to these people, there may also be community-based organisations and programmes, such as:

- non-governmental organisations
- faith-based organisations
- other local organisations such as women's groups
- child welfare forum and child protection committees with members chosen by communities
- home-based care programmes, and so on.

Ideally, babies and young children have their natural places within communities and the culture of each community includes a natural disposition to support the development and wellbeing of those young people. And communities naturally support families that are struggling. But the impact of poverty, conflict, and HIV and Aids on communities can be substantial and can reduce their ability to function normally. In addition, they may find that outside help is limited, leaving them to look after themselves with whatever resources they have. In some communities, people fear and therefore stigmatise those living with HIV and Aids. This can mean that babies and young children and their families find themselves marginalised and left to their fate.

HOW COMMUNITIES CAN SUPPORT BABIES AND CHILDREN'S PSYCHOSOCIAL WELLBEING

An African proverb says: *It takes a village to raise a child.* This means that communities have the duty to complement the child-raising responsibilities of families. They therefore need to have the will and ability to make things function as they should for babies and young children, to respond naturally to their developmental needs, and, if necessary, to provide support for individual families and their young children. That can mean raising a collective awareness of people's needs and problems and assisting them to find practical ways to address these needs and problems. It can also mean addressing attitudes about HIV and Aids to counter stigmatisation and marginalisation.

Given that healthy psychosocial development is part of holistic child development, communities need to find ways to support

that holistic development. And since babies and young children thrive best in whatever they regard as their families, the most basic aspect of support is helping families to remain viable. Obviously this includes helping to ensure that food and shelter are sufficient; and that fear, stigmatisation and marginalisation don't prevent the access to health and education facilities of affected people. But the nature of families is changing in many settings, for example one-parent families may be more common; both parents may have died and been replaced by an older sibling who now heads the family; or grandmothers may find themselves providing the vital family environment.

Things to think about and reflect on: community support for families

It is essential to assess the situation of each affected family and to develop strategies and approaches that respond precisely to its needs. This can be complicated. For example, consider a family headed by a grandmother:

1. What practical challenges confront the grandmother and her family?
2. Are the family's basic material needs being met?
3. What strengths might that grandmother have?
4. What special vulnerabilities might she have?
5. What strengths might that family have?
6. What vulnerabilities might the family have?
7. How could the community reinforce and build on those strengths to confront the challenges and protect the family from the vulnerabilities?
8. Who are people who could most naturally be involved in supporting the family?
9. How can you ensure that they (the parties you referred to in question 8) are willing and able to do so?
10. Who else could offer support?
11. What other resources such as local organisations and statutory services are available?
12. How could you ensure that these resources are reaching the family?
13. Are there shortfalls in what can be provided?
14. How could these be filled?
15. Are those services properly co-ordinated and working well or is there duplication of effort?
16. How can this duplication, if necessary, be sorted out?
17. Who has the power to make the necessary changes?
18. How do you reach and influence those people?

Community members and support for young children

Babies and young children need a stimulating environment if they are to grow healthily. Additionally, they need to feel secure, live within a safe routine, and be able to adapt naturally to new circumstances. Experiences with babies and young children in post-conflict settings show that this kind of stability and normality is vitally important, not just to their ability to thrive, but also to their psychosocial wellbeing. To support babies and young children impacted by HIV and Aids, community members can interact with them as they always have, reflecting on what is traditionally normal for them, and the ways in which they contribute to establishing that normality. That means making sure that they have all the experiences, relationships, opportunities, learning moments, guidance, care and support that their communities have always provided, in line with local norms and customs.

Collectively, community members can also:

- provide access to all community facilities for all family members
- generate a supportive environment in which everyone helps babies and young children to understand what is happening (reality orientation)
- enrich the environment, for example, by establishing play centres, supporting the schools in ensuring access to all children, and organising games, events and outings.

However, some babies and young children, such as those affected by poverty, conflict, and HIV and Aids, may need special attention. Depending on the local culture, some community members have more direct roles to play in supporting babies and young children, for example naturally helping babies and young children to cope with reality by:

- listening to them
- encouraging them to express how they feel, experience and understand something
- clarifying things with them
- comforting them.

In addition, teachers and religious leaders can ensure that babies and young children are not isolated or teased as a result of stigmatisation, while older community members can encourage their own young children to maintain normal relationships with affected children, for example by welcoming them in their homes.

Things to think about and reflect on: community members and organisations who could contribute to the psychosocial care and support of babies and young children

1. What qualities do non-family members of the community need to support babies and young children?
2. Which community members are likely to have these?
3. What kind of support could each of them offer?
4. Would any of them need training or advice before the member could help?
5. Who are the appropriate role models in the community?
6. Are there older children who could act as peer educators?
7. What precautions would you as a caregiver take before the members work with babies and young children?
8. How could caregivers evaluate their contribution?
9. Which organisations are suitable to provide psychosocial care and support?
10. What roles could schools and teachers have?
11. What roles could health service providers have?
12. Are there suitable community-based organisations?
13. Are there suitable faith-based organisations?
14. Are these organisations aware of the need?
15. Do all members who could be involved have the necessary knowledge and experience?
16. Do people understand key children's rights issues for babies and young children whose parents and/or guardians are living with HIV and Aids, for example, providing them with a birth certificate; protecting their future by ensuring they leave a will; arranging future guardianship?

Obstacles to community support for babies and young children, and their families

Practical problems such as inadequate food security, lack of resources, absence of professional support workers, non-governmental organisations (NGOs) being out of sync with communities (perhaps because each party has differing expectations or objectives), and an apparent lack of skills among community members can all be potential obstacles. Stigmatisation and discrimination associated with HIV and Aids are also barriers to preventing communities supporting babies and young children and their families. Many factors are responsible for these barriers, including a lack of understanding of the disease, myths

about HIV transmission, prejudice, a lack of treatment and social fears. Stigmatisation, sometimes generated or sustained by media misinformation, also can weaken the collective will.

In addition, cultural practices can work against effective action, particularly those that regard children as passive vessels that have to be filled by the perceptions, ideas and visions of adults. Communities may also struggle to adapt to the changes that HIV and Aids can cause, for example, the emergence of households headed by 12-year-olds.

Things to think about and reflect on: overcoming obstacles to community support

1. Do you know enough about a community to assess its general situation and viability?
2. How could you fill any gaps in your knowledge of this community?
3. What specific problems facing the community must be tackled?
4. What resources are available to support babies and young children psychosocially?
5. Which resources are lacking?
6. How can necessary additional resources be generated?
7. What community development approaches could help build community resources?
8. How well does the community understand its obligation to support babies and young children?
9. Could you organise consultations and collaborative problem-solving sessions with community members to raise awareness and help find positive ways forward?
10. How has the community traditionally supported the development of babies and young children?
11. Which local rituals and traditional practices are appropriate?
12. Do community members need help to enable them to respond to the psychosocial needs of babies and young children?
13. Is stigmatisation and marginalisation a problem in the community?
14. How can this be combated?
15. Should parents living with HIV and Aids come together to discuss their experiences, needs and ideas? What are the arguments in favour of this? What are the arguments against this?
16. How could a community respond positively to a family headed by a 12-year-old?

The third circle of support: wider society

A society is a collective of all its members that exist for the wellbeing of those people. But national and local governments, major employers, political parties, NGOs and other civil society organisations such as religions organisations and trades unions make up the structure of society and define its functioning to a large extent. The impact of HIV and Aids and the need to respond adequately has been heavy in some societies and the ability of their established structures to cope with it is under considerable strain.

Nonetheless, they cannot afford to neglect the wellbeing of babies and young children who are 'the future'. That means that societies have not only to sustain the systems that support the holistic development of babies and young children, for example, via national education and health programmes, but also that they must respond to special factors associated with HIV and Aids.

Psychosocial support

Babies and young children need their societies to continue to value them, and to do everything possible to help them thrive and overcome their difficulties. This means going beyond meeting basic needs. It means that societies must go beyond responding only to the HIV- and Aids-related needs (in respect of the physical, mental and emotional wellbeing of youngsters). All children, and especially babies and young children, need to:

- be protected from discrimination and marginalisation
- know that they belong
- know that they are accepted and valued for who they are.

Essentially, this means that society needs to promote positive attitudes towards them and their families, and to combat such factors as fear about HIV-positive people. It's a matter of developing a positive social environment for them.

Protection from HIV and Aids

Society has a role in protecting babies and young children from HIV infection and Aids-related diseases, and supporting families as they cope with infection. One important target group for prevention is young adults. In many countries that is the group heavily impacted on by HIV and Aids. Young adults continue to be at high risk of infection. More alarming is the fact that these young people make up the next generation of parents. Also critical is the need to counter MTCT – that is, babies and young children being infected by their mothers

before or during birth, or through breast feeding. In addition, ensuring that parents living with HIV and Aids remain alive and as healthy as possible helps to preserve families and keep them viable, thereby ensuring that babies and young children continue to enjoy and thrive in the love of their parents. Finally, and most importantly, babies and young children living with HIV and Aids have the right to medical treatment.

Treatment and care of parents and caregivers living with HIV and Aids

Overall, treatment and care includes:

- voluntary counselling and testing
- ensuring enough food and nutrition
- eliminating stigmatisation and discrimination
- offering spiritual support
- making sure that they receive the right medication
- preventing and/or treating infections that take advantage of the fact that they are HIV-positive (opportunistic infections).

Informed consent to testing is very important; and underlying this is the need to ensure that they understand all aspects of their condition and treatment, including the importance of adherence to the treatment.

One of the difficulties of HIV counselling and testing (VCT) is that people at an early stage of infection may show no symptoms. Yet this is the time when treatment is most likely to be effective. In addition, it appears that people knowing their status can help them to stay healthy for longer. This means that the sooner a person knows that he or she is HIV-positive, the better. It is important for HIV-positive people to have counselling and support as they adjust to their condition; and that they receive education about preventing transmission of the HI virus to others.

The challenge for societies is to ensure that HIV-positive people get the support and treatment that they need. For many, this means overcoming a range of problems associated with a lack of professional resources, inadequate infrastructure and the ravages of HIV and Aids. However, there are many examples of necessary facilities being set up to ensure that people get what they need. One key strategy is the development of practical approaches that acknowledge local realities such as the absence of professional staff, and that find ways of building on local resources. Such approaches include the development of simplified initial-testing kits that can be administered by trained non-professionals; and the

identification of the kinds of people who have the potential to provide both good counselling and the support needed to ensure that medication regimes are kept to.

Treatment for babies and young children living with HIV and Aids

HIV infection can severely affect babies and young children's development even during the earliest stages of infection.

It can impact on their physical growth, psychological development, emotional-well being, and so on; and it can seriously affect their immune systems, so making them more susceptible to common childhood diseases. Anti-HIV therapy is very effective for babies and young children – but, because the youngsters are still developing and growing, their responses to treatment are not necessarily the same as for adults. It's not yet fully understood to what extent powerful drugs affect the immune systems of young people. However, it is clear that babies and young children living with HIV and Aids need to have the correct treatment. To provide these on a large scale means a massive commitment by society that includes not just making the drugs available, but devising practical systems to ensure that they reach all affected children and that they are properly controlled and administered. As with treating infected parents, mobilising community resources can be highly effective in the local delivery of drugs and training in their use.

**Things to think about and reflect on:
society's roles in prevention, treatment
and psychosocial care and support**

1. What are the psychosocial needs of babies and young children in your community that society ought to be responding to?
2. What is society offering in response to those needs?
3. Are national prevention programmes reaching your community? If not, what is stopping them?
4. How can a caregiver ensure that these measures do reach the community?
5. Are people aware of them?
6. Are people – especially those particularly at risk – reacting positively to them?
7. Are people changing their behaviour?
8. Are relevant radio and television programmes accessible locally? If not, can caregivers get tapes or transcripts of them?
9. In your community could you form coalitions to promote education?
10. Are anti-MTCT measures available in your community? If not, why not? What would it need to ensure that they are available?
11. Is treatment available for infected parents to prolong their lives and thereby maintain the viability of the family? If not, why not? What would it need to ensure that it is available?
12. Are all babies and young children receiving the basic support that society should be delivering, for example in health and education?
13. What national laws generally support the wellbeing of babies and young children and support their psychosocial wellbeing? How could a caregiver use these to improve things?
14. What specialist advice and treatment is necessary and available (or could be available), for example via professional care-workers?
15. What are international organisations offering? How can this be accessed?
16. What roles could there be for the private sector, for example local employers, national companies and multinationals?

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5

Loss, bereavement, grief and mourning

Introduction

Loss, bereavement, grief and mourning are all psychosocial issues that are pertinent to children and families affected by poverty, conflict, and HIV and Aids: millions of children have lost their parents, caregivers and family members; millions of parents have lost their children; many communities have lost entire generations.

An explanation of these terms is useful:

- **Bereavement** is what happens to people as a result of losing someone or something important to them, especially the loss of a relative through death.
- **Grief** is the resulting mental anguish of such a loss.
- **Mourning** is one of the ways in which people adjust to loss and cope with their grief. In many cultures, there may be a formal set of customs for mourning, for example people wearing a particular colour for a certain time.

Babies and young children are almost totally dependent on their caregivers to meet their emotional and physical needs, therefore separation or death of a regular caregiver is one of the most frightening and painful events children might experience. Young children, just like adults, need to grieve loss, especially the death of those they love. Grief can be seen as a natural part of their healing. Grieving can involve expressing many painful emotions and can be a long-term process. Although most babies and young children, given time and good support from loving people, recover naturally from grief, it does need to be recognised and ways need to be found to help them deal with it.

Babies and young children do grieve

Not all adults understand that babies and young children grieve. Some cultures do not even expect them to do so. In these settings, they may not be given opportunities to

grieve, and may not be supported adequately in their grief because it is not recognised. The following myths about death and grieving may prevent children from receiving the understanding, care and support that they need:

- young children should not be told the truth about death because they are too young
- babies and young children are too young to remember for long; they will soon get over it
- babies and young children don't feel loss and grief
- avoiding discussion of death helps young children get over death quickly
- it is better to keep babies and young children away from funerals and burial places.

But, as for all people, grief in babies and young children is a normal emotional response to something that affects them adversely and strongly, especially if it is associated with the loss of a loved one. Just like adults, children become attached to those closest to them. They love, and they experience the loss of a loved one (a parent, caregiver, friend, or a pet) as a very traumatic event. The resultant grief may mean that they experience anxiety, fear and guilt. Initially they may not accept or understand that their loss is permanent and they may also develop physical problems, such as physical pain. In some babies and young children, grief can lead to lasting developmental disorders such as delays in their physical, intellectual, social and emotional development.

One of the challenges in supporting babies and young children who are grieving is that, even when they can speak, they may not be able to express what they are feeling in a direct way. They usually cry, withdraw, or show other non-verbal signs to express their sense of loss. In fact, crying is such an important form of expression in babies and young children, that it is said, *The child who doesn't cry dies in the*

blanket on its mother's back. This African proverb tells us something very important: children who do not express grief may need help the most.

Reflecting on what they have lost, and observing them closely – as with all children – can provide useful insights into their psychosocial wellbeing. Because of the link between loss and grief, it can be useful for adults to realise the perceptions and feelings that a baby or young child may have. This is especially true of babies and young children affected by HIV and Aids, because of the extreme situations the youngsters can be in and the massive disruption that loss through HIV and Aids can bring to their lives.

Babies and young children in families affected by HIV and Aids

The likelihood of suffering the loss of parents, caregivers or other loved ones is much greater for children in HIV- and Aids-affected families. The loss of a parent or caregiver to an Aids-related illness, compared to death from other causes, may be especially difficult for children and may cause an intense form of grief. We will now discuss some of the factors that may cause this.

Parents who are unable to maintain their parenting roles throughout their illness

As the illness progresses in parents, it can seriously affect their ability to sustain their normal parenting roles. For example, they may no longer have the energy to care for their children, play with them, or talk to them.

Economic effects of long term sickness

Aids usually weakens infected people over a lengthy period. This has cost implications and can mean economic hardship. Infected parents are less and less able to work, yet in need of expensive and prolonged treatment. Other family members may be left destitute, homeless and without the means to buy or grow food.

Suddenness of change and resulting shock, especially for the youngest children

Babies or young children may not understand that a parent or caregiver is going to die, nor be prepared for the death. When death comes, it is sudden and shocking. From their point of view, everything was fine and then suddenly nothing is the same.

Babies and young children as carers of their parents

Quite young children may find that they become carers of their parents, for example, by helping to meet physical needs. Essentially, these children lose their normal childhood and are obliged to take on adult roles without preparation or understanding for their coming loss.

Fear of what is going to happen

Seeing their sick parents, and recognising that their condition is getting worse, young children may suffer from the fear of a parent's impending death. Yet their parents may not be well enough to help them prepare for it.

Who is next?

Losing one parent is highly likely to cause young children to be anxious about a remaining parent – and even about their own wellbeing and mortality.

Confusion about the nature of death

Young children may well experience confusion about the nature of death. For example, they may not understand its finality and that their parents will not return. Some may believe that they can get their parents back if they wish to. They may also suffer guilt and ask themselves if they somehow caused it, for example, by not doing what they were told.

Anxiety about their long-term future

Young children can look ahead, and may well worry about what will happen to them when a parent dies. They may wonder about where they will live and who will look after them.

Stigmatisation

Aids is often a highly stigmatised condition that can result in young children being marginalised and excluded by their peers, neighbours and other community members. This can mean they are cut off from the support of those in their social network and this increases their risk of neglect. Labelling, such as 'defiled', may be associated with the stigmatisation.

Change of routine

Babies and young children feel secure if they have a familiar routine. A parent's death is disruptive of both their daily routine and the normality of their lives.

Change of home

Babies and young children feel even more insecure in a new place than adults do. After a parent's death, it is best if young children don't have to move to a new home or, worse still, a new area, as they lose everything they know and everyone who is familiar to them.

Separation from siblings

When a parent dies, a family may no longer be viable. However, to separate children from their siblings further adds to their uncertainty and sense of loss.

Dispossession

Many children may lose their family property and inheritance to debt collectors and even to other family members.

Abuse

Babies and young children who lose their families may be vulnerable to abuse in their new 'families'. This abuse may involve:

- expectations of them working harder than other children
- being given less food and clothing
- being made to do unsuitable household jobs
- being offered less love and support – not being accepted as full family members
- not being allowed to go to school
- losing their possessions
- having benefits intended for them misused
- experiencing physical, sexual and psychological abuse.
(See Chapter 6 on abuse.)

Behaviour as an expression of grief

The behaviour of babies and young children is very important as this is an indirect way of expressing their grief. The limited language development of babies and young children may make it hard for them to talk about their grief; while the grief itself may restrict them from expressing it directly. It can take a lot of careful work and observation to understand how they really are feeling. One approach is to assume that they are likely to be grieving and then find ways of establishing if they are and to what extent. The point is to prevent unexpressed grief becoming despair.

How grief may affect babies and young children at different ages and stages of development

The ways in which babies and young children experience loss and demonstrate grief will vary, among other things, according to their ages and stages of development. These ways may vary according to factors such as the love and understanding that they have from those closest to them, their sense of security, the extent to which things are relatively normal in the rest of their lives, and the extent to which their psychosocial needs are still being met.

In some ways, children grieve differently from adults. Depending on their ages and stages of development, they may grieve for a while, and then seem to forget all about their loss. But they have not forgotten, and they may grieve in an on-and-off way over many weeks and months. Children may also 're-grieve' at a much later stage, as they grow up. This is because, with each developmental stage, a child's emotional and cognitive understanding of death will develop and they will start to process aspects of their loss in more sophisticated ways.

Babies in the first two years

- They may lose their mothers' milk, the best possible nutrition for them.
- They may lose the bonding, comfort and sense of security they get from breast feeding.
- They may lose their sense of being loved, cared for and protected.
- They may feel they have lost the normality of their world.
- They may feel abandoned or separated from those they have known.
- They may become irritable.
- They may change their eating patterns.
- They may withdraw from emotional contact with others.
- They may develop bladder or bowel problems.
- Their normal development may slow or even regress.
- They may become quiet and lethargic.
- They may have difficulty in concentrating or becoming involved in activities that would normally engage them.

Children from two to five years

- They may lose their sense of being loved, cared for and protected.
- They may be more susceptible to physical illnesses.
- They may sense that they have lost important role models

and are left to find their own ways forward.

- They may feel alone and be frightened.
- They may show emotion only for short periods of time. This does not mean that they are not grieving, only that their attention span is relatively short. It can also mean that they need a rest from grieving.
- They may have trouble sleeping.
- They may have nightmares, and say, for example, 'There are things that want to eat me at night.'
- They may fear that they will also die.
- They may develop depression and lose interest in things that they used to enjoy.
- They may be fearful of separation.
- They may become angry with the departed person.
- They may have temper tantrums.
- They may start being more childish than appropriate for their actual age.
- They may start to be excessively naughty.
- They may cling to adults too often or for too long.
- They may behave unnaturally well.
- They may start sucking their thumbs again.
- They may develop headaches or stomach disorders.
- They may feel sick or ill.
- Their toileting and hygiene routines may break down, for example they may start wetting their beds again.
- They may have difficulty eating.
- They may show signs of being overwhelmed or lonely.
- They may lose the social environment that they are accustomed to.
- They may lose important development opportunities.
- They may lose their self-respect because of stigmatisation.
- They may connect the death to whatever happened just before it, for example that the nurse came and therefore the death is her fault.
- They may not understand that death is final.
- They may forget that a person has died.
- They may be confused about the nature of death, for example a child may ask, 'Why did they put my mother in that box? How will she breathe?'
- They may have trouble understanding what is happening around them.

Children from five to eight

- They may experience all the symptoms mentioned earlier but could also be much more aware of their loss

and its importance. In addition, they may experience the following.

- They may stop looking after themselves properly.
- They may lose hope for the future.
- They may be jealous of children who still have their parents.
- They may feel that life has been unfair to them.
- The loss of parental care and the associated environmental changes may make them aware of the restrictions they are now living under.
- They may lose their trust in people.
- They may feel excluded from normal social development because of discrimination.
- Their grief may be unspoken and expressed only through their demeanour and behaviour.
- They may start to behave dishonestly and start telling lies.
- They may be much more fearful about what losses mean.
- They may be angry about what has happened.
- They may feel guilty, for example 'If I had been a good boy, my mother would not have died.'
- They may attempt to bargain, for example 'If I am a good boy, my mother will come back.'
- They may deny reality, for example 'My mother is coming back soon.'

Supporting babies and young children to deal with loss and grief

Children often mourn, communicate and heal more through their behaviour, including their play, than they do through words. It is therefore important to make a *special* effort to stay close to, play with, listen to and offer support to babies and young children who have experienced loss.

A baby or young child's sense of insecurity about the death of a parent or caregiver is often *worsened by the secrecy and silence* that surrounds the death. This makes it difficult for children to understand what is happening and may contribute to their sense of helplessness and fear. Yet adults often exclude babies and young children from discussions of death on the grounds that they:

- will become upset
- are too young to understand the concept of death
- do not need to know about such things
- think death is not discussed in their culture.

Many societies and cultures tend to avoid discussion of death, especially with children, and especially before a person dies. In many cultures, talking about imminent death before the actual death is taboo or unacceptable.

One of the most important things anyone can do for grieving young children may be to help them understand what is happening. Whether it is before or after a death, failure to include young people in discussions of death can mean that they remain silent about their pain, worries and fears. They can also be left without any way of understanding what death is all about. As the Fula of west Africa say, *Silence is also a form of speech.*

Excluding young children from discussion about death is sometimes seen as a way of telling them that death is too terrible a thing to be spoken about. This can increase their anxiety and fear, and can be a barrier to them expressing their thoughts and feelings as part of their grieving process. (See Chapter 8 on communication.)

Talking about the fact that a parent or caregiver is dying (or terminally ill) can be helpful to young children who are witnessing the dying. Young children are not stupid. They may overhear adults and know or sense the truth. Being open about the concept of death can be helpful to them.

Sometimes adults who avoid a 'difficult' open discussion of death openly with young children, using the excuse that children won't understand, are protecting *themselves* more than the youngsters. This could be related more to the adults' inability to talk with young children about death than to what is right for the child. Often, also, adults are wrapped up in their own grief and worries about the future, and have little time or energy to help children grieve. Without clear and open communication with adults, young children can be left feeling isolated, alone and unsure about what is happening and what will happen. Certainly, it takes courage to talk with children about death. But they may need accurate information about what is happening to their sick parent or caregiver, and especially what is going to happen when that parent or caregiver dies.

Discussion allows young children to prepare themselves for what lies ahead and for grieving when the death happens. Allowing young children to say goodbye to a parent or caregiver can help in the healing process as it is a formal acceptance of what is to be. This is so much better than a child having 'unfinished business' to manage after the person has died. The most important advantage of discussing the death before it happens is that it gives both the child and parent or caregiver time to acknowledge what is happening, and to share what they need to emotionally. Again, this can be a platform or foundation for healing after the parent or caregiver has died.

Young children need help in understanding the concept of **death**. They need to know *what happens* when people die, for example Christians believe that the soul leaves the body.

Children also need to understand the *beliefs* about death of different communities, cultures and religions. Many people believe in life after death, that is, in heaven and/or ancestors. By providing an explanation of death, beliefs can both provide a more positive context in which youngsters can make sense of their loss. Death is a natural part of life – a natural 'moving on'. Allowing young children to attend funerals and to take part in rituals after death helps also helps them come to terms with death.

In their attempts to understand the concept of death, young children may show great interest in the process of dying. They may ask all sorts of difficult questions, including:

- How does a person die?
- Why did the person die?
- What happens when a person dies?
- Did the person die because I was naughty?
- Will it happen to me?
- Does dying hurt?
- What happens to a person's body once it is buried?
- Where do people go when they die?

Such questioning is a normal and healthy process and adults should try to answer these questions as honestly and simply as possible. However, it is always important, to explain the permanence of death to a young child in an honest, appropriate way, and not to tell them fairy-tales or to suggest that their parent or caregiver will come back. This is because another kind of loss young children experience is when they find out that something they believed to be true is not true. This is especially painful when they realise that an adult they trusted has lied to them. As the Akan of Ghana say, *One falsehood spoils a thousand truths.*

After a parent or caregiver has died, adults may try to avoid mentioning their absence in a young child's presence. But, in fact, young children need to remember and protect their relationships with dead parents. This is implied by the saying of the Sotho of South Africa: *One who brings condolence is never drowned.*

Ways of helping youngsters maintain their sense of connection and identity include:

- encouraging young children to talk about their parents as much as they want to, when they are ready to do so
- displaying some of the parents' belongings

- visiting the graves of the departed
- looking at photos
- sharing memories.

The aim is to help them to come to terms with their thoughts, feelings and emotions. Supporting them in the correct ways can ensure they recover as quickly as possible; and it can also help to ensure that their reactions to loss do not worsen and become deep, long-term problems.

Depending on local cultures and the ages of young children, useful support could start before the actual loss and could include:

- preparing children for the departure by gently explaining what is to come
- showing them that they will be safe and loved and cared for by people who they know and trust
- resolving the question of who is to be a child's new caregiver
- reassuring the child that the future is secure
- reassuring a dying parent that their children will be properly looked after
- preparing **memory books** can be very helpful – especially if the affected children themselves are involved. Memory books can include:
 - the life story of the dying parent
 - stories about ancestors
 - letters to the child from the parent
 - photos of the parents, family and their home, drawings from the child, and so on.

Memory boxes are a similar idea as they can also include articles that were precious to the parents, and items that evoke good memories, for example souvenirs of family gatherings.

Both memory books and memory boxes can help young children remember the good times they spent with their parents.

They might benefit from being with the parent close to the time of death and they might also be involved in the funeral service in ways appropriate to their ages and stages of development, and in line with local traditions and customs.

When a parent or loved one has died, coming to terms with something so traumatic as their loss may well be a gradual and unfolding journey for many young children. During this journey, babies and young children *need the love, support and protection* of at least one caring adult – as they do throughout their lives.

It is also important to recognise that individuals grieve differently, and that this is as true for children as it is for adults. There is no right or wrong way to grieve, although some

aspects of grieving, as practised by a particular culture, may be quite formal and the focus of ceremonies.

Perhaps the most important thing to remember is that babies and young children need to have real opportunities to express their grief. This means ensuring that they are ready to express themselves, are comfortable with the concept of death, feel safe, seem strong enough to cope with it, and have the time, space and resources necessary.

Good communication at a time of grieving is essential. Adults who seek to accompany babies and young children through their grief need to have empathy in the suffering of children. It can help if they understand the way they feel themselves about grief and loss in their own lives. They also need to be able to 'hear' children – as children express themselves through words, actions, behaviours, drawings, telling stories, play and drama. (See Chapter 8 on communicating with young children, and Chapter 9 on play.)

Death evokes many emotions which young children cannot name or label.

It's very important to talk with young children at their language level – helping them to express their feelings can be all that they need. This is especially true if they have support from people who are caring for all their physical and psychological needs, offering love and protection, and generally supporting their natural recovery.

Early on, they may go through **periods of denial** and may pretend that their parents are alive or are coming back. Local cultural norms may expect this because it is a well understood way in which young children protect themselves from a hurt that is too painful to bear. Denial is quite normal in the short term. However, as their journey progresses, it's important to think about what could be causing positive or negative changes in their behaviour. This can help caregivers to tune in to the effectiveness of their support; it can help them spot new needs; and it can help them avoid thoughtlessly disciplining bad behaviour, or believing that a child who is suddenly quiet and behaving unusually well, is no longer suffering sadness and loss.

The key is to ensure that babies and young children each have at least one principal caregiver who is capable of looking after all the basic needs, and who also recognises and understands the special needs the young child may have because he or she is grieving from loss. The principal caregiver needs to be able to work carefully and naturally with the child to support him or her in grieving, minimise the loss, or find

ways to compensate for it, especially in the case of a baby's mother dying. Babies and young children need to:

- bond quickly and well with their new principal caregivers
- be with people they know, including siblings and neighbours
- enjoy a lot of physical and other contact
- wake to a loving welcome
- hear gentle, loving talk
- retain their usual eating, sleeping and playing schedules
- have all their other usual routines re-established
- enjoy a safe, secure and stable environment
- have all their normal toys and resources around them
- be in environments they are used to
- be comforted when they become upset.

Older children may have additional needs. For example, those of three to five years could need:

- to have a non-frightening, simple but honest explanation of what death is
- to be reassured that their future is secure
- an adult who they trust who can answer their questions
- someone who is understanding when they are upset or scared
- to continue to have their normal functions, duties and responsibilities in the family and the community
- reassurance that they did not do anything to cause the death
- reassurance that they are still loved
- to know that it is good to ask questions
- to play and have fun
- to be reassured that they shouldn't be ashamed of having negative thoughts about the deceased
- encouragement for their spontaneous positive thoughts and actions
- adults around them who avoid expressing negative reactions to their grief, for example saying, 'Stop behaving like a baby!'.

At the age of six and beyond, children may also need:

- fuller and truer answers to their questions
- to have the nature of death explained to them – that the body stops working and the person stops feeling
- not to be overloaded with information – and have it 'rationed' so that they can come to terms with it
- to know that it is good to show emotions (the examples of adults can be important to them in this)
- to participate in rituals such as funerals (if they wish to), in line with local cultural norms

- to take on new responsibilities to help support the family, again in line with local norms.

Some additional considerations for supporting babies and children in the context of HIV and Aids

Children who have lost their parents to Aids should not be labelled as 'Aids-orphans' or singled out as different from any other orphans. Nor should any orphans be stigmatised (or treated with contempt and made to feel inferior) because they have lost their parents as they are usually not responsible. To allow them to be labelled can lead to their social isolation, as well as increase their risk of neglect or abuse from members of their community. Aids stigmatisation especially often cuts off babies and young children from social support networks – even those within their extended families. As part of helping them to cope with their grief, it's essential that those around them – including their peers and those in institutions such as churches and schools – continue to welcome them and mix with them normally. Babies and young children who are grieving because of pending or actual bereavement also need to be treated the same before and after the death of their parents or caregivers. This helps to give them a sense of continuity. Although they are facing tremendous loss, the rest of their world is still as it was, and continues to be safe, supportive and welcoming.

Things to think about and reflect on: basic considerations in supporting grieving babies and young children

1. What are your own feelings about loss and death?
2. How do you think these might help your understanding of how babies and young children feel?
3. Are there local norms, beliefs and practices that can help a caregiver in working for the benefit of babies and young children who have suffered loss?
4. How could a caregiver use these?
5. Are there any that you feel present a challenge to what babies and young children need?
6. Would it be appropriate to introduce the idea of changes in these? If so, how would you advise a caregiver to go about this?
7. How could you check that a parent or caregiver is really 'hearing' babies and young children?

**Things to think about and reflect on:
telling a child about death**

1. In your culture, what are the beliefs for telling young children about death openly and honestly?
2. What are the arguments against telling young people about death?
3. What beliefs and myths about death are common in your culture?
4. What are the good points of these beliefs and myths for babies and young children?
5. What are their worrying aspects?
6. How would a caregiver start the process of discussions about death with young children?
7. How would a caregiver judge the amount and nature of what young children should be told?
8. What would worry a caregiver about increasing young children's understanding of the concept of death?
9. What could a caregiver do to help young children prepare themselves to grieve for terminally ill loved ones?
10. How would a caregiver help young children to express what they feel about death?
11. How would a caregiver help a young child understand that grieving is normal?
12. How would a caregiver cope with any negative feelings they might have?
13. How would a caregiver help them regain hope?

References and resources

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6

Abuse

Introduction

Babies, young children and women facing the effects of poverty, conflict or HIV and Aids are particularly vulnerable to abuse. Child abuse is a very complex issue, especially when it involves very young children or babies. Different views and beliefs exist about child abuse, ways to deal with it and how to prevent it.

In this publication, child abuse is defined as any action or treatment inflicted on a child that causes discomfort, pain or danger to any aspect of the child's wellbeing. It is also associated with neglect or the lack of action to ensure that the needs and rights of the child are met – so ensuring positive, healthy development and growth into adulthood. The perpetrators of child abuse can be either men or women, or boys or girls as are the victims across all forms of abuse.

Forms of abuse

No form of abuse, against anyone, is justified. This is especially true of babies and young children; they are *defenceless and vulnerable*. Even some locally accepted beliefs about punishment of child misbehaviour can be seen as abuse of one sort or another. Abusing children is a form of cruelty that can have deep and long lasting effects on their healthy psychosocial development and wellbeing.

Many people automatically suspect sexual abuse when a child is abused. Babies and young children can be subject to a range of abuses, including:

- physical abuse – violence against their bodies by adults and other (usually older) children
- emotional, psychological and verbal abuse – violence against their emotional and psychological wellbeing, especially by those closest to them; this is often done by

threatening or using language that is demeaning, hurtful or insulting

- social abuse – assaults on their social wellbeing by family members, peers, neighbours and other community members
- sexual abuse – sexually driven assaults on their psychological and sexual wellbeing by adults or other (often older) children
- neglect – which in extreme cases is a form of abuse.

Common effects of abuse include:

- developing a confrontation approach to situations
- being overly defensive
- developing an inability to trust others or difficulty in doing so
- developing an aggressive attitude to others
- inflicting violence on others who are vulnerable
- losing self-confidence
- being fearful of new situations
- being anxious about meeting new people
- suffering emotional problems associated with self-protection
- fearing close relationships

Physical abuse

Physical abuse of young children includes:

- cruel or harsh bodily treatment, for example beating a child for misbehaviour
- physical pain and harsh hidings being inflicted
- being made to work in ways that their bodies are not yet ready for
- general maltreatment
- neglect
- bullying
- withholding food.

Physical abuse can have many negative effects on babies and young children as they grow. While all children respond differently, some of the specific effects of physical abuse include:

- death
- physical injury and trauma, for example broken bones, bruised muscles or burnt skin
- possibly becoming violent against other children themselves.

Emotional and psychological abuse

Emotional and psychological abuse includes:

- failing to offer the love that young children need
- withdrawing that love
- hurting young children through damaging words
- demeaning them and their achievements
- threatening them, for example by saying that they will be abandoned if they are naughty, or that they will go to hell; this can leave them anxious, hurt and bewildered
- insulting them
- failing to recognise and honour their achievements
- failing to reassure them after a confrontation, and so on.

As the African proverb says, *A cutting word is worse than a bowstring; a cut may heal, but the cut of the tongue does not.*

Social abuse

Social abuse includes:

- insulting young children
- making it clear that they are not as welcome as they should be
- stigmatising them, for example because of HIV and Aids in their families
- bullying at school
- excluding them from social groups, events and games, or including them against their will
- having and expressing negative views about them and their families
- equating poverty with social unacceptability
- seeing physical disabilities as being barriers to social acceptance
- seeing learning difficulties as being barriers to social acceptance
- excluding them because they were born out of marriage, or to single parents.

It is important that young children have every opportunity

to develop their social roles and find their own comfortable place in the social order, a place that welcomes them for who they are. This is true within their families, in their immediate neighbourhoods, in their crèches, preschools and schools and in their wider communities. To help them thrive psychosocially, children must belong, feel understood and respected, and contribute in their own unique ways. Exclusion from any of these conditions or being restricted to token relationships can be very damaging. The effects of HIV and Aids often deprives children of much needed support, leave them feeling isolated and unwelcome, and may hinder or slow their recovery from grief.

Sexual abuse

Sexual abuse includes:

- leading children to have age-inappropriate thoughts about sex and their sexuality
- luring or pressurising them emotionally or psychologically into age-inappropriate relationships
- inappropriate looking, touching or stroking
- penetrative sex, using a baby or young child in any way for sexual gratification or satisfaction
- incest
- showing a child pornography, and filming or making pornographic images of children
- having sex with babies and/or young children in the completely mistaken belief that it cures HIV infection or Aids-related illnesses.

The **norms** of societies play an important role in developing and determining our sexual behaviour and our gender roles in our families and communities. Cultures differ with regard to definitions of sexual behaviour and gender roles. Some may have strict rites and ceremonies to affirm that children have reached sexual maturity and will now assume their adult roles.

The definitions of various cultures also differ with regard to the age of consent for sexual intercourse, and attitudes to sex outside marriage. There are no absolutes for sexual norms and values; they depend on local beliefs and practices. However, child sexual abuse, which, as we noted earlier, includes any sexual activity between adults and pre-pubescent children, is wrong and cannot be condoned. The extreme severity of this abnormal behaviour has resulted in some communities labelling the victim as being defiled and ostracising them and their families.

Each of us learns how men and women should behave

sexually, and what is acceptable and unacceptable. Most cultures have clear rules or understandings about what constitutes sexual abuse against babies and young children – and may have sanctions against those who break the rules. Some adults do break these rules, however: Babies and young children must have protection against such adults. The best source of this protection should be those who are closest to the youngsters. However, it is important to note that often sexual abuse is inflicted by people that the children know well, and may also be allowed or condoned by other adults, perhaps because they lack the power to prevent the abuse. We can't therefore necessarily assume that babies and young children are safe in their family groupings.

Specific effects of sexual abuse of babies and young children include:

- infection with the HI virus
- shame and humiliation
- self-blame for the abuse (This is because they frequently believe that they have somehow done something to invite or deserve the abuse. Some child abusers set out to reinforce the child's sense of guilt. For example, they may tell children that this is a punishment for having been naughty.)
- withdrawal and depression
- inflicting harm on themselves or may even become suicidal.

The longer-term effects include:

- life-long mental health problems
- stigmatisation
- problems forming and sustaining, mature, loving sexual relationships as adults
- low self-esteem and a lack of self-respect, especially sexually
- sexual dysfunction (frigid and/or impotent) or promiscuity in later life
- sexual deviance and abuse
- becoming child abusers themselves.

However, it is essential not to generalise or to stigmatise sexually abused children as this will only add to their burden. Rather, we should do everything in our power to give them the *additional love and support and encouragement* they need in order to ensure that they become healthy and happy adults.

SEXUAL ABUSE OF BABIES AND YOUNG CHILDREN AFFECTED BY HIV AND AIDS

Child sexual abuse is extremely damaging psychologically, socially, emotionally and physically to all children and, aside

from great suffering, may cause developmental and learning problems. All children are vulnerable to sexual abuse but being affected by HIV and Aids may increase their vulnerability. Often child abusers take advantage of vulnerable children, including babies and young children, therefore caregivers need to be specially vigilant.

Children affected by HIV and Aids are especially vulnerable to sexual abuse because of the following:

- They may not receive adequate care or protection from a loving and trustworthy adult, as parents and caregivers may be preoccupied with their problems or be too ill to take care of them.
- They may be exploited sexually to gain an income or to gain shelter, food or clothing.
- They may feel lost and alone and be at the mercy of predatory adults.
- They may be misled into viewing the abuse as a sign of love and protection that helps them cope with life.
- Children and their families may be socially marginalised or stigmatised because of HIV and Aids and therefore have lost the protection of the community.

SIGNS AND SYMPTOMS OF POSSIBLE SEXUAL ABUSE IN BABIES AND YOUNG CHILDREN

Children seldom tell caregivers outright that they are being sexually abused as they may feel ashamed, despite the fact that the abuse is not their fault. Often they are told by the abuser to keep the abuse secret, and may be threatened with terrible consequences if they tell anybody what is happening. However, those closest to an abused child should be alerted by any physical signs, in conjunction with a doctor or nurse's assistance if necessary and possible. Physical signs of abuse include:

- unusual marks or bruises in the genital or anal area
- redness or swelling in the genital or anal area
- pain or bleeding in the genital or anal area
- difficulty in walking
- lack of energy and general ill-health, including headaches, fever and stomach aches
- any evidence of a sexually transmitted infection, for example discharge from the genitals
- difficulty in passing urine
- lack of bowel control due to anal penetration
- torn hymen.

Behavioural signs can also signal that a child has problems.

However, caution and careful and sympathetic investigation are needed to establish just what those problems are.

Some signs and symptoms which might indicate sexual abuse include:

- suddenly exhibiting age-inappropriate knowledge of sexual behaviour
- suddenly exhibiting explicit sexual behaviour
- suddenly using 'dirty language'
- unexpectedly exhibiting sexual forwardness
- acting out sexual scenes with toys (See Chapter 9 on play.)

Other behavioural changes that can be significant include:

- becoming anxious, fearful, shy or withdrawn
- becoming aggressive and bullying
- returning to bedwetting or soiling
- showing excessive temper tantrums
- changing sleeping patterns
- suddenly having nightmares
- crying excessively for no apparent reason
- changing their attitudes and behaviour towards particular people
- showing fear of particular people
- changing eating patterns
- showing increased anxiety or fear
- harming themselves physically
- becoming distrustful of adults
- avoiding contact with people generally
- starting to perform badly at school
- losing some or all of their powers of concentration
- writing about or drawing things directly or indirectly linked to their abuse.

All of these changes in behaviour may well be caused by events other than sexual abuse. However, they do indicate that something is wrong, and that further exploration is required to identify the cause of the problem. They also indicate that it can be necessary to talk with significant others to discuss their observations about how a child is behaving. It is important not to jump to conclusions but to *sensitively investigate* the actual situation that a child is in and come to a confident conclusion. Often, it is a combination of these signs, along with the physical signs listed earlier, that indicates that there may be sexual abuse rather than some other behaviour.

PREVENTING SEXUAL ABUSE OF YOUNG CHILDREN

Even young children *themselves* can be agents in helping to prevent sexual abuse, by being taught:

- about their bodies
- biological names for body parts
- self-acceptance and a balanced attitude to nudity
- that some body parts are private
- that there are acceptable and non-acceptable ways of talking about and touching sexual organs
- that loving relationships do not involve secrecy and fear
- to be careful when someone talks about keeping secrets
- not to accept gifts or sweets for secret activities
- through songs and stories about where, how and from whom to get help.

Young children require careful and ongoing guidance on what is right and wrong in relationships with adults, and what to do and who to go to if they are worried. Sensitively handled by people they trust, especially their parents or caregivers, this guidance can help young children realise that they do not have to 'go along' with certain kinds of behaviour. They could also be encouraged to report any troublesome behaviour by adults, so that it can be carefully investigated if necessary. Obviously, the degree to which any of this may be effective is dependent on their ages, and on the quality of their relationships with their caregivers.

Complementary efforts by neighbours and community members concerned with the wellbeing of young children

These efforts are important and should aim to establish and maintain an abuse-free environment for babies and young children. They can include:

- clarifying people's understanding about the nature of sexual abuse
- identifying the potential for child abuse
- agreeing with them about what is acceptable and what is not acceptable in adult-child relations
- agreeing with them what can be done to sort out possible problems
- discussing with them effective ways of monitoring children's wellbeing when they are away from home.

The efforts may also include deliberately planned and organised preventative actions that focus on:

- public awareness of child abuse and its effects on the child victims
- helping adults to be aware and alert at all times to ensure that their children are not being abused
- rekindling in adults the African spirit of 'your child is my

child' and therefore watching out for the wellbeing of all children in their communities

- assisting adults with child-abuse tendencies to seek help
- using local media to make the community constantly aware of child abuse and how to prevent it
- encouraging and helping parents and caregivers to develop friendly but respectful relationships with their children
- clarifying for children the differences between respecting and fearing people, even their own parents; mistaking fear for respect encourages child-silence which is one of the ideal conditions for child abuse
- helping children to identify 'trusted adult-buddies' in their families or communities with whom they can discuss general things, including abuse
- providing information and contact details of support institutions and structures for child abuse
- conducting community workshops, campaigns and events that raise awareness of child abuse
- identifying and publicising ways of helping children protect themselves against abuse
- ensuring that child-abuse offenders are caught and punished severely.

In many cases, there may be warning signs in the behaviour of a potential abuser. These signs, once noted by adults, can be followed up and dealt with before any damage is done. The signs of possible problems include:

- over-closeness of an adult with a child
- inappropriate physical contact
- being found at an unexpected time or location with a child
- arranging to be alone with a child
- changes in a child's behaviour towards an individual, for example that he or she seems suddenly anxious or frightened of the person or seeks too much physical contact with that person
- changes in a child's demeanour towards an individual, for example he or she is too involved with the person.

However, while prioritising the wellbeing of children, it is essential to check that such warning signs are not simply the result of perfectly innocent behaviour. This calls for a great deal of care and sensitivity in approaching a person who is under suspicion.

Things to think about and reflect on: preventing child sexual abuse

1. How could young children be helped to contribute to their own protection against sexual abuse?
2. Who are the people closest to young children who can form their first line of defence?
3. What could these people do to ensure that the babies and young children in their care are protected?
4. Who in babies' and young children's social worlds could also contribute to their protection?
5. What roles could these individuals have in protecting babies and young children from sexual abuse?
6. Who are the community leaders who should be involved in discussions about prevention of child abuse?
7. Are there any local beliefs or customs that should be examined?
8. What kinds of protection systems could the community adopt? For example, would the local situation benefit from a formal child-protection committee? Could this committee monitor crèches and day care centres?

Supporting young abused children

When we suspect that a child is being abused, we should always keep in mind the best interests of the child. This means we should always believe children in principle and ensure that they are protected from the alleged abusers. Centrally, they need support in their healing and in moving on from the trauma they have experienced. This is firstly a matter for their principal caregivers but their efforts can be reinforced by neighbours and community members with whom the children are normally in contact. In all relevant cases, babies and young children need medical examination and care – and may even need urgent medical attention. Counselling by a trained counsellor, if available, may be needed. (See Chapter 10 on counselling.)

As we try to support babies and young children, we need to be aware of the complexity of their emotions and feelings. For example, abused children:

- may feel ashamed
- may feel guilty because they think they did something to deserve the abuse
- may feel guilty about any punishment that their abusers may face

- may have mixed and confused feelings towards their abusers, especially if the abusers are known to them
- may not want to see the abusers suffer any harm or 'lose' them, especially if the abusers have always treated them well in other respects.

Emotional healing may not occur naturally through forgetting and ignoring. More often, healing requires that the children come to acknowledge the abuse, in a safe way, and gradually come to terms with it. Unfortunately, adults often find it difficult to deal with child abuse and struggle to help children to express the trauma they have experienced. By adults following some basic principles, they can help all those concerned with abused children's wellbeing and recovery.

These principles include:

- protecting them from the abuser if known
- hearing them
- believing them
- reassuring, loving and comforting them
- helping them to re-engage with people healthily
- helping them gently to resume their normal lives
- helping them to understand that the future will be better
- ensuring that they have continuity of support from the same group of people being around them and available to them, at least for the medium term.
- engaging them in activities and strategies that will help them recover.

If necessary, try to ensure that the child is counselled by a professional counsellor. (See Chapter 10 on counselling.)

Protecting young abused children from contact with the abuser

If the abuser is identified, then the person can be dealt with, and the child can see that the abuser is no longer a threat. Sometimes the abuser is not known to the child, and the child, therefore, may be unable to identify them. On the other hand, the child's behaviour when the abuser is near will often give clues. It is preferable to remove the abuser and not the child.

Hear them

Children may express themselves in many different ways. Abused children may have special difficulties in talking about what has been done to them because of the trauma of the event, or because they simply don't know how to express what has happened. Discussions with young children can take many forms, many of them linked with play and observation,

(dolls, puppets, fantasy play and drawings are examples). 'Hearing' them through observation and careful interpretation of their play and other activities, can give important insights into their psychological and emotional wellbeing. (See Chapter 9 on play.)

If the children are old enough to talk about the abuse, it's important to empathise and be sympathetic to show that you care. Being calm and open can also help children to feel that it is normal to talk about their trauma. Reacting to what they say may discourage them from disclosing anything further. Caregivers' own feelings should not influence their ability to listen to and support the children. In addition, although caregivers may feel anger, repulsion or hatred against abusers, it's important that they maintain a calm, non-judgemental attitude for children to be able to tell their stories. (See Chapter 8 on communication.)

Believe them

When young children open up and express things that suggest abuse, they need support and reassurance, not accusation and doubt. Young children do not invent or lie about sexual abuse: mercifully, at least until the event, they lack the experiences that teach them what it is. The first reaction must therefore be to believe them and to launch all necessary actions. Young children should always be believed, until there is proof that no abuse has taken place.

Reassure, love and comfort them

Maintain and even enrich the atmosphere of love, support, acceptance and trust that they always used to enjoy with their families, neighbours and communities. *Never* blame the child for what has happened. Let children know that they are trusted, and that actions are being taken to protect them.

Help them to re-engage with people healthily

Abused babies and young children may feel unable to engage with others for a while. They need to be carefully helped back to the social normalities that they were used to before the abuse. This should be a gradual and well-calculated process as they may have lost trust in their previous relationships.

Help them to gradually resume their normal life

Carefully helping abused babies and young children to return to the normality of life is very important in their recovery. It is important to monitor their emotional and psychological

wellbeing and to provide the support that they need. For example, they may feel anxious or ashamed as they see their friends again (abused children sometimes feel unworthy of friendship) – a warm welcome from their friends can help.

Help them to understand that they will get better

Young children are resilient but sometimes they have fears about their future and how that future has been affected by the abuse they have suffered. Parents and caregivers must show them that these fears are groundless by explaining how their lives will continue as before and that the people they always trusted are still there with them, will look after them and help them to grow happily and healthily.

Ensure that they have continuity of support

As mentioned earlier, the people closest to babies and young children are the people who provide important support to them. For abused babies and young children, continuity of support from these people is especially important; it helps reassure them that they are loved and respected, and it can help to ensure that they return quickly and successfully to their ongoing development.

Engage them in activities and strategies that will help them recover from abuse

Engage young children in activities that help them express themselves and work through their problems. Any kind of activity that enables them to achieve and thereby regain their self-esteem is useful, for example playing normally with other children, being creative and following new interests. Strategies that help them to confront and work through their feelings are also important. These can include:

- seeking support
- seeking advice from trusted adults
- learning to counter unhelpful thoughts by looking at the positive side of things
- keeping in mind that things are getting better and that the bad times are behind them.

Things to think about and reflect on: supporting abused children

1. What local norms, practices and mechanisms exist in communities that support babies and young children?
2. What local myths or norms could work against the best interests of an abused child?
3. How would you advise a caregiver to deal with these?
4. Who are the people in your community who can best support abused babies and young children?
5. What kinds of preparation might they need?
6. How would a caregiver supply this?
7. How would you judge the emotional and psychological states of abused babies and young children?
8. How would you monitor their ongoing emotional and psychological states of abused babies and young children?

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7

Resilience: the ability to bend but not to break

Introduction

Early in this publication we said that even though the effects of poverty, conflict, and HIV and Aids are huge and disruptive, the ability to cope depends on the resilience of children, families and community members. In this chapter, we look more closely at the concept of **resilience**.

What is resilience?

Even though young children all over the world face illness, domestic violence, war, poverty, famine, droughts or floods, some children seem to cope quite well, whereas others are overwhelmed. A young child's ability to cope has much to do with resilience. Here are three definitions of resilience:

1. When we think of a person who is resilient we usually picture a person who tries to cope with problems and someone who does not give up easily when faced with difficulties. However, like all people, young children are vulnerable psychologically when things are difficult, but, just like other people they can also draw on this inner strength called resilience.
2. Researchers have defined resilience as the human capacity to face, overcome and be strengthened by or even transformed by the adversities of life and the ability to bounce back after stressful and potentially traumatising events. Resilient children are generally better able to cope with life's adversities.
3. Catholic Aids Action describes resilience as a process whereby resilience is the outcome of a negotiation process between the individual and his or her environment in order to maintain a healthy self-definition. The International Resilience Project defines resilience as, 'The universal capacity which allows a person, a group or a community to prevent, reduce or surmount the negative effects of adversity.'

Things to think about and reflect on: definitions of resilience

1. Which of the earlier definitions do you like best, and why?
2. What is your understanding of resilience?

When do young children need to be resilient?

Young children may need to be resilient for different reasons. They may need to cope with parents or caregivers who are sick, they may have lost people they love, they may be neglected, or have a serious illness, or they may find it difficult to handle smaller daily problems.

Young children who are resilient are better able to cope with adversity, combat the effects of trauma and recover from the consequences of significant problems.

How can adults help young children develop resilience?

As with so much else with young children, resilience develops as part of their healthy holistic development; a process that is greatly helped by loving, supportive caregivers who are there to meet the children's needs. Love, reassurance and security support the development and maintenance of their resilience and help strengthen their psychosocial wellbeing.

What are the characteristics of a resilient young child?

Resilient young children may possess and display some of these characteristics:

- positive self-esteem
- emotional intelligence
- creativity and innovation
- problem-solving (of simple problems) and generating solutions
- inquisitiveness and curiosity (wanting to know everything)

about a matter so that they can deal with it)

- openness, friendliness, trust and forgiveness
- positive memories of experiences and people
- quickness when learning
- good sense of humour
- determination
- risk-taking and a preparedness to make mistakes
- endurance and perseverance.

Resilience can be developed and reinforced by providing babies and young children with opportunities to develop these characteristics. Adults can promote young children's self-esteem, for example, by praising efforts as well as success and by giving comfort when they fail, coupled with encouragement to try again.

Optimistic attitudes by those who surround them are also important. If older children and adults show that they can cope, young children will begin to believe that they can also find ways to progress. These important role models for young children should provide positive examples for them to follow.

Things that young children can learn through role modelling include understanding the importance of:

- cherishing the good things in life
- having positive, hopeful attitudes
- determination
- taking increasing responsibility for their own lives
- taking pride in their strengths
- acting on what they believe to be right.

All young children need unconditional love from those close to them. They need to know that nothing will stop these people from loving them, no matter what happens. An adult may not agree with what the young child does but the child must always know that he or she is lovable as a person.

Promoting a young child's resilience

Research shows that catastrophic stressors can threaten the integrity of a young child's ability to think and solve problems but that if good care-giving and cognitive development are sustained, human development is robust even in the face of adversity.

The International Resilience Project divides the factors that contribute to resilience into three categories, namely 'I have', 'I am' and 'I can' factors. We have presented these factors in child-friendly language:

'I HAVE' FACTORS

'I have' factors are the external supports and resources that promote resilience, and involve:

- connections with positive role models
- trusting relationships
- structures and rules at home
- access to health, education, welfare and security
- faith, religious and cultural affiliations.

'I have' statements are about how babies and young children view the world. Many of the statements are about the sense of belonging that babies and young children develop when accepted by family and community, for example:

- I have people who love me.
- I have people who help me.
- I have people who help me learn to do the right things.
- I have shelter.
- I have food.
- I have clothes.
- I have friends.
- I have a future.
- I have hope.
- I have pride.
- I have knowledge.
- I have life skills.
- I have opportunities.
- I have a culture that I belong to.
- I have my own identity within that culture.
- I have potential.
- I have energy.

'I AM' FACTORS

'I am' statements are about the inner strength of young children. These statements comprise their feelings, attitudes and the beliefs they have in themselves, for example:

- I am lovable.
- I am confident.
- I am happy.
- I am important.
- I am proud to be who I am.
- I am valued and respected.
- I am respectful.
- I am safe.
- I belong.
- I am hopeful.

'I CAN' FACTORS

This group of factors relate to the child's social and interpersonal skills. 'I can' statements are about how babies and young children behave when they are with others. 'I can' statements refer to abilities a baby or young child develops when provided with opportunities to observe others and to experiment with ways of interacting, for example:

- I can do things, for example dress myself.
- I can try to solve problems.
- I can love.
- I can communicate readily with others.
- I can play.
- I can learn.
- I can help others.
- I can be helped.
- I can laugh.
- I can feel for and care about others.
- I can protect myself.

Some of the points discussed in the next section have been mentioned earlier; they are repeated in more detail because they provide important clues about what parents and caregivers might do to support and grow the resilience of babies and young children with whom they are in contact.

Further characteristics of resilience in babies and young children

We have already said that babies and young children cope better with adversity when they have the capability to:

- understand an adverse event, for example the death of a parent, or abduction, etc.
- believe that they can cope with a crisis because they know that they have some control over what happens. (See Chapter 5 on loss.)

Resilient young children are usually comfortable with a wide variety of emotions, and are able to understand their own emotions and can express them in words or actions, for example 'I am angry/sad/irritated.' (See Chapter 8 on communication.) A resilient young child also has a good **autobiographical memory** in which he or she saves personal memories. Resilient young children:

- have a good sense of belonging
- know where they belong
- are grounded at home and in the community
- have a sense of their own culture, whether in the present or in the past

- understand how they fit into a family, small group of friends, the school class, the community or the church. Resilient young children are able to look for and find emotional support from other people. They are self-confident and also confident of the support of peers and caregivers. This support may change from time to time; it may not be provided by the same person over an extended period of time but may change, as the child's needs change.

A resilient young child:

- has interest in others
- feels the need to help others
- has a feeling for the needs of others and is able to help
- has a strong value and belief system
- has a vision of moral order and a sense of justice
- knows what is right and what is wrong
- senses what is unacceptable behaviour.
- has a strong spiritual or ideological belief system. (This belief system may include faith in any kind of transcendent being, whether one God, several Gods or faith in the power of the ancestors; this is usually influenced by the child's upbringing and culture. Some children (particularly older children) will develop some sort of political or cultural ideology, or may identify with a certain cultural, political or religious leader.)

Resilient young children are creative, innovative, curious and eager to learn. They are able to use materials in their environment to ensure their survival and wellbeing. Resilient young children are able to imagine a future and this gives them something to live for and goals to work towards.

Further ways to help young children develop resilience

There are various ways in which caregivers can help babies and young children in their care to develop resilience:

- They should provide a safe, nurturing environment in which the young children's needs are met. This includes access to health care, education and welfare services. It is important for young children to feel secure at home and to feel that they belong at home.
- They must spend time with babies and young children, listen to them (instead of talking about them), and show an interest in them and in what they do, think and feel. It is important to play with them.
- By answering questions and showing the babies and young children new and interesting things, we encourage them to discover their own initiative, creativity and interests.

- They should teach young children to communicate with other people. By showing them how to express feelings and ideas and how to solve problems and conflicts, they encourage them to become increasingly responsible for what they do and say.
- They should help young children to understand other people's feelings and to respect the needs of others.
- They should allow young children to make mistakes. We all make mistakes. We learn by our mistakes.
- They should help young children to recognise and understand their mistakes. They must encourage children to correct their errors, and should support them as they deal with negative thoughts, feelings and behaviour.
- They should try to involve young children in day-to-day activities as well as in family rituals, cultural rituals, religious rituals and festivals.
- They should teach babies and young children about family routines. It helps children if caregivers provide clear routines for the day and expect children to stick to the routine.

Things to think about and reflect on: working with young children's natural resilience

1. Who are the people who could best support the development of resilience in each baby and young child that a caregiver works with?
2. Do these people know enough about resilience and their roles in its development?
3. If so, how could you suggest helping them to learn and understand?
4. What problems can you foresee in this work?
5. How would you advise overcoming these problems?
6. How could caregivers use the aspect of resilience in their work on the psychosocial wellbeing of young children?
7. What would a caregiver need to be cautious about as he or she did this?
8. How would you judge how successful the caregiver's work had been?

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8

Communication and psychosocial care and support

Introduction – what is communication?

Communication refers to the process of **exchanging messages**. Exchanging messages involves giving and receiving messages. Human communication occurs at two main levels – non-verbal (not using speech) and verbal (listening to and speaking a language).

Although older children and adults tend to rely on spoken language to communicate, much of each message which younger children convey is non-verbal. People often respond to that part of a message that is conveyed through body language, facial expression and the tone that is used, rather than to the actual, spoken words.

Many non-verbal aspects of communication, such as eye-contact, posture, and use of hand signs or gesture, vary across cultures, and are important for showing respect, politeness, etc. This is particularly significant when working in a multi-cultural context as it is easy to offend people if the message sender is unaware of what the non-verbal communication conveys.

The importance of communication for babies and young children who need psychosocial support

No one knows more about how babies and young children are feeling and being affected by a situation, and what needs they may have, than the young children themselves. It is necessary, therefore, to find out these responses from the children, and it means finding ways to recognise, understand and give the right interpretation to what they tell or show caregivers.

How do babies and young children communicate?

Research indicates that babies are able to hear and respond

to the voices of their parent(s) even before they are born. Very young babies are able to differentiate their mothers' voices from other voices.

During the first months of life babies are able to hear the language(s) spoken by the people in their households and they gradually become familiar with the language tones and sound patterns. Before they are able to actually say any words, they understand quite a lot of language. Young children also respond to the tone and volume of the languages they hear and are sensitive to the emotional messages conveyed.

Birth to three years

In the first months of life, babies:

- express their physical needs, for example hunger or discomfort
- respond to what is happening to them, for example they can be startled or frightened
- don't fully understand the concept of other people to try to communicate with them
- gradually become aware that their sounds and actions cause responses from those around them. For example, their crying causes caregivers to pick them up and feed them. If the results of their sounds and actions are positive and rewarding, babies will be encouraged to pursue these early ways of communicating.

During this time, people closest to them – especially mothers or the main caregivers – can recognise what the babies' behaviour indicates and they can take appropriate action, for example they may cuddle and soothe babies that have been frightened by a loud sound.

In these first months, the basis for two-way communication can be established by people in the babies' environment.

These people can build trusting relationships with them:

- by meeting their basic needs such as feeding and nappy changing
- through cuddling
- through facial expressions
- through touching
- by talking with them
- by holding them
- by attracting their attention
- by playing with them.

Quite soon babies begin to respond. Their responses include:

- smiling
- laughing
- reaching out
- throwing
- crying
- having tantrums
- shouting to get attention
- copying sounds.

Babies rapidly develop their ability to communicate. For example, they:

- start communicating their feelings through physical expressions such as crying
- quickly begin to engage with those closest to them, responding to their voices and faces, seeking responses from them, imitating their movements and sounds, smiling at them, laughing with them and expressing frustration through physical movements
- start using an increasing variety of sounds and noises which will gradually become the foundations of the language they learn to speak
- begin to try to exert an influence, through gestures and noises, and by reaching for objects to show that they want them.

Positive, rewarding responses and interactions from families and caregivers are very important in stimulating babies and young children.

In the first two years, babies come to understand a lot of what is said to them and what is said in their immediate surroundings. They are able to follow simple instructions, identify people and objects by name and their 'understanding vocabularies' increase rapidly. Families may assume that young children do not fully understand what is being discussed in their presence because they usually cannot speak conventionally yet. If matters such as illness, loss, trauma,

etc. are being discussed, the babies or young children might understand enough to become fearful or confused and this might manifest in their play and behaviour.

By the age of two, most children start to use words in their home language and many begin to combine words to form simple sentences such as 'daddy come' and 'all gone'. However, much of their expressive communication still relies on gesture, sounds and actions.

From three to seven years

As children get older, their understanding of language increases tremendously. Their vocabulary and knowledge of grammar develops rapidly. More importantly, they become increasingly aware of how language is used in their cultures. This includes knowing about:

- non-verbal aspects of communication such as showing politeness through appropriate eye-contact, body posture, etc.
- verbal aspects of politeness
- what topics may be spoken about and by whom
- what names and vocabulary may be used
- how feelings and emotions are expressed
- what questions may be asked, when and to whom.

By the age of seven, most children are competent and confident communicators in their home language. They start to rely more on spoken language to express feelings, share information, inquire about things they are interested in, etc. They often ask lots of questions and they are able to talk about complex and abstract things, to reflect out loud about how they feel, and to analyse things verbally.

Things that can impact on young children's ability and willingness to communicate

In principle, babies and young children should feel most comfortable communicating and interacting with those closest to them. However, in practice this is not always the case. Some adults are not very skilled in listening and responding to them. Some adults may not take young children seriously and may behave in ways that are counteractive to good communication. For example, some adults believe that:

- it is the place of young children to listen (**one-way communication**, or **adult-to-child communication**)
- young children have nothing of interest to say – they don't know enough to have a valid opinion
- young children's opinions are not as important as the

adult view ('adults know best' attitude)

- young children need to be told what to do and think
- they should put their own interests first
- a superficial interest in what young children say is enough
- using judgemental language is acceptable, for example 'She is a naughty little girl.'

In addition, the ways in which young children communicate, and their skills in doing so, may have been restricted by the norms of their families or communities and by the opportunities they've had to develop abilities and confidence in expressing themselves. Again, it is important to find ways of helping these young children to understand that it acceptable to talk about themselves, their thoughts and feelings.

Communicating with babies and young children: some guidelines

The following guidelines are applicable for all adults – parents, caregivers, teachers and counsellors – engaged with babies and young children.

Listening to them

It is important for caregivers to:

- have eye-contact if and when appropriate
- get down to the children's level by sitting next to them or bending down
- give them full attention and not be involved in other tasks when they are trying to share information
- listen.

Speaking with them

It is equally important for caregivers to:

- use the children's home language if possible
- use vocabulary and sentence complexity that are age-appropriate for young children
- use content which is appropriate to the ages and needs of the young children
- not ask too many questions but rather allow the children time to speak
- ensure that their body language and facial expression match their words so that the young children do not get confused by mixed messages
- be good role models
- be clear.

Things to think about and reflect on: communicating with babies and young children

1. How do babies communicate?
2. Which sources can caregivers use to get information about how babies are feeling?
3. What do you think you could deduce from watching the behaviour of babies?
4. How can you check these ideas?
5. What aspects of babies' and young children's behaviour would make you concerned?
6. What kinds of actions would you take as a caregiver if you saw these aspects of behaviour?
7. What should caregivers be careful about and sensitive to when taking action?
8. What are some of the obstacles to communicating with babies and young children?

Psychosocial issues in communication

People who are concerned with the wellbeing of babies quickly learn to understand what the youngsters express by observing their behaviour, facial expressions, body language and reactions, and so on. They naturally empathise, and see the baby or young child as a vulnerable being.

Researchers Bråten (1998), Stern (2003) and Trevarthen (1992) have pointed out that empathic identification or participation is a spontaneous, participatory process. It happens when we see somebody close to us, somebody who is inside 'the zone of intimacy' and who is suffering or experiencing something unusual. This 'natural' ability to understand and communicate with babies and young children may be disrupted, however, when parents or caregivers are experiencing acute stress themselves due to environmental conditions, such as conflict and poverty, HIV and Aids-related illnesses, or emotional trauma as the result of loss and grief.

To a large extent the ways babies and young children are treated are influenced by the individual caregiver's definition of the baby or young child. When a child is perceived as being worthy of love, positive interaction takes place. The parent or caregiver smiles at, touches, talks to and engages with the child, and the child responds. However, if a caregiver has a negative view of young children, seeing them, for example, as 'monsters', bewitched, or punishments for sin, empathy is blocked and withdrawn, and the children may be treated

with indifference or at worst as 'valueless objects'. This in turn affects the children's concept of themselves and they withdraw, and the zone of intimacy is compromised.

One clue to problems in infancy and later life is given by what is called 'failure to thrive'. This relates to babies who are not developing in line with local expected norms, despite their basic physical needs being met, for example their physical progress being slower than it should be and their responses to the environment and to those around them being limited or unexpected. This suggests a lack of healthy inter-relations with others – especially with their parents or caregivers.

Recent research supports the need for sensitive assistance from adult caregivers to ensure children grow and thrive.

The International Child Development Programme

The International Child Development Programme (ICDP) is a psychosocial intervention that provides simple, useful guidelines for parents and caregivers, and networks of support to *improve the quality of interaction and the relationships* between caregivers and children. It is a flexible, community-based programme which focuses on sensitising parents and caregivers to the significance of their definitions of a child, and sees a baby or young child as a 'person'. It provides **three dialogues with guidelines** to create good interactions between caregiver and child.

THE EMOTIONAL EXPRESSIVE DIALOGUE OF THE ICDP

This dialogue, which begins at birth, is characterised by loving, warm, reciprocal interaction between the parent or caregiver and the baby or young child. The ICDP approach highlights four guidelines:

1. expressing positive feelings and love toward the baby or young child
2. seeing the baby or young child's expressive initiatives, and acknowledging and responding to them when appropriate ('tuning into' the child's state, feeling and intentionality)
3. engaging in intimate dialogue or expressive exchanges, where feelings are disclosed and experiences shared
4. acknowledging and affirming the child and giving appropriate praise.

THE MEANING AND EXPANSIVE DIALOGUE

In addition to establishing stable and trusting relationships, babies and young children need to develop an understanding of themselves and the world around them. In the early years this takes place through active exploration and guidance by parents and caregivers. At this stage 'joint attention and joint involvement episodes' (Shaffer 1996, Tomasello 1999), 'guided participation' (Rogoff 2003), 'scaffolding' (Wood, Bruner and Ross 1976) and 'mediation' (Klein 1992) in 'the zone of proximal development' (Vygotsky 1978) comes in. The ICDP approach highlights three guidelines:

1. joint focusing and attention by pointing, showing or gazing
2. giving descriptions and providing meaning for what is being focused on ('What is it?')
3. expanding beyond descriptions through comparisons, narratives, stories, dramatisations towards helping answer the question ('Why?')

In the context of conflict, poverty, and HIV and Aids, and with the engagement of sincere caregivers, this dialogue has helped young children understand and come to terms with difficult situations, redefining what has happened to them and thus generating hope and creating meaning for their lives.

THE REGULATIVE DIALOGUE

Another aspect of helping babies and young children cope in difficult circumstances is fostering feelings of 'being in control', through the development of self-control. The ICDP approach again involves communication between the caregiver and the baby or young child, helping the child reflect, see alternatives, preview consequences, restrain and control himself or herself to act strategically. This guideline includes three steps:

1. guiding and supporting the baby or young child's actions and initiatives without taking over
2. planning and previewing the consequences of one's actions
3. setting positive limits where rules are negotiated and agreed upon in a mutually respectful, friendly environment.

Communicative interaction between the parent or caregiver and baby or young child is a two-way process. It is not only the parent or caregiver who contributes to this communication; the baby or young child is an important contributor as well. When a baby or young child's signals are unclear due to illness, malnutrition or grief, etc., they may not be picked up and responded to. In turn, this may result in neglect, leading to the young child's failure to thrive.

When young children are able to talk and express themselves

As children learn to talk and become more eloquent, their ability to tell others about themselves can increase enormously. In the first years of talking, however, they may:

- not understand what is happening to them
- how it is affecting them
- not be able to express themselves very accurately
- not know the right words
- simply not feel able to talk about the most important things in their lives
- withdraw into themselves
- misinterpret their experiences
- fantasise.

To help overcome these potential problems, it's important to ensure that they feel comfortable in expressing themselves.

To do this, caregivers should note the following:

- Ensure that children have at least one key adult or older child with whom they can talk easily. Such people can encourage children to express themselves fully.
- Ensure that the children feel safe.
- Use their names when talking with them.
- Speak courteously with them.
- Show understanding and caring, by listening attentively, and having and showing a real interest in what they have to say.
- Respect what they say, for example by acting on a request.
- Use language that they understand.
- Ask questions and listen to their answers.
- Create a space that is welcoming and relaxed.
- Invite them to talk, starting with general things (such as what they have been doing) and progressing carefully to more significant things (such as their worries).
- Respond to what they say by using it to develop discussions and dialogue.
- Use dolls, Persona Dolls, puppets and other toys to encourage dialogue.
- Encourage them to ask questions.
- Provide opportunities for play.
- Invite them to make drawings about their situations and talk about them.
- Invite them to make up stories about whatever they need to talk about.
- Encourage them to make up performances or songs that can express what they need to share.
- Work with them in groups so that each child can

encourage the others to express themselves.

- Respect their feelings.
- Understand and respect their fears.
- Try to get clarity on what children cannot always express directly.
- Be honest with them.
- Respect their privacy and confidentiality.

Things to think about and reflect on: talking with young children

1. Who are the most appropriate people to talk with young children?
2. What problems might such people encounter?
3. What could be used to help those people overcome those problems?
4. What other sources of information could be used to ensure that a caregiver has an accurate picture of how a young child really is?
5. What are ways to assess the accuracy of what young children tell you?
6. What are ways to assess the accuracy of what you learn about young children from people around them?
7. What are ways to assess the accuracy of your impressions from observing young children?
8. How would you achieve the right balance between these sources of information?

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9

Play and psychosocial care and support

Introduction – what is play?

The young child's right to play is entrenched in Article 31 of the United Nations Convention on the Rights of the Child. This states that 'every child has the right to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural activities and arts.'

What is meant by play? There are many differing views on what play is and why it is important. The main features of play are that it:

- is universal – all children (and adults) play
- is self-initiated and intrinsically motivated
- gives pleasure
- is a process
- is active
- involves exploration
- is governed by rules (with rules often evolving as children play).

The following is a useful definition of play by the Children's Play Council in the UK.

'Play is an essential part of every child's life and vital to their development. It is the way children explore the world around them and develop and practice skills. It is essential; for physical, emotional and spiritual growth, for intellectual and educational development, and for acquiring social and behavioural skills. Play is the generic term applied to a wide range of activities and behaviours that are satisfying to the child, creative for the child and freely chosen by the child. Children's play may or may not involve equipment or have an end product. Children play on their own or with others. Their play may be

boisterous and energetic or quiet and contemplative, light-hearted or serious'.

The way young children play, the games they play as well as the people they play with, may differ from culture to culture. One of the main benefits of play is a sense of wellbeing and this starts when babies and very young children engage in sensory motor play with parents or caregivers and start exploring their own abilities in a safe, encouraging environment. Two important aspects for children to develop positive self-esteem are feeling that they belong and are loved and feeling that they are capable. Both these aspects can be reinforced during early play. This affirmation, both verbal and non-verbal, is very important for the children's psychosocial development as they learn about themselves and their abilities while they form close, positive relationships with the significant caregivers in their lives through play.

The letters of the word P-L-A-Y are a reminder of its many functions:

- P is for **perceiving**: young children explore the world through play. They find out what effect they have on their environment and what effect their environment has on them.
- L is for **learning**: play is a learning process through which babies and young children make sense of objects, of people, of good and bad experiences and of the world.
- A is for **acting**: young children learn by being active and doing things, especially by copying and imitating the actions of others. This is why it is so important to role-model good behaviours to young children. They absorb everything and may not be able to select what to imitate on the basis of whether it is good or bad, right or wrong.
- Y is for **yes**: play allows young children to safely explore and express their feelings.

Types of play

Understanding play and its importance to young children may be easier if it is divided into three different – but often inter-related – types of play.

1. **Sensory-motor play** is about using their five senses (touching, seeing, hearing, tasting and smelling), and their motor skills or voluntary body movements (for example touching, holding, pushing, crawling, kicking, balancing).
2. **Symbolic play** is when children use make-believe or pretence, on their own or with others, and so develop their creative and exploratory abilities. A child might start off using a real object such as a toy car and pretend to be driving it and later push a block of wood and pretend that it is a car. The same block of wood could become a mobile telephone at a later stage.
3. **Games with other children** teach children about co-operation and working successfully with others, for example when playing games such as hide-and-seek and board games. 'Rule games' help children learn about social interactions such as taking turns and playing different roles.

Sensory-motor play

This refers to play which uses the five senses and develops motor skills. It begins as soon as babies begin to move and use their senses and bodies, and is actually their way of beginning to learn about the world. It is a time when babies and young children should feel loved and safe, enabling them to explore their surroundings and abilities with confidence. They learn to recognise and explore different sounds, sights (colours and shapes), tastes and smells, and different feelings (textures, temperatures). For babies and very young children, this kind of play involves a lot of eye-contact, touch, and sounds (speech and other) with their main caregivers. It is partly through play that young children develop their first social relationships, with parents (both mothers and fathers are important), caregivers, siblings and other significant people in their immediate environment. Sensory motor development can be facilitated by providing babies and young children with appropriate stimulation. This could involve the use of every day objects (such as handling vegetables) and could include toys, which help them use and understand their five senses and which help the development of their motor skills. Such stimulation includes:

- talking with them, even before they can understand language
- using different tones, pitch and rhythms in talking with them

- singing to them and moving their limbs in time to the rhythm
- including actions with the words of songs
- demonstrating love by appropriate holding, hugging, stroking, cuddling and kissing them (helps them in trusting and connecting to others)
- gently surprising experiences such as disappearing from their view and then unexpectedly appearing in a different area of their vision ('peek-a-boo' kind of games)
- offering objects that they can safely explore using their mouths, eyes and hands
- repeating the experiences over and over again
- playing games with objects that include noises and different textures
- presenting things that they have to reach for
- hiding things and then revealing them
- encouraging them to participate by responding to their reactions, for example by showing surprise, or pleasure when they do something
- encouraging them to imitate actions, for example hand clapping
- showing them cause-and-effect, for example that clapping hands makes a noise
- developing games into new activities so that there is progression in their experiences
- playing with mud, water and sand
- providing safe spaces where they can explore objects in their environment
- climbing, swinging, running, balancing, etc.

Symbolic play

Make-believe or pretend games can start with children aged two. These games are essential for the development of thought, creativity and imagination. Symbolic play allows young children to explore different roles – such as parenting, for example – by copying adult behaviour. In role playing, young children tend to act out home themes where they frequently change their role and there is little continuity in the theme. Later on their themes incorporate situations outside the home and they are able to maintain a role and a theme for the duration of the game. By the age of 5–6 years, they often develop complex pretend themes and they may or may not use objects as props and create rules for their games. Children at this age often find it difficult to separate reality from fantasy and this should be kept in mind when trying to understand the play of young children who might be in need

of psychosocial support. As children's capacity for symbolic play, and their skill and imagination continue to develop, they may start to create things. For example, they will use damp sand to build a model of a house, or pieces of plastic to make cups and plates so they can act out social occasions. This sort of goal-oriented activity is very important, although it can be frustrating for young children as they struggle to match what they make with what they imagine it to be like.

In symbolic play, as in all play, it is important for caregivers to:

- give young children the freedom to perform as many tasks as possible for themselves
- encourage them not to give up
- respond positively to the results of their creative efforts
- protect them from objects that can harm them (for example sharp objects), especially when they are given the freedom to perform as many tasks as possible for themselves.

Note: In their play, young children tend to act out events and situations which are familiar to them and these might include cultural practices and rituals which differ from those of the caregiver or practitioner. It is important that their play actions are not judged as 'wrong' or inappropriate just because they are different. Children's behaviour needs to be understood within the context of their family and culture.

In playing symbolically, young children may well:

- use everyday objects as substitutes for things they need in their symbolic play
- invent roles for themselves, other people and objects
- believe that imaginary things are real
- take on the roles of others
- dress up
- create and explore alternative identities for themselves
- act out events with using one or more of these roles or identities
- read books, create and act out stories
- invent people (imaginary friends, for example) and create stories around them
- create alternative settings or worlds to inhabit during their play
- use play to work through troubling events or issues which they are not yet able to express using words
- explore ideas and refine them in line with their play experiences
- use painting and drawing
- play with blocks
- explore things that are troubling them through play that

appears to be about something else

- talk about the fantasies they have created even when they are not playing
- need adults to understand, empathise with and support their fantasies
- need to be helped in adjusting their fantasies to match their realities
- need to be helped to develop conflict resolution skills through playing out different possible solutions to the issue being dealt with.

Games with other children

Very young children are in the egocentric, 'me' stage and tend to play alongside each other, enjoying being near each other but often showing little interest in what the others are doing.

From the age of about three or four years, children often start to play games with other children. This is a time when they are moving from a 'me' stage to a 'we' stage, and they are starting to:

- develop empathy and compassion for others
- understand and adjust their feelings in these settings
- interact, communicate with and understand others through their play
- lay the foundations for their social future
- learn about co-operating and sharing
- recognise and accommodate the needs of others
- make their own needs known to others

All of this is very important in their social development because it can help them to have successful relationships with other children. Group play can also give young children a sense of belonging and counteract feelings of isolation. If they play with children who are facing similar challenges, this can be a useful step towards mutual support.

Some of this play may be quite formal and involve rules. Such rules teach young children socially important lessons such as playing fairly with one another, and also give a structure to their play that helps them organise both their experiences and the outcomes of those experiences. Sometimes the rules are invented or modified by the children. Later, children may join in team games and learn to make their personal contribution to the wellbeing of the team. It is helpful to start with co-operative games, particularly with the very young child. These are games where everyone contributes to the outcome or solution so that children learn about taking turns and following rules before they play competitive games

that are about winning and losing.

As children get older they become increasingly capable of reasoning and debating. However, initially, they may not be able to select what is right from what is wrong. They may imitate whatever they see others do, and may follow examples that are not positive. To help them, siblings and caregivers can role-model appropriate behaviour, and can talk to them, explaining what is right and wrong, (acceptable and unacceptable), and why.

How play can be affected by HIV and Aids

Babies and very young children living with sick or dying parents and/or caregivers who are too weak and lacking in energy to play, or whose parents have died, possibly would not have the opportunity to engage in the early sensory motor play which is so important for their general feeling of wellbeing as well as being important for their holistic development. It could become necessary for them to be moved to live with other family members or caregivers and they might also be separated from their siblings and familiar surroundings so that they lose other possible play partners and play objects. Poverty, lack of food security and lack of safe play spaces could also impact on their general health and development as well as their ability to play.

The emotional impact of living with very sick parents and/or caregivers can be very significant on young children's psychosocial development in terms of forming meaningful relationships as well as in dealing with emotional factors such as fear, anger, distrust, etc. All children living in these difficult situations would benefit from play opportunities which enhance psychosocial wellbeing and some children may be in need of play interventions by trained counsellors to give more specific psychosocial support. (See Chapter 10 on counselling.)

Older children's play opportunities could be reduced as they take on additional responsibilities of caring for sick parents or caregivers or younger siblings and sometimes they are unable to continue attending play groups and school where they could enjoy the support and pleasure of friendships with other children. Young children whose parents have died from an Aids-related illness sometimes are excluded from their usual play activities with friends due to stigma and other beliefs and this can significantly affect their development and wellbeing.

Children who are themselves ill would be restricted in

their play opportunities due to weakness and discomfort, and sick infants also might be deprived of the physical contact and playful interactions they need due to negative attitudes and stigma.

Why play?

Some adults don't understand the importance of play for the development of young children. They seem to believe that it's just about having fun or being noisy and messy. However, play is natural to children and is very significant in their growth because it contributes to their intellectual, social, emotional and physical development. It does this by:

- involving them in physical activity
- encouraging experimenting
- involving them in solving problems
- involving them in imitating and making things that are new to them
- allowing them to act out their thoughts and experiences
- allowing them to demonstrate their reactions to what is happening in their lives
- giving them opportunities to co-operate with other children
- opening up new ways of exploring and learning.

It is vital to encourage babies and young children to play. But it is also important to play with them. It is a way of forming relationships with them that help them to develop trust and to express themselves. These deeper relationships enable us to learn from them both, because of the increased opportunities of dialogue with them that play gives. Such close involvement can mean that caregivers will more accurately interpret what they are expressing through their play.

Discussions with older children about their play can help youngsters to express verbally what they are feeling, explore things that are troubling them and come to terms with those things. In addition, play can be relaxing and fun and can give young children the opportunities to achieve as individuals, and to be successful socially with others. Through play, they can therefore:

- get relief from tensions or worries
- express what they are feeling, often symbolically
- have their self-respect reinforced
- develop a sense of being worthy and valuable
- develop their ability to take on tasks, deal with difficult situations, and be creative and resourceful
- learn to accept who they are and what they can do
- develop their confidence

- develop their ability to take responsibility for themselves and their actions
- develop understanding for others
- learn respect for others
- develop a sense of empathy and compassion.

Play is important in their psychosocial development because it is one of the ways in which they:

- relax and have fun
- establish themselves as individuals
- develop close attachments to family members
- develop their creativity
- have opportunities to socialise with peers, other children, and community members
- learn about the benefits (and problems) of co-operating with others
- interact with and make sense of their world
- learn to accept and control their feelings
- can be helped to adjust to new situations
- can explore the new situation and be prepared for change.

In playing, particularly in games with other people, there is often the risk of failure and of 'losing' which can be upsetting to young children. There is also the possibility of being excluded by other children or of becoming the 'victim' or target of vindictiveness. They would then need the support of family members or caregivers in responding to these situations.

Babies and young children are able to communicate their thoughts, feelings and states of mind through play. Adults can hear the children's words and observe their actions at play, and can often learn about their difficulties and problems. Play can also be a useful tool in supporting babies and young children who need special help, including those who have suffered bereavement. (See Chapter 5 on grief.)

Play to support babies and young children's wellbeing

All babies and young children benefit from being given opportunities to play. Ideally, play should happen in the home and in the community with a variety of play partners.

A variety of stimulating play opportunities which will provide pleasure as well as age-appropriate opportunities to encourage holistic development should be made available where possible. These could involve:

- creating safe places and spaces to play
- providing caring play partners

- providing appropriate play materials (Sophisticated toys and activities are not necessary for successful play. Families can involve young children in activities such as finding matching shoes and then taking them to the appropriate person or hiding potatoes and getting the child to look for them and put them in a pot.)
- appropriate music and songs which can be used very effectively to share information and values in a child-friendly way and influence attitudes in a positive way
- using music and dance, which can contribute to a sense of accomplishment and wellbeing (This is also an effective way to get children to interact co-operatively.)
- using stories and dramatisation to model positive attitudes towards other people
- modelling and developing appropriate ways of dealing with exclusion or conflict can be done through play.

All young children, including those who are directly affected by HIV and Aids can be empowered by indirectly learning about universal precautions through everyday play. For example, this can be done at home or as part of an ECD programme where caregivers and practitioners model precautions such as wearing gloves and washing hands when caring for sick dolls in the 'make-believe area'.

Another precaution which can be modelled during play is that children should 'nurse' cuts and grazes themselves by covering the 'sore places' and asking for help if adult help is available.

Family members or primary caregivers should be included in play activities, and where possible, they should be the primary play partners, particularly for babies and very young children so that appropriate social relationships can be established which are beneficial to both the children and the caregivers.

Field workers can be trained as Play Partners and visit young children at home.

Things to think about and reflect on: play and its importance

1. Do family members and caregivers understand the different types of play?
2. Is the importance of play recognised sufficiently by caregivers and siblings?
3. If not, what could caregivers do to show them that it's important?
4. Are they aware of their roles in encouraging play?
5. Are they able to play or create play opportunities in ways that are appropriate for children of different ages?
6. If they feel a young child needs more specific help, do the caregivers know who to refer to?
7. What is the role of the wider community in providing appropriate play opportunities for babies and young children?

Play to help young children who need more-specific psychosocial support

Play is also useful in both understanding and helping distressed young children. A child may require more-specific therapeutic intervention if a caregiver detects behaviour such as the following:

- not playing spontaneously
- declining to play
- not playing for long
- not enjoying play
- being destructive or negative in play
- play that is centred for too long on themes such as death
- being aggressive to others during play
- not playing easily with other children.

Play intervention is done by a trained counsellor. (See Chapter 10 on counselling.)

Directed and non-directed play intervention

Two basic forms of play can be used to support young children psychosocially. The first is directed play. This is a structured approach that allows children to safely re-experience traumatic events. The idea is to establish a play environment that recreates, in a non-threatening way, the possible source(s) of their problems.

The aim is to help them both express their feelings and begin to cope with those feelings. One way of using directed

play involves devices such as dolls, puppets, or cut-out cardboard or cloth figures that are the subjects of a story that parallels children's experiences. The toys and play materials should be carefully selected to meet the needs of each individual child. The young children develop the story and explore the lives of the figures, guided by adults. This can be effective if children are too frightened, ashamed or embarrassed to share their experiences directly.

However, directed play can also be risky and may worsen their trauma if the play experiences are too close to their actual experiences. Besides possibly subjecting children to further trauma, adults can also misinterpret what they hear and see. It is vital that adults conducting such play undergo training and thorough preparation, and it needs special understanding and sensitivity.

The second kind of play for supporting young children psychosocially is non-directed play. This involves providing appropriate materials and opportunities for children to play in a safe environment and encourages them to express themselves freely. Adults observe, and may also talk with the children about what they are doing and why.

Playing alone or in groups

Young children should be given the opportunity to play alone as well as in groups. If a particular child seems to need special support, then playing alone at first may be best. Later, he or she might benefit from playing with other children. Groups of young children of about the same age or stage of development can usefully play together so they can enjoy companionship, learn from and about one another and perhaps share and explore their feelings, thoughts and experiences. Many children are more comfortable in a group where they are not the only focus of attention, and where they can get to know themselves better through interaction with other children their own age. Groupings like this allow them to learn to compare and contrast different ways of behaving, and to learn new games and skills. They can also become more capable of expressing themselves if they see other children doing so.

However, therapeutic group work – especially with traumatised children – has its challenges, for example:

- It can be difficult to make sure that all children are getting what they need.
- Some children are good at making themselves 'invisible'.
- Some children may refuse to join in.

- Some children in the group may demand so much attention that others suffer.
- Some children may disrupt group play by being aggressive.
- Some children may not feel accepted by the group because of their condition or situation.
- Some children may actually be rejected by the group.

Fortunately, these challenges can be overcome, for example by:

- preparing activities
- having a range of activities available for sub-groups if necessary
- being prepared to switch activities
- making sure there are enough adults or older children to watch every child, to help facilitate integration and respond to any needs
- making all children feel welcome and important
- making them feel that they belong
- ensuring there are opportunities for involving all in choosing activities, rules and decisions
- supporting children to help them participate
- offering success to all rather than failure to many
- praising efforts
- praising personal achievement rather than competitive achievement.

Play that can help young children express their experiences and feelings

Many kinds of play can be useful in discovering how children are feeling about, and coping with, their situations. Some kinds of play will appeal more to a given child than others; the children should choose.

Bear in mind that many of the play activities listed in the next section involve a lot of talking. Very young children are not able to use language to express thoughts and feelings – it is better for these to be shown by what the children choose to play with and the way they play. Toys and activities made available to the children should be appropriate to their ages and needs. The interpretation of their play requires skill, knowledge and sensitivity of observers.

We will now discuss some possible selections of play activities.

STORIES

Young children love stories, and these can be carefully used to stimulate discussion around difficult subjects, such as death, abuse and sexual abuse.

Use of 'pretend-characters', story lines that mirror reality, and imaginary settings can prevent children from being adversely affected by the story-telling, for example having animal characters to explore human realities. Using stories carefully can reassure young children that topics such as abuse and death may be spoken about, and can allow them to identify with characters who have experienced or felt similar things to them. It can also show ways of coping with problems, thereby demonstrating that there are solutions and that there is hope.

Children can tell their own imaginary stories, during which they can be encouraged to express their experiences and feelings, by inventing elements, and using 'pretend characters' and fanciful settings. This can make it easier for the children to express themselves and talk about their problems (as they don't feel they are talking about their own lives). But it can be difficult for adults who are trying to learn from them to decide how much of what the children talk about in their stories is based on reality, and which parts are important.

PUPPETS AND DOLLS

Similarly, puppets and dolls can help children act out different roles and tell their stories. Stories can be developed by more than one story-teller as the puppets interact with one another. By talking through puppets or dolls, children may feel safer in expressing their feelings, especially if the puppets are people or animals (real or imaginary) that they feel comfortable with, and can empathise with.

Some children may be able to express themselves better through characters who are troubling or challenging to them – but this can be a risky approach. Puppets need not be complicated and difficult to make (paper bags and decorated socks work well), and may be best invented and made by the children themselves who then become involved with the characters as they make them.

PLAY-ACTING

Children – especially young children – find it much easier to represent thoughts and feelings in actions rather than to describe them in words. Play-acting can allow the children to express themselves in ways that are safe for them, because they feel that their actions and words are not related to their own experiences. Again, as with puppet-play, when children stage a play, they usually interact with other children while developing the words and actions.

DRAWING AND PAINTING

When children draw or paint, they often reveal their emotions and thoughts, for example a picture of a large black cloud over a very small house may mean that the child feels threatened. However, it is important not to 'over-interpret' what a drawing may mean. Instead, invite children to talk about their pictures and explain them. What children say may not directly express their thoughts and feelings – rather it may offer parallels and allusions, something that is true of many of the activities outlined in this section.

PICTURES

Rather than asking young children to draw or paint objects or scenes themselves, a caregiver may ask them to respond to pre-selected pictures that are about emotions or situations. These pictures can also involve 'pretend-characters' and settings. By discussing with the children what they see in the pictures, they can express important things. For example, a picture of faces with different expressions gives children the opportunity to identify emotions that they are feeling, even if they don't know the correct vocabulary.

MODELLING WITH CLAY

Clay, play-dough and plasticine are easy for children to use to create their own three-dimensional toys or dolls. Once the objects are made, children can then use these in their own stories. As well as helping them express themselves, making models can help give them a sense of control and achievement.

WRITING

Older children who can write can put down thoughts and feelings that they are unable to express out loud. They may be able to do this by writing stories (including stories of themselves, their families and their realities), and by writing poems and songs. Writing letters to those they have lost may also help in their recovery. Encouraging the children (with care) to write about both positive and negative experiences and feelings can be revealing. Even very young children can pretend to 'write' by using squiggles and invented letters.

Things to think about and reflect on: using play to support the psychosocial wellbeing of babies and young children

1. Within your culture, what play activities could help you to understand more about children's psychosocial condition?
2. Could you develop any of these to help children express themselves better?
3. Could you safely add to these activities? If so, what would guide you in choosing and developing those activities?
4. What local norms and beliefs would you need to be aware of?
5. How could you help caregivers understand what children are expressing through play?
6. What special materials might young children need and how could these be provided?
7. How could you ensure caregivers discuss their observations with one another and with you?
8. What kinds of locally appropriate play could help babies and young children to come to terms with difficulties?
9. What kinds of locally appropriate play could help them to become happier?
10. What kinds of locally appropriate play could help them to enjoy better social relationships with their families and friends?
11. What are the dangers of using play to help young children express themselves?
12. How could these kinds of play harm young children?
13. What could you do to ensure that young children will be safe as they play?
14. Does your community have a children's play group or a children's support group? If not, would it be appropriate to set one up with adults and older children?
15. If needed, who could young children be referred to for specific psychosocial support in your community?

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10

Counselling young children with psychosocial problems

Introduction

The PSS pyramid model in Chapter 2 emphasised that it is appropriate to offer counselling to only the most severely affected children (near the tip of the pyramid). These children must be selected for counselling based on acute symptoms of dysfunction, and not because they belong to a particular category of children, for example orphaned and vulnerable children (OVC), formerly abducted children, etc.

Definition of counselling

In general, counselling young children might be defined as helping them to find ways to express their feelings and thoughts; and then working with them to help them feel more positive, hopeful and better able to cope with their lives and prospects.

It is important that counselling is understood as facilitating a slow process of healing and not as a 'quick fix'. This recovery process gradually emerges in an 'up and down' way.

Counselling involves two groups: those who receive the counselling and those who offer it.

Those who receive the counselling

In individual counselling, there is one counsellor and one client or patient. In group counselling there is usually one counsellor and several clients or patients. Family counselling is a form of group counselling.

Those who offer the counselling

This second category of counselling is defined by those who offer the counselling, and the level of training or experience a counsellor has.

- **Specialist counselling** refers to counselling offered by a trained psychologist or mental health professional.

- **Lay counselling** refers to counselling offered by a faith leader or religious leader, a community worker or a teacher who has some training in counselling.
- **Peer counselling** refers to counselling offered by a young person who is of similar age to the client and who has been trained in counselling.

Care and support offered by families, friends and caregivers outside of counselling rooms

Let's return to our definition of counselling young children. In general, this type of counselling aims to help children find ways to express their thoughts and feelings, and then assists them to feel more positive, hopeful and better able to cope with their lives and prospects.

Sometimes the best support come from caregivers, family members and friends, and is far removed from any counselling room or counselling service. Normally, although they may not know it, counselling is actually what many families naturally do when they provide what is known as 'emotional containment' to children experiencing problems.

Family members – parents, siblings, grandparents, for example – are ideally placed to be aware of the children's thoughts, feelings, and worries and the sources of those worries. Similarly, children can find support in others whom they know well and whom they trust. These people include their friends, members of other families and the children's teachers or other adults who know them well and with whom they feel confident. These forms of support are very important and are similar in their effects and objectives to counselling.

Where informal support and more-formal counselling differ, however, is that more-formal counselling is offered by an expert who is not in the family, household or circle of

friends. In some instances young children and adults may feel more able to talk about individual and/or family problems with someone whom they don't know and who is outside their immediate family or community.

We therefore refer to support from within the family, household, friends, etc, as 'everyday family and community support', and support from a trained 'outsider' as counselling.

Sometimes, especially in small communities, the lines between support and counselling might become blurry, because nearly everyone in the community is 'not an outsider'. The important factor then is that the person has received training in counselling and that the counselling process is more formal than the kind of support that can and does happen everyday in households and communities. The following make counselling more formalised:

- There is usually a set time for the counselling session (for example 30, 45 or 60 minutes, etc.).
- Usually it happens in a dedicated space (for example a counselling room).
- It is usually conducted by a trained counsellor.

Overall, counselling is guided by a recognition of what young children need in psychological or emotional terms. However, if all these needs can be met in the household and the community, there is probably no need for specialised counselling.

Typically, a child's needs:

- to feel loved
- to feel safe
- to belong to a family
- to be listened to and feel heard
- to have a structured and regular daily routine
- to have good role models
- to have his or her natural resilience strengthened (See Chapter 7 on resilience.)
- to have good behaviour reinforced
- to play, especially with other children.

Counselling should also not be seen as a long-term alternative to the treating of these needs at household and community level, but rather as a kind of crisis intervention at times when the circles of everyday community and household support are broken.

In many settings it is likely that there are no, few or not enough psychiatric and clinical psychological services for children with more severe psychological disturbance. It is therefore important that only the most severely affected

children are referred to these services (if the services exist), and that the other less-severely affected children are referred for lay (non-professional) counselling, or for structured group interventions. Of course, it may happen that a child is referred to a lay counsellor who then assesses the child and refers him or her for specialised counselling.

Identifying those who need counselling

It is important to assist parents, caregivers and community members to correctly identify which young children need to be referred for counselling. Margot Waddell's *Inside Lives* describes the typical developmental stages that children pass through and gives a comparison of more-worrying behaviour. The book covers the needs and behaviour of children from early infancy through to adolescence.

It is not easy to identify which young children need counselling. Sometimes parents and caregivers overlook those children who are quiet and well behaved, those that are well dressed and well fed, or those that are too close to them. Sometimes 'gut reaction' will tell them when a child has a problem.

Further on we discuss the most common problems presented by young children in southern and eastern Africa (in the time of HIV and Aids and in response to the triple impact of the pandemic, poverty and conflict). These problems may result in referral to appropriate counsellors.

Before referring any child for counselling, it is also important for a caregiver to ensure that the problem is not being caused by a medical condition, for example poor bladder- or bowel-control caused by a virus, and not related to mental health. The age of the child must also be taken into account as this will affect a parent or caregiver's expectations of the child's reaching of the various developmental milestones.

The sudden onset of any of the problems may also be a sign that something is interfering with a child's life. Many of the problems may be a normal response to loss, neglect or abuse. Rather than view them as 'disorders', they should be seen as indicators that the child may need extra psychosocial support.

We have provided the following list to help organisations working with young children to recognise more-serious psychological problems being experienced by children. However, it must always be kept in mind that 'the problem is the problem' and that 'the child is not the problem'. Whatever description or diagnosis is used, the problem must never be confused with the child. The child should be helped to believe

that the problem can be fixed and that it does not indicate who he or she really is.

BABIES AND EXPRESSIONS OF DISTRESS

Babies of up to 12 months primarily show their distress through eating, sleeping and behavioural disorders. In some cases these are extreme, such as head banging, freezing behaviour, adopting defensive postures. A poor bond between caregiver and baby can profoundly stunt a baby's emotional and cognitive development. In the context of HIV-positive parents who may not be able to respond to their baby's needs, the deprivation can have significant effect on the baby, unless there are alternative attachment figures on whom the baby can rely for consistent attention and love.

SEPARATION PROBLEMS

The primary-attachment figure may not be the parent but another family member due to illness, work-related absence or death of the parents. Children who lose one or both parents before the age of 11 are likely to become clinically depressed, unless protective factors such as having established relationships with alternative attachment figures like extended family members are in place.

BIRTH-HISTORY PROBLEMS

Research has shown that it is helpful to have someone, either a friend or family member, with the mother during the birth of her baby. This support promotes bonding between mother and child, as it helps her cope with the stressful experience of labour and allows her to be more responsive to her baby. Thus support that is given to the primary caregiver helps the infant in need, rather than an intervention aimed at the child.

FEEDING PROBLEMS OF BABIES OR YOUNG CHILDREN

Babies bond with caregivers primarily by being fed and nurtured, feeling safe, held and loved, and being kept warm and dry. Food refusal by the baby or young child and an inability to thrive, where for non-medical reasons the child does not gain weight may be related to the caregiver-child relationship. For instance, food may be offered inappropriately or aggressively.

Similarly a loss of appetite or a dramatic increase in appetite may reflect a baby or young child's emotional distress.

BEHAVIOURAL PROBLEMS

Early behavioural problems include:

- loss of bladder and bowel control
- speech problems, for example talking non-stop or not talking at all, and stuttering
- poor concentration
- inability to keep still; needing to be continually active
- frustration and inability to persevere at tasks
- anger or irritable and destructive behaviour, for example breaking things intentionally
- sleep disturbances such as nightmares, sleep walking and sleep talking
- age-inappropriate sexual behaviour (Some public masturbation is normal for children aged three to five years, for example girls pressing up against objects or boys playing with their penises. It is a problem only when the behaviour is excessive and compulsive, especially with older sexually-abused children, who need to learn that this type of behaviour is private. See Chapter 6 on abuse.)
- acting as though the children are much younger than their actual age, for example inappropriate thumb sucking, clinging behaviour and excessive neediness
- eating objects such as paint, chalk; a specific disorder (called Pica) involves children eating unusual things and risking harming or even killing themselves, for example death because of the lead in paint
- anxiety symptoms that include hair plucking, head banging or nail biting
- suicidal behaviour or ideation.

Children as young as four have tried to take their lives. A child may explain a suicide attempt as an accident, for example drinking a cleaning agent, or rat or insect poison, jumping from a high place or overdosing on available medication in the household. Attempts at self-harm can include cutting behaviour to draw blood (sometimes in areas concealed by clothes), cigarette burns on the skin, peeling the skin off the soles of the feet so revealing raw patches.

If a child is thought to be suicidal, a thorough investigation by a mental health professional must be conducted in order to assess the risk to the child of successfully killing himself or herself. In some cases the child is hospitalised or preparations are made to ensure that a caregiver acts as a 'suicide watch' to keep the child safe. In addition, medication for treating the depression or any other psychiatric disorder may be necessary if this is found to be the underlying problem.

Work with the caregivers or family is vital in understanding why the child wants to die, for instance because of abuse or depression. Deeply depressed children can feel there is no other way out of their painful situation but through suicide. If the child is coping with abuse, it is necessary to assess the family to ensure the child will be safely looked after.

EMOTIONAL PROBLEMS

Emotional problems include:

- excessive sadness or depression
- frequent tearfulness
- excessive fear, for example startling by a loud noise
- separation problems, for example not wanting to be separated from a parent, caregiver or teacher
- having new fears, appearing 'numb', and showing no emotions despite extreme circumstances
- somatising – often having stomach aches, or other vague pains – these may be real medical problems and should be checked first
- loss of interest in previously enjoyable activities, apathy and having no energy

SOCIAL PROBLEMS

Social problems include:

- aggression, bullying and cruelty to people or animals
- starting fires, damaging property, stealing, and playing truant
- excessive defiance and opposition to authority and disruption of organised activities
- problems with the police and running away from home
- substance abuse
- withdrawal
- poor understanding of or compliance with social rules
- indifference to what is happening with others and lack of empathy.

It is important that these behaviours are diagnosed both early and accurately – the behaviour may not just be a sign of naughtiness and may require specialist help. If not attended to early on, the problems may increase and result in the individual engaging in anti-social behaviour, for example inflicting extreme abuse and even killing.

LEARNING DISORDERS

Early childhood is the ideal time in which to identify possible learning difficulties. Young children may exhibit difficulty in

understanding early literacy and numeracy. A child's skills such as communicating, matching, sorting, comparing, counting and reasoning may be delayed. A marked difficulty in learning to read, write or calculate may signal a learning difficulty, but it may also signal an emotional problem. This type of problem may indicate that the child needs additional education support or referral to a specialist.

An assessment of intellectual ability conducted by a psychologist or a neurological assessment conducted by a developmentally trained doctor can identify a biological problem that accounts for the learning problem. In that case provision for remedial help or special schooling can be organised if such resources are available. Although this can be difficult to accept by the parents it can ease the young child of pressure to be as competent as other children. Parents can also be helped to see that the child is not lazy, but has a real limitation. Children with learning disorders may have features of depression because of their struggle in trying to keep up with their peers. When provision is made for their 'differentness' they can feel hugely relieved and the depression may lift spontaneously. For this reason, children placed in a particular remedial school in Johannesburg, are not counselled for the first three months – to make allowance for this recovery possibility. Learning disorders may also include:

- losing development gains already made
- declining school performance
- attention and hyperactivity problems.

PSYCHIATRIC DISORDERS

Children under extreme stress or having survived life-threatening circumstances can develop psychotic disorders in which they cannot distinguish reality from non-reality. It is necessary to be able to differentiate between young children going through the harmless and normal phase of pretending to have imaginary friends whom they talk to. For them the imagined friends are real.

In contrast, the psychotic-induced hallucinations are different. With these, older children may be unconcerned with seeing strange phenomena. For instance they may see a book open and shut on its own and cannot explain how that happens, or report hearing strange voices speaking to them of people they can't see. They may feel frightened of the voices or be at ease with them. Sometimes the voices will tell them to do harmful things, for example kill themselves.

Problems such as these can be helped medically and

children need to be treated appropriately, ideally by a child psychiatrist, or an adult psychiatrist if necessary.

It must be remembered that the presence of any of these symptoms does not necessarily imply that a child is mentally ill. In certain contexts, some symptoms may be normal reactions to abnormal circumstances. There is a strong anti-labelling movement among many health practitioners. They do not support the classification of mental health problems into 'labels' or 'disorders' (as in the Diagnostic and Statistical Manual of Mental Disorders Text Revised, (DSM IV-TR), published by the American Psychiatric Association.) Once a person is classified and labelled with a particular diagnosis, for example anti-social personality disorder, disruptive behaviour disorder, depressive personality, etc., the classifications may work against and stigmatise that person.

For these reasons, this publication discourages the use of such classifications at a primary health care level. Even the DSM IV-TR regards the presence of any one of the symptoms under any disorder as insufficient evidence for a child to receive a particular diagnosis. Generally the severity of the symptom and its co-existence with several other related symptoms is necessary before a diagnosis is made.

What is counselling and how is it done?

There are many forms of counselling but in general counselling can be divided into:

- solution-focused counselling in which the solution or goal of the client is considered more important than the problem
- strength-based approaches in which the resilience, strengths and abilities of the client are considered before focusing too strongly on the problem
- problem-centred counselling (the client must have a good understanding of the problem and its history before it can be solved)
- directive counselling in which the counsellor works with a specific agenda and directs the process
- non-directive counselling in which the counsellor mostly listens and offers support, allowing the client to determine the content and direction of the conversations
- play therapy or counselling is suitable for young children whose verbal skills are not yet well developed
- art counselling, which is also suitable for young children whose verbal skills are not yet well developed.

Principles of counselling

To be successful, counsellors of young children need to establish relationships of trust with them. Young children need to feel confident and know that their feelings and thoughts are being heard, taken seriously and understood. Key to this is the skill of the counsellor in helping young children to express themselves – through talking and play. (See Chapter 9 on play.)

Counsellors need to be aware of their own feelings about topics and issues which might come up, for example on religion or gender; and should be aware of their own cultural beliefs and how these might affect – positively or negatively – how they respond.

Confidentiality is an important part of the child-counsellor relationship. Feedback to caregivers should be about the themes the child reveals, for example anger, rather than about anything the child has said about other people. A contract with the child in which confidentiality limits are discussed is helpful. In cases involving abuse, counsellors have to find ways of making sure that the affected child is prepared for what the counsellor must do, which may be to inform social workers and the police. The child must also be convinced that any innocent people will be protected as a result of his or her disclosure.

Practical points to guide counselling

- Make sure that the young children know they are not alone and that people are there for them who can help them.
- Understand their stage of development, and how they perceive the world.
- Listen attentively and with complete commitment to them.
- Understand exactly what a therapist is being told by carefully exploring what the children are expressing.
- Give them plenty of time to ask questions.
- Use language that children can understand.
- Come up with responses that are appropriate.
- Help children recognise and build on the strengths that they have, including their resilience.
- Help each child to recognise and accept people and other resources that can support them.
- Work with the children to discover practical, realistic ways forward.
- Jointly reach decisions about what to do.
- Avoid telling the children what to do and imposing the beliefs or judgements of the therapist.

- Don't blame or preach.
- Avoid making promises that can't be kept.

When are young children the right age to receive counselling?

Generally, individual counselling is not suitable for pre-verbal babies, although joint parent-infant or caregiver-infant counselling is an effective form of counselling. Children aged three or more, however, are able to express themselves in individual play counselling.

Counselling young children and involving the wider social system

Counselling young children, especially joint family-child work, involves regular feedback meetings with caregivers and family, as well as teachers, to gain information about developmentally appropriate behaviour, school performance and social relationships at home and at pre-school. For instance, if a child is being bullied, this can be discussed with the caregivers and feedback given to the school personnel so that they can intervene. Feedback sessions with the parents or caregivers can be built into the counselling programme every few weeks as an opportunity to get information on the child's progress at home (without the child being present). Often, when the child is brought to a counselling session, the caregiver tells the counsellor about relevant events.

The child can be present at meetings with the caregiver to get developmental history and relevant background information. This gives the young child a sense of what the caregiver's concerns are and the reasons for seeing a counsellor. It may be necessary for the caregiver only to meet with the counsellor to discuss difficult topics where it may not be appropriate for the young child to be present, for example where the caregiver has had a history of sexual abuse.

The next decision the counsellor and caregivers make together focuses on which **form of therapy** is best, given the resources of the programme or community clinics and the needs of the young child. This may emerge in the initial interview or may come out later on. For instance, one-on-one therapy offers the young child space to express himself or herself and feel important, especially a withdrawn, introverted child. Similarly a child who is angry with a family member and needs to express those feelings without being inhibited by that particular person can benefit from the freedom of expressing his or her feelings in the safety of therapy. In other

cases the family or caregiver can be included in the counselling as they are fundamental factors in the young child's primary social environment. In counselling, looking at how the family system is organised and the dynamics of the relationships can allow for changes that dramatically help the child as well as other family members. In this way family counselling is a good resource as it is helping a group of people and not only one individual.

Research shows that both **individual child counselling and family counselling** have benefits and are equally effective in helping young children in need. Where resources allow, it may be possible to offer both individual therapy as well as family therapy.

Trauma counselling or trauma debriefing

This type of counselling focuses specifically on the *traumatic event* and its impact on the survivor. It aims to support the various coping strategies used by the survivor. In the context of HIV and Aids, poverty and conflict, the survivor could be adults or young children or both.

It is recommended that survivors receive treatment at least 36 hours after the traumatic event as it is likely that they will be in a state of shock prior to the event and therefore not be able to absorb much. At least four to six trauma debriefing sessions (as opposed to a single session) are recommended.

Can trauma debriefing re-traumatise survivors?

There is debate about the value of trauma debriefing. Trauma debriefing has often been criticised as re-traumatising survivors but this research has been based only on once-off trauma debriefing sessions and not on the usual four to six debriefing sessions usually conducted over a month or more. The trauma debriefing model is highly effective and helps individuals to realise that it is normal to experience their various often-disturbing symptoms

The **Wits Integrated Trauma Debriefing model** is a good resource for this intervention and has evolved from work with political, domestic and other forms of trauma at the Centre for Violence and Reconciliation. Much work on trauma has also been developed within the field of Narrative Practice, particularly by Michael White and the Dulwich Centre. The focus of this trauma work is not so much on the retelling of the traumatic event itself but on how the events challenged the beliefs, values and hopes of the survivor at the time of the

trauma, and *what the survivor did that contributed to his or her survival*. This focus is less likely to cause secondary trauma.

Exposure to natural disasters has a devastating impact on the psychological and social wellbeing of children, adolescents and adults. It is now widely accepted that early psychosocial interventions that help to make the effects of trauma less severe by alleviating psychological distress and strengthening resiliency must be an integral part of humanitarian assistance. In the case of children and adolescents, psychosocial interventions also aim to maintain or re-establish their normal development process.

The broad framework for planning and implementing psychosocial programmes is provided by the relevant Articles of the Convention on the Rights of the Child, and by the United Nations High Commissioner for Refugees (UNHCR) Guidelines on Protection and Care of Refugee Children.

Specific support for children who have experienced trauma

1. Support for babies and young children:
 - Re-establish routines.
 - Provide opportunities for verbal and non-verbal expression of feelings and thoughts.
 - Permit the child to sleep close to a parent for a limited time.
 - Provide opportunities to express emotions through play.
 - Allow repetitive re-enactment of disaster through fantasy play, with parent clarification of what actually took place.
2. Support for school-aged children:
 - Encourage expressions and play enactment of their experiences.
 - Resume normal functions as soon as possible, but relax routine expectations.
 - Provide opportunities for structured but not demanding chores and responsibilities.
 - Encourage physical activity.
 - Answer questions about the disaster honestly and simply.
 - Avoid giving children access to very vivid depictions of the event in order not to overwhelm them.
 - Give the children permission to discuss their uneasiness by acknowledging your own fears.

3. Support for teenagers:

(This section may also be useful for young parents.)

- Encourage group discussions with peers and adults (reduces the sense of isolation, and normalises the child's feelings).
- Provide opportunities for physical activities (preferably involving the teenager's peer group) to help reduce tension.
- Provide reassurance that ability to concentrate will return.
- Temporarily reduce expectations for expected levels of performance at school and home.
- Encourage participation in home and community recovery efforts.
- Encourage expression of feelings.
- Encourage teenagers to maintain contact with friends and to resume athletic and social activities.
- Encourage discussion of disaster experiences with peers and significant others.
- Group discussions are helpful in normalising feelings.
- Encourage healthy outlet of aggressive feelings; screaming in a pillow, pummelling a punching bag, walking and running.

Things to think about and reflect on: understanding and meeting young children's counselling needs

1. What symptoms and degree of severity thereof should a caregiver look for in young children that indicate a need for specialist counselling?
2. What symptoms and degree of severity thereof should a caregiver look for in young children that would indicate a need for lay counselling?
3. How should a caregiver plan and prepare the young child for counselling?
4. What possibilities exist within reach of a caregiver for children to be treated by a trained counsellor? What are the alternatives where there are no possibilities?
5. How would you monitor the effectiveness of the counselling?

Principles to guide psychosocial programming

- Nearly all children and adolescents who have experienced catastrophic situations will initially display symptoms of psychological distress, including intrusive flashbacks of the event, nightmares, withdrawal, inability to concentrate, and others.
- Most children and adolescents will regain normal functioning once basic survival needs are met, safety and security have returned and developmental opportunities are restored, within the social, family and community context.
- Trauma counselling should *never* be the point of departure for psychosocial programming, because structured, normalising, empowering activities within a safe environment will help the majority of children recover over time.
- Trauma counselling should not be provided unless an *appropriate and sustained follow-up* mechanism is guaranteed. Defence mechanisms exist for a reason and breaking them down before the child is ready and in a safe physical and emotional environment leaves him or her open and vulnerable to re-traumatisation. There are serious risks associated with trauma counselling carried out by non-professionals.
- Dramatic consequences for a child's life pathway can have more-damaging consequences for the child's wellbeing than the traumatic event itself.
- Grounding all psychosocial interventions in the culture, unless it is not in the best interests of the child, is both ethical and more likely to produce a sustained recovery.

Psychosocial interventions based on the above principles

- Ensure that interventions are based on consultation with the affected communities, reflect on what they need and take into consideration the age and stage of development of the children involved.
- Understand and respect the culture and religion of the affected population.
- Help children, family members, friends and neighbours find out what happened to those who are missing, and find each other, and let them know that efforts are underway.
- Set up 'child-friendly' spaces as soon as possible and activities that normalise the lives of children.
- Restore normal schooling as soon as possible.

- * Encourage children to ask as many questions as they want to ask.
- Reconnect children with family members, friends and neighbours.
- Focus and build on interventions that strengthen the population's resiliency and resources, and current and traditional ways of coping when they are in the best interests of the child.
- Involve youth in organising activities for younger children; undertakings that give an affected person a sense of accomplishment have a healing effect.
- Set up support group discussions – if possible, accompanied by involvement in concrete activities that give a sense of accomplishment and control over one's life.
- Promote and support interventions which preserve and reinforce the cohesion of the family, and discourage any which risks separating children from their families.
- Promote activities and opportunities that allow children to express their experiences and feelings only if:
 - the child is ready for this expression – eliciting emotional material too early can cause more distress and potential harm to the child
 - caregivers can ensure further, on-going comfort and help.
- Identify referral services for the small number of children and adults who will need professional, medical assistance (some of these people may have had pre-existing psychiatric illnesses).

These guiding principles represent the views of the following agencies:

- The International Rescue Committee (IRC)
- Save the Children UK (SC UK)
- The United Nations Children's Fund (UNICEF)
- The United Nations High Commissioner for Refugees (UNHCR)
- World Vision International (WVI).

Organisations working on behalf of children are strongly encouraged to endorse these principles.

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11

Bringing it all home

Conclusion

The most important and powerful resources for psychosocial care and support are the primary caregivers.

This publication draws on two main areas, PSS and ECD. Much of the focus in the approach to ECD centres on learning in babies and young children's social, emotional, physical and cognitive development. In the introductory chapter we pointed out that is a mistake to try to treat each area of child development separately.

When a caregiver or parent engages in almost any activity with a child (such as feeding, bathing, walking a child to school, etc.), elements of learning, communication, play and psychosocial support should all be present. **Mainstreaming PSS** means ensuring that the child feels socially and emotionally supported in every part of his or her life – at home, in the classroom, on the playground, in the street, on the way to school, at the clinic, at the soup kitchen, at the kids' club, etc. Mainstreaming PSS means making sure that this 'stream or river' of wellbeing flows widely, strongly and continuously in and around the child so that we look at every aspect of a child's life through 'PSS-tinted lenses'.

What follows is a list of practical ideas for primary caregivers to realise their potential as *the most powerful, valuable and important PSS and ECD resources in the life of a child*.

Irrespective of his or her level of formal education, every primary caregiver has the potential to shape and influence the lives of the children in their care. In return, the caregivers can be rewarded with the love and joy that comes with rearing happy, hopeful, curious children.

The list presents lessons and inexpensive ideas that do not

rely on specialists or outside experts or on funding, but that draw on the inherent expertise of ordinary and extraordinary people found in every community. It brings together the various topics that have been presented as separate chapters in this publication but that in reality form an integral part of nearly every moment of personal or social life.

Ideas related to learning

- Children learn most easily and most readily from the people they know best. Thus parents and caregivers are in a good position to be really effective teachers.
- Babies learn about things through their own actions and through their senses. Babies and young children should not be prevented from touching things unless it is really necessary or unsafe for them to do so. By always hearing, 'no, no, no' the baby will lose its natural sense of curiosity and will learn much less.
- From an early age, babies and children can be taught about the similarities and differences between things.
- Children learn mostly by imitating and copying. They should be allowed to copy older household members and caregivers and need lots of encouragement and patience because they may not copy something correctly first time.
- Learning should be fun for child and for caregiver too.
- Allow children to make mistakes and to learn by trial and error.

Ideas related to attachment and separation

- Babies need and love bodily contact with others, for example being tied to their caregiver's back in a piece of cloth or blanket.
- They also need lots of practice in using their hands and

fingers to strengthen the small muscles. Depending on their age, let them practise reaching, grasping, tearing paper, picking things up and putting things down, opening and closing, and taking things in and out of containers, and threading big beads or toilet rolls.

- Older children need time and space to practise separating by degree from their caregivers who, while being mindful of them, should not be overly controlling.
- Research has shown that it is very important that babies have the opportunity to crawl, whereby they learn coordination, depth perception, curiosity, etc.

Ideas related to nutrition

- Feeding a child can be done in a playful, caring and teaching way – this ensures that PSS, nutrition, communication and learning (how to chew or use a spoon, experiencing different tastes and textures and names of foods, etc.), all come together.
- For children to get to know different tastes, don't mix together too many foods.

Ideas related to counselling

The most effective way of helping babies and young learners deal with the problems they experience in contexts of HIV and Aids, poverty and conflict, is to *use the resources that exist closest to them*; namely their families and communities. Involving children in the psychosocial recovery process, discussing with them their perceptions, and how they see their needs can all be done in an age-appropriate way by those people who matter most to them. Only in extreme cases should the young child be referred to specialist services.

Ideas related to oral story telling

- Telling stories provides opportunities for passing on rich cultural knowledge and values and gives a sense of belonging.
- It develops a young child's capacity to listen, share, predict and develop imagination.
- It builds concentration, attention, vocabulary, memory and knowledge.
- Children's names (first names, surnames, nicknames) are important. Often there are stories behind the names that tell the children who they are and where and how they belong. Children should be told these stories.
- Encourage children to tell their own stories.
- Story telling creates opportunities to explore themes of

loss and grief, and emotionally complex issues.

- Make storytime a time of bonding.

Ideas related to books

- Children love to look at books, listen to stories and tell their own stories.
- Books help children to learn more about themselves and their feelings, for example feeling scared on the first day at school.
- Through books, children learn about people and what they do (for example the shopkeeper, nurse, doctor, etc.).
- By spending time with children and reading them stories, sharing reading (where the child and caregiver read slowly together) or discussing a book, children learn to listen, read and speak better. They also learn to think, understand and to ask and answer questions.
- Younger children need simpler books mostly with pictures and simple text that can be read to them.
- If there are no books in the local library or resource centre, it can be fun to make books with or for children.

Ideas related to their bodies

- Children enjoy looking at their image in a mirror. It helps them to know what they look like and to explore their own bodies. Caregivers can use this opportunity to teach important information and talk to the child.
- Songs and rhymes are an enjoyable way of learning about parts of the body and how they move.

Ideas related to singing

- Singing is a great way to bring harmony into the life of the child and to teach them about culture, new words, etc.

Ideas related to playing

- Playing with other children, both younger and older, is one of the **most important ways** children learn emotional, social and cognitive intelligence.
- Encourage friendships.
- Use mud, water and sand activities for therapeutic and educational benefit.
- Encourage dramatic play and dressing up.
- Observe play, and use this for assessment purposes.

Ideas related to language development

- Don't correct every language mistake children make.

- They will learn by listening to others.
- Help children to recognise the words in their community (for example, street signs) and in their homes (for example writing on packaging, etc.).
- Concepts are best first understood in the child's home language before being introduced in a second language.
- Children are able to become bilingual and multilingual without interfering with their overall language and cognitive development.

Ideas related to communication

- Talk about feelings (caregivers' and children's) to help them develop emotional literacy and to be in touch with their own feelings and the feelings of others.
- Laugh with children and not at them.
- Demonstrate love and affection both physically and verbally through smiling, gesture and expressions such as hugging.
- Talk to children about difficult issues like loss, trauma and everyday disappointments.

Ideas related to drawing

- Children should be encouraged to draw and talk about their drawings.
- Never make fun of or criticise a child's drawing.

Ideas related to writing

- Encourage children to experiment with writing, using their own squiggles and scribbles. This will develop writing skills and promote expression and communication.
- Model writing for children, by recording their words in stories.
- Provide opportunities for children to write freely without fear of correction or criticism. Have fun with phonics.

Ideas related to counting

- Help children to count and learn numbers, and how to work with them.
- Sing number songs to younger children, count together, look for numbers on coins and signs, etc.
- Sort and count out objects, for example spoons and plates.

Ideas related to television

- *Limit* television time and balance it with outdoor or active play.
- Select age- and content-appropriate programmes.

- Talk together as a family or household about what the children have viewed and what they think about it. (Encourage critical thinking.)

Caregivers' needs

Finally, if primary caregivers are to be acknowledged as the most important resources for children in the context of HIV and Aids, their needs must be satisfied. These needs may be related to:

- physical, social, emotional, nutritional and intellectual needs
- time with their own families
- nurturing relationships
- burnout
- stress management
- support networks (the three circles of support are relevant)
- resources for help.

The REPSSI vision is that *all* children affected by HIV and AIDS, conflict and poverty benefit from stable, affectionate care and support'. To this end it is essential that primary caregivers also benefit from stable, affectionate care and support – from themselves, their families, their community and society. This is the responsibility of all.

Biographies

Jonathan Morgan

Jonathan Morgan, a 'not-very-clinical' psychologist in public practice, currently works for REPSSI. His job involves knowledge transfer and development, and he works with approximately 100 frontline organisations across 13 countries in southern Africa and eastern Africa. His preferred method of working combines elements of Narrative Therapy, Art Therapy and Participatory Action Research. In 1999, his and the Great African Spider Writers' book, *Finding Mr Madini*, was published in Cape Town by David Philip. This 'detective thriller' documents the life-stories of ten homeless people, all of which intersect with Jonathan's own life-story. Jonathan's second publication, *Long Life – Positive HIV stories*, (Jonathan Morgan and the Bambanani Women's Group, published by Double Storey Books, 2003) – harnesses the creative energies of activists, writers, artists and photographers.

Jonathan's current passion is *The Hero Book* (published by REPSSI) in which children are invited to be the authors, illustrators and main characters in a hand-made book that explores psychosocial challenges.

Jonathan edited Chapter I (entitled Introduction) and Chapter II (entitled Bringing it all home).

André Viviers

André Viviers is a social worker, currently employed by UNICEF South Africa where one of his key responsibilities is ECD. Working at different levels and in various contexts on children's rights and development, his work has involved:

- working on early childhood development
- working with street children
- working in the child protection system
- managing a children's home
- working with children in conflict with the law.

He has also been a guest-lecturer in social work locally and abroad, and was involved in tutoring students in child-care and youth-care work at the former Technikon South Africa (now part of the University of South Africa). André has developed study guides and numerous training guidelines. He

has published a number of articles on aspects related to child rights and has been involved in the development of books for very young children. He is a keen advocate of psychosocial care and support as being vital to the survival, development and education of babies and young children, and a firm believer on the power of play (and play as the most natural state of childhood).

André edited Chapter 2 (entitled Psychosocial care and support (PSS) for and babies and young children) and Chapter 5 (entitled Loss, bereavement, grief and mourning).

Margaret Irvine

Margaret Irvine works in ECD and also in the fields of inclusion, spirituality and education leadership. She has been deployed in the ECD field in several African countries, in disciplines such as ECD curriculum, facilitator-facilitation and ECD policy. Currently she is an education lecturer at the University of Fort Hare (East London).

Margaret has written and illustrated a publication on facilitator-facilitation, published by Bernard van Leer/ UNESCO, and enjoys anything to do with critical thinking, creative thinking, problem solving, listening and talking, gathering information, making plans, and effecting and reflecting on them. Currently Margaret is doing a PhD on mysticism, visual creativity and leadership.

Margaret edited Chapter 3 (entitled Holistic child development including psychosocial support) and Chapter 4 (entitled Being part of psychological care and support).

Juliana Seleti

Juliana Seleti is an ECD specialist, having been a trainer, researcher and materials developer in the field. Her present focus is education policy development and implementation. Initially trained as a high-school teacher of History and English, Juliana has specialised in ECD. Some of the institutions she has worked for are the University of KwaZulu-Natal, the Education Training Development Practice Sector Education Training Authority (ETDP SETA)

and the SABC (Takalani Sesame South Africa). She is also one of the ECD Global Leaders for the World Forum on Early Childhood Care and Education. Recently she presented her PhD, from the University of Pretoria, which uses the national Department of Education's ECD policy in South Africa as a case study.

She is currently employed by the national Department of Education as a Chief Education Specialist in ECD where she works on policies and programmes for children up to four years of age.

Juliana edited Chapter 6 (entitled Abuse).

Snoeks Desmond

Snoeks Desmond works as an independent consultant in materials development, training, evaluation (and anything else interesting that comes her way). She was the founder and director of the Family Literacy Project from 2000 to 2007. Prior to that she worked as a consultant on many projects, including Takalani Sesame (South Africa) and was director of Training and Resources in Early Education (TREE). Her concerns are for young children and their right to a good start in life. To achieve this she works mainly with adults who care for children – those taking a parental role in the home or those who work in the range of outside-the-home facilities. She has an M.Ed. (Adult Education) and is currently registered for a D. Tech.

Snoeks edited Chapter 7 (entitled Resilience: the ability to bend but not break).

Carol Smith

Carol Smith is a trainer, educator, researcher and writer. She has been involved in ECD programmes and research, teacher training, anti-bias programmes, special needs and community-based childcare projects in rural and urban areas in South Africa since 1979.

From 1998 to 2003 she was based in the United Kingdom (UK), teaching, tutoring and consulting in ECD and childcare, and anti-discrimination work. Carol has worked with Persona Doll Training since its inception in 2000, training across the UK, and in New Zealand, Iceland, India and Germany. She has also provided on-going support to practitioners using Persona Dolls in the London area.

Carol is now co-ordinating the South African Persona Doll Training project and offering Persona Doll Training to Early Childhood Development and Foundation Phase trainers and

educators. The project makes SA Persona Dolls. Training, materials and support assist educators and trainers to use Persona Dolls to implement the Revised National Curriculum with a focus on values education, child rights and life skills.

Carol edited Chapter 8 (entitled Communication and psychosocial care and support).

Mary Clark

Mary Clark is a speech and language therapist with a particular interest in facilitating language development through play. She enjoys developing new games and activities. As a member of the training team of the non-profit organisation (NPO) Inclusive Education Western Cape, she has assisted with inclusion programmes for learners experiencing barriers to learning and with the development of appropriate teaching materials to encourage early home-language literacy.

Mary previously worked in Specialised Education and Support Services with the KwaZulu-Natal education department which included work in ECD. Mary is chairperson of the Western Cape branch of Active Learning Libraries South Africa (ALLSA), a NPO affiliated to the International Toy Library Association. ALLSA strives to make play materials and opportunities accessible to all children (and their families).

Mary has helped develop training and teaching materials for ECD. She also offers a variety of workshops to parents, caregivers and educators on facilitating communication skills in a multilingual, multicultural context and on play.

Mary edited Chapter 9 (entitled Play and psychosocial care and support).

Judy Morgan

Judy Morgan is a clinical psychologist who graduated from the Tavistock Clinic in London with a Masters degree in infant observation. She then completed another Masters degree in clinical psychology at the University of Johannesburg. She has worked with children and families from underprivileged communities at both Coronation and Helen Joseph Hospitals where she was head of department. Judy has worked primarily with traumatised populations as well as supervised and trained intern psychologists.

Judy edited Chapter 10 (entitled Counselling young children with psychosocial problems).

Brighton Gwezera

Brighton Gwezera is employed by REPSSI as the Sub-Regional Manager for the central region (Zimbabwe, Mozambique, Botswana and Angola). He has peer-reviewed for the *Vulnerable Children and Youth Studies Journal* and reviewed an article on sex, drugs and young people for *International Perspectives*, 2007. He has won an ASC Scientific Committee sponsorship to present a paper at the European Conference for African Studies, Netherlands, 2007. Brighton has written an article published in the *Chris CABA* journal (Topic: The impact of Psychosocial Support and disclosure on ARV Therapy), 2005.

Alex Tigere

Alex Tigere is employed by REPSSI as a Programme Officer. In his last project he led the development of a PSS manual for home-based care (*Weaving hope for our children*). Alex has vast experience in PSS facilitation and training. He has facilitated workshops for countless organisations in Zimbabwe and Botswana, e.g. Catholic Relief Services, Viva Network, Marang Child Care Network and Farm Orphan Support Trust. Alex has a lot of experience in working with children at community level.

Brighton and Alex facilitated a peer-review of the first draft of this document with REPSSI partners in Botswana.

Ncazelo Ncube-Mlilo

Ncazelo Ncube is a registered Educational Psychologist with a lot of interest in Narrative Practices and community work. She has over ten years' experience in working with children, youth and communities affected by HIV and Aids. Ncazelo is an ardent development worker with specialised skills in psychosocial care and support for children, families and communities in crisis. She has amassed skills in working at grassroots' level and in curriculum development, training and technical capacity development in the area psychosocial support, particularly in the context of HIV and Aids, poverty and conflict. Ncazelo also has extensive experience in programme management and leadership. Her life time passion is to contribute to the psychosocial wellbeing of children, youth, women, families and communities living under the harsh realities in Africa and beyond. Ncazelo is a trained narrative therapist/practitioner.

Ncazelo was the team leader of the development of *PSS for under 5s*, which informed this publication.

Ncazelo Ncube-Mlilo is a psychologist with extensive experience in Narrative Practice and work with children. She is the co-author of *Tree of Life* – a child-centred narrative-based psychosocial tool – and is a psychosocial advisor within REPSSI.

Jo Stein

Jo Stein has been doing qualitative HIV and Aids research since 1991. She has an MA in Psychology from the University of Cape Town. She has published journal articles in the areas of psychosocial support for people living with HIV and Aids, nurse-counselling, HIV and Aids stigma, HIV and Aids media advocacy, and the Anti-Retro Viral Treatment roll-out within the context of integrated primary health care. She has written newspaper articles about orphans and vulnerable children. She has also completed a literature review on the psychosocial impact of HIV and Aids on children for REPSSI, entitled *Sorrow makes children of us all*, as well as edited a special edition of the *AIDS Bulletin* on orphans and vulnerable children commissioned by REPSSI.

Jill Sachs

Jill Sachs is a teacher by profession and has extensive experience in ECD, ranging from classroom teaching and management to ten years as Deputy Chief Education Specialist in the KwaZulu-Natal Provincial Department of Education. In this capacity she was responsible for setting up the systems and structures for the phasing-in of the reception year in the province. One key focus area was curriculum development and she led the team which, in conjunction with UNICEF and the Media in Education Trust, designed and developed the three-module In-Service Grade R Teacher Training Programme which is used in four provinces. She also served for a number of years on the Provincial HIV and Aids Task Team and was responsible for the development of the ECD teacher training and support programmes offered to some 4 000 Reception Year teachers in KwaZulu-Natal.

She currently is engaged in exciting work as the Education Programmes Manager for Caversham Centre and Education Trust. She is the designer and developer of the early years' teacher training programmes offered by this arts-based accredited service provider. She has recently undergone training as a facilitator for the International Child Development Programme and her particular passion at

present is, through creativity and the arts, to enhance the confidence, knowledge and skills of teachers and caregivers and thus help transform the lives of our youngest citizens.

Gill van Wyk

Gill van Wyk is an early childhood education specialist, with a wide range of experience in the ECD sector, including management, governance, policy development, curriculum development and support and assessment. She has been involved at various levels of state education: in the classroom as a teacher; as a school principal; and at district and provincial offices as co-ordinator, advisor and planner. Her current work involves running projects, developing programmes and materials to support the implementation of the National Curriculum Statement Learning Programmes from Grades R to 3.

Gill originally qualified at the University of Natal for a secondary school career, but later retrained for ECD. Years of teaching young learners convinced her of the significant role of psychosocial development and support for young children and families. She is a persistent advocate of developmentally appropriate ECD practice – especially learning through play.

Gill's role in this publication has been that of overall editor and proof reader. In this task she has worked in conjunction with Richard Rufus-Ellis, a professional editor and proof reader.



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REPSSI

Psychosocial Wellbeing For All Children

ISBN: 978-0-620-40186-9