

Milivoj Jovančević, Mladen Knežević & Ljubomir Hotujac, editors.

# Providing assistance in crisis situations to families with babies or toddlers



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## Foreword

Milivoj Jovančević

Every day we witness numerous crisis situations in the world. Wars, floods, earthquakes and similar catastrophes result in a large number of casualties, strongly mobilising the public to offer various forms of assistance. Apart from the tragic images, statistics and individual human stories, there are no reports concerning the consequences of these events on the youngest of people – children in their first months of life. This is quite unjustifiable, for we know that they are the most vulnerable and most valuable group in any society. Their exceptional vulnerability derives from their absolute, existential dependence on the help of others and their immature stress defence mechanisms. This paradox probably results from a lack of awareness concerning the bases of early growth and development in human beings, of children's needs and their ways of communicating with the people around them. There is a deeply-ingrained stereotype which says that small children do not understand anything, and that whatever is experienced in earliest childhood is forgotten. This leads to the conclusion that small children do not pose a special problem in crisis situations, and that it is enough to satisfy their bodily needs – providing warmth and food, and preventing bodily illness. Unfortunately, all such conclusions are mistaken. True, at their earliest age children's rational communication is quite meagre; but for this reason emotional communication and the need to feel loved and protected are essential to further growth and development. It is on these foundations that children's image of the world surrounding them and of themselves is made; how much they can trust those around them, how successful their communication is, and how well others understand their needs and signals. Without such feelings and experiences there can be no healthy growth and development, for children cannot survive without love. In crisis situations children are often left without their primary caregivers, while those who remain bear the burden of trauma and its psychological consequences, which deeply disturb the harmonious development of the early parent/child relationship.

Guided by their personal experience, the authors of this manual wish to focus attention on the exceptional importance of organising specialised assistance in the area of early growth and development for children caught up in crisis situations. Moreover, we believe that it can aid in achieving successful parenting and a happy childhood in normal conditions of life as well.

## 1.0. Introduction

### 1.1. The Croatian Psychiatric Association's Experience with Psychosocial Assistance Programmes during the period 1992 - 1998

Mladen Knežević, Ljubomir Hotujac

The war in Croatia and in Bosnia and Herzegovina represented one of the largest crisis engagements in Europe following World War II. For UNHCR, an organisation whose mission is refugees, operations in the territory of the former Yugoslavia were the most complex in many respects. One area of special significance was psychological assistance, which was implemented in the most comprehensive manner possible. There were several reasons for this, the most important being that earlier UNHCR crisis operations had demonstrated the importance of psychological assistance in many conflict situations, and that assistance methodologies had been developed, especially in the large refugee camps in Vietnam. Much experience in the area of psychological assistance to refugees and displaced persons had also been gained in the countries that gave them asylum. Another very important factor in the level of development of this type of assistance was that both Croatia and Bosnia and Herzegovina were European countries with high pre-war standards of general health care, such that in certain areas of the two countries some of these standards had not been re-attained even 15 years after the end of the war, primarily for economic reasons.

Intensive fighting in Croatia lasted for no more than three months, followed by an extended stalemate in areas occupied by Serb rebels. This latter period lasted nearly four years. During this time around 25% of Croatia's sovereign territory was occupied. Some 250,000 people from these areas were forced to flee and seek temporary housing in the unoccupied part of the country. Some 47% of those who were forced to flee were able to take their basic personal possessions with them, while no less than 43% could not do so (1).

When intensive fighting began in Bosnia and Herzegovina, nearly a million people were forced to flee from that country. Around 250,000 of them found shelter in refugee camps in the Republic of Croatia, while around 650,000 succeeded in fleeing to other European countries, with some later finding refuge in non-European countries, on nearly all the world's continents. As in Croatia, the war in Bosnia and Herzegovina started when the JNA (the Yugoslav National Army, which had a pro-Serbian orientation) attempted to occupy its national territory, meeting with armed resistance from Bosniaks and Croats. Unfortunately, in 1993 armed conflict broke out in Bosnia and Herzegovina between Bosniaks and Croats as well. As the political background of this conflict is not relevant to this study, we shall not discuss it further. The reason for mentioning this fact is to point out that some 250,000 refugees from Bosnia and Herzegovina, most of them Bosniaks, were residing in Croatia even during the conflict between Bosniaks and Croats, receiving all possible assistance from Croatian aid workers, professionals and volunteers alike. One of the largest organisations providing psychological assistance was the Croatian Psychiatric Association, in whose project only highly-trained professionals, members of the CPA, were involved.

At the height of the refugee crisis in this region, the number of Croatian citizens who had fled from occupied areas of the country and refugees from all parts of Bosnia and Herzegovina residing in Croatia totalled about 700,000. Refugees and displaced persons thus made up around 15% of the total population of the newly-founded state, whose economy had been systematically destroyed by the war. This represented an enormous human, economic, psychological and political burden on a country which was still at war. If we were to make a comparison based, for example, on the population of the USA according to its 1990 census, then that country would have had to accept exactly 37,444,904 refugees. This would certainly represent a huge economic burden even for a country like the USA.

At the start of the war in Croatia, the Ministry of the Interior established the Medical Headquarters of the Republic of Croatia, as the supreme command structure for health services. This was one of the best-organised elements of the country's defence throughout the entire war, and it provided significant support to other elements of both the military and civilian structures. One highly developed element of the Medical Headquarters was its Mental Health Division, which took a very active part in all its work from the very outset, from targeted activities (preparing command structures for wartime operations) to the most general tasks, such as participation by Mental Health Division staff in Croatian Radio's regular broadcasts, where topics vitally relevant in individual phases of the war were discussed.

The most direct form of activity by the Medical Headquarters of the Republic of Croatia were its mobile teams, which provided aid to people who had remained in areas exposed to heavy attack. Members of these mobile teams visited the inhabitants of such locations, who had sought protection in cellars and other types of shelters, and offered them psychological assistance of the most direct kind. Mobile teams for psychological assistance were also organised in hospitals where people injured in the war were treated; the teams working in the rehabilitation centres where patients were sent following surgery were especially active. This broad range of activities by the Mental Health Division also gained the attention of numerous foreign organisations monitoring wartime developments in Croatia, so that some of these activities received special financial support. The first organisation to provide quite concrete material and personnel support for psychological assistance to displaced persons in Croatia was the French humanitarian organisation Partage, which was headed by the paediatrician and great humanist Alexandre Minskovsky. Having come from a family of Polish refugees himself, Minskovsky showed a great sensitivity for the psychological problems of displaced persons living in the Špansko housing settlement in Zagreb. Here the first complex, interdisciplinary team for psychological assistance was formed, serving as a model for the development of many similar teams. Based on the experience of this first team, which was made up of 16 specialists, other teams were developed to operate in the 26 largest settlements where refugees and displaced persons were housed. The teams provided assistance to more than 30,000 people in these settlements, and from 1992 to the completion of the project at the end of 1998 more than 200 Croatian specialists in the areas of mental health and psychiatry, as well as other types of physicians, social workers and special education teachers, had worked in the teams.

The Croatian Psychiatric Association, in carrying out its activities, faced the most difficult kinds of crisis situations involving refugees and displaced persons. Therefore, our basic position

was that, given the scope and complexity of the problems we were confronting, basic project activities should be performed only by experienced and highly-trained professionals. Only a certain number of tasks were entrusted to volunteers, who worked closely with the core professionals in each expert team. Project activities were adapted to the varying circumstances in individual refugee and displaced person settlements, as characterised by the client composition of the settlement, its location, and the like. In certain settlements, for example, the number of adolescent pregnancies among young refugees and displaced persons was a particular problem, and so the team's activities were adjusted accordingly (2). Refugee camps housing Muslims from Bosnia and Herzegovina, such as those located in the centre of Zagreb, made for a particularly complicated situation at the time of hostilities between Croats and Muslims in Bosnia and Herzegovina.

All of the project activities were coordinated by the Croatian Psychiatric Association, while the most important project financier was UNHCR, whose experts also oversaw project implementation. The project activities came to an end in 1998, at which time it was concluded that this kind of general psychosocial assistance should be transferred to ordinary state structures. Only highly-specialised teams for supporting families with pregnant women and small children remained in the settlements. It was considered that this particularly vulnerable group of displaced persons and refugees required ongoing specialised assistance. As this project for assistance to pregnant women and families with newborn children was not financed by the UNHCR programme, but rather by the Swedish humanitarian organisation Rädde Barnen, it was not carried out in all refugee and displaced person settlements, due to limited financial resources.

Based on the same operating methodology, teams with a very similar composition were active in neighbouring Bosnia and Herzegovina. The Croatian Psychiatric Association aided the development of a small non-governmental organisation made up of specialists – physicians, psychologists, educators and social workers alike. The teams operated in the territory of western Herzegovina, with specialists from the Croatian Psychiatric Association training team members and supervising their activities. The teams provided “general” psychological assistance based on the model developed in the Špansko displaced person settlement in Zagreb, while specialised teams for supporting and assisting pregnant women and families with newborn children were also organised, likewise based on our methodology. The activities of these teams was financed in part by UNHCR, while the teams for assisting pregnant women and families with newborn children in Bosnia and Herzegovina were financed entirely by the Swedish humanitarian organisation Rädde Barnen. Here we should mention that our friends and colleagues from Rädde Barnen were the only ones to recognise the need of providing assistance to the youngest inhabitants of refugee and displaced person settlements. Although the Croatian Psychiatric Association developed this project and submitted it to many organisations which had financed psychological assistance projects, only Rädde Barnen understood the needs of this highly specific population and decided to assist the project through both material and human resources, sending highly-trained specialists to take part in training and supervisory meetings with members of the Croatian Psychiatric Association teams several times during project implementation.

Such intensive activity and highly professional provision of services resulted in application of this model in western Bosnia and Herzegovina immediately following the cessation of hostilities

in that area. A non-governmental organisation was established in Bihac and the Cazinska Krajina area, based on the model developed by the Croatian Psychiatric Association and working under the supervision of its members (3). Based on the specific characteristics of the population in that area, special emphasis was placed on activities by teams assisting pregnant women and mothers with newborn children. This newly-founded non-governmental organisation now operates independently, with members of the Croatian Psychiatric Association occasionally participating in a supervisory capacity.

## Model of Activity

The model was developed based on the experience we had gained since the very start of the war and in wartime conditions, and was continually adapted to the situation encountered in each settlement. One important reason for the differing implementation of this basic model was the great variance in size among settlements. In Croatia there were two settlements which were exceptionally large, with up to 8,000 people dwelling there at various times, from children being born to old people dying. The great majority of refugee and displaced person settlements housed several hundred people, up to a maximum of one thousand. These were mainly hotels on the Adriatic coast, in which refugees and displaced persons had been housed. There were also some very small settlements containing only a few dozen displaced persons and refugees and situated in small localities far from the main transportation routes. The great majority of the settlements in Croatia were located at a safe distance from the fighting. Several of them, however, were quite near the front line; and so living conditions there were even more complicated and difficult, as were, consequently, the tasks which the members of our teams had to perform.

The basic areas of activity by psychosocial assistance teams in the “Croatian model” of psychosocial assistance in refugee camps were as follows (3):

### 1. Status assistance

Many displaced persons, particularly older ones and those with a lower level of education, had unresolved status issues such as pension insurance, disability insurance, and the like. Refugees were faced with the added difficulty of being in the territory of another country, and thus less able to communicate with some of the system’s institutions; therefore, it was necessary to assist them. Since a feeling of security is one of the basic questions in solving the problems that result from a traumatising experience, resolving status issues proved to be an exceptionally important area. Status issues are not just an administrative problem that becomes especially pronounced during war or similar events; rather, they also have a much deeper symbolic significance for anyone affected by such events. In such a situation, status issues become, symbolically, a question of personal identity and the identity of a social and ethnic community in difficult circumstances. For precisely this reason, resolving status problems is a highly demanding task, not just because the administrative structures which are to oversee these activities have disintegrated or are difficult to maintain (especially with regard to personnel), but also because such services, in carrying out their work, often even aim at a certain lack of efficiency. Sometimes state organs (if they are still functioning) have

not made important decisions regarding how to handle people seeking housing and shelter. Sometimes an administrative structure seeks to exploit the drama of refugees and displaced persons in order to create various kinds of pressure on its “opponents”, as well as elements in the international community, for the sake of certain political aims. It sometimes happens that various organisations blackmail refugees into this or that religious or political affiliation, giving them assistance only if they manifestly accept certain ideas. The members of our teams observed many such forms of pressure during their work in a number of the largest refugee and displaced person settlements. Social workers on the psychosocial assistance teams tried to solve the majority of problems connected with status issues via the system’s basic institutions, in such a way that, in the main, displaced persons and refugees themselves took part in resolving these issues, thereby retaining control over this area of their civil liberties. Assistance was particularly necessary in the case of refugees from neighbouring Bosnia and Herzegovina, who found themselves in a much more difficult situation. In order to resolve their problems, our teams called on the assistance and cooperation of various humanitarian organisations active in their area.

## **2. Material assistance**

Material assistance did not form part of the concept of our teams’ basic activities. The basic idea was, first and foremost, psychosocial assistance. However, certain situations were such that it was simply impossible to do anything in a settlement without first securing the minimum material conditions for the people living there. In the most dramatic situations, the team located sources of material aid in order to alleviate the most severe real-life problems; this was mainly done with the support of humanitarian organisations associated with our most important financiers, UNHCR and the French organisation Partage. Some collective centres were in such material difficulties that their basic life functions were being directly threatened. This was especially the case with those centres to which refugees from neighbouring Bosnia and Herzegovina had been transported following the dramatic events of the war. The team’s basic task was to find material assistance not for the long term, but rather only in emergency situations, while seeking more permanent solutions by aiding the development of social structures in the settlement, that is, of displaced persons and refugees themselves, and by contacting various humanitarian organisations. In this way, it was possible for the members of our teams to remain within the bounds of their activity.

## **3. Organising housing centres**

Centres organised in provisional premises must be adapted to the living conditions of the people in them. Many of these people, particularly displaced persons, were urban residents with relatively high standards of housing, hygiene and health care. Therefore, organising refugee camps involved not just requirements of a hygienic and sanitary nature, but also an important element of psychological work. Special attention had to be paid to possible premises for children and to education and specialised forms of work with them. Many parents showed signs of difficulty in adaptation, and so working with children was also a way of ensuring time for productive, uninterrupted work with parents, and for parents to relax and to establish a new social network in dramatically altered circumstances. This segment of activity was likewise left to the settlement’s social struc-

ture, the responsible authorities, and other humanitarian organisations. However, the members of our teams lent their professional knowledge and involvement to this aspect of the development of refugee settlements as well. In those settlements where we also organised teams for assisting pregnant women and families with newborn children, it was necessary to secure adequate space for the work of paediatric teams, as these required specially equipped premises. It is interesting to note that these members of the teams showed a particularly high level of activity, and it was they who, in general, most quickly and successfully found the necessary infrastructure for their work.

#### **4. Assistance to school children**

One of the more significant psychological burdens on displaced persons and refugees is that the link between their past and future has been broken. In normal family circumstances, children's success is something which can provide optimism. Likewise, monitoring children's progress in school is a good indicator of the overall climate in a family. A third factor is no less important. That part of the population housed in collective centres represented a negative social selection. Those who succeeded in maintaining more considerable personal potential and material possibilities found a more favourable solution than the collective centre. The children of people housed in collective centres had more often had problems in school even before the war. The team's work opened up the possibility of solving, via expert assistance, not only certain current problems connected with being a refugee, but also those which had emerged earlier.

**4a.** From the very start of project development, care for adolescents was regarded as an especially sensitive problem. Adolescents are in a particularly difficult situation since, due both to their age and the demands facing them, as well as the kind of contact they have with adults, they have "no time" to wait for a slower and more thorough process of renewal of their resources. Likewise, the time between their becoming refugees, with all the objective and subjective difficulties this entails, and their being obliged to assume a social function is a relatively short one, and for this reason they are in greater danger than small children. One especially sensitive problem is the development of their identity. Burdened by a separation which is, in any case, characteristic of this time of life, their important role models are all losers, people who, having lost the battle for their homes and property, have been driven out and humiliated. In these circumstances, separation undoubtedly has special characteristics.

A certain number of adolescent girls became pregnant in the refugee camps. It should be stated at once that, for a great many of the girls whose pregnancies we monitored, it could not be said that this resulted from behaviour that deviated from the cultural sphere in which they originated (2). In other words, it could not be said that these young women somehow suddenly (due to their condition as refugees) became promiscuous (for the great majority of them truly were not) or completely uncritical regarding their own sexuality. We may claim with a high degree of probability that, in the circumstances of their culture, they would have become pregnant even if they had not been in a refugee camp. However, every adolescent pregnancy constitutes a risk in a number of respects, and this was also true here. Therefore, the members of our teams accorded such cases special attention.

**4b.** Psychological assistance for preschool children. The kindergarten (where spatial and personnel resources allow it) is a very important place in the collective centre, not only in terms of children's education, but for helping the entire family as well. Mothers, dejected and in danger of losing part of their identity, are able to make use of the time when children are at school for themselves and their own problems, as well as for trying to revive, in the available conditions, at least some semblance of a family atmosphere. A kindergarten is also a good diagnostic tool for identifying problems in the family and signalling team intervention.

## **5. Assistance to adults**

The customary procedure in crisis situations of these dimensions is to provide assistance to children. While this is certainly justifiable for a number of reasons, in the final analysis it is insufficient and, at times, even unproductive. For the majority of children live with parents who sometimes have quite prolonged traumatic experiences – both personal experiences and those which stretch across several generations. Thus the parents of today's children are themselves the children of those who experienced World War II, and not seldom do they live with grandparents who experienced World War I.

Moreover, parents have difficulty in organising their own identity. As displaced persons or refugees, they have lost the battle for their homes and jobs. Having saved their children and a minimum of personal property during the war, they have undergone a deep personal crisis, and for this reason often focus more on organising their own integrity as best as possible than on caring for their children. For this reason, children in collective centres seem, to the casual observer, to be neglected by their parents. Moreover, it is often quite obvious that it is children who look after their parents; that is, a certain inversion of the typical family roles has taken place. For this reason, care for parents is extraordinarily important, since only by creating some sort of family atmosphere can we expect children to make progress as well. Such care must be comprehensive, and should not be limited to psychological support in the strict sense; rather, it must encompass the entire spectrum of status problems of the adult person (parent).

## **6. Assistance to families with pregnant women and newborn children**

A specific form of assistance must be provided to families with pregnant women or mothers with infants. Although everyone and each person individually is deeply affected by such situations, experience in working with displaced persons and refugees has shown that the most vulnerable families are those which include pregnant women or mothers with newborn children. However much the birth of a child may be an exceptional event and a special joy, in the conditions of a refugee camp it is also confusing and frightening, and this is precisely why such families require expert assistance. The Croatian Psychiatric Association's teams quickly recognised this specific need, and had already begun forming specialised teams to work with such families in a relatively early stage of project development. In general, these teams were led by a paediatrician, and also included a specialised paediatric nurse and a psychologist. A psychiatrist served as the team's consultant at the regional level. All the teams received support from project managers and regular supervision. They were functionally linked to the basic teams working in a given settlement, and exchanged informa-

tion among themselves. It should be pointed out that these teams were among the most active elements in the relatively large system of psychological assistance to refugees and displaced persons. In smaller refugee and displaced person settlements, where such teams could not be organised, members of the basic teams were trained to work with families with newborn children, occasionally receiving direct assistance from the project centre. This programme was developed with expert and financial support from Rädga Barnen – Save the Children Sweden and UNHCR.

Psychological assistance in the strict sense of the term was provided at the following levels:

- 1. At the level of informal, everyday contact. This is particularly important in our culture, where people who need help expect it to be offered in their homes. This is essentially different from the traditional “ambulatory” approach, and our experience with this method of work has been excellent so far. Teams are accepted directly in the settlement, and there have been practically no serious conflicts between team members and displaced persons and refugees.
- 2. Targeted contact in situations where a certain family needs more structured support.
- 3. Assistance in the form of individual and family psychotherapy in the settlement.
- 4. Assistance in clinics, where such a procedure is indicated and therapy cannot be performed in the settlement.
- 5. Assistance with hospitalisation, in the most serious cases.

The procedures listed in items 4 and 5 are exceptional, and were implemented only in cases where there were medical indications. In one settlement where, by sheer coincidence, a large number of mentally ill people were found,<sup>1</sup> such an orientation marked a precedent in Croatian psychiatric practice. As the possibility of hospitalising such patients was considerably limited in regional medical systems, psychiatrists opted for hospitalisation only where the most severe exacerbation of the illness had occurred, while many cases which would, in normal circumstances, lead to hospitalisation were nonetheless handled within the family circle in the settlement.

### Cooperative network:

• a) The trained volunteers consisted of two large groups. The first included people who performed various duties in the settlements, such as settlement heads, school and kindergarten teachers, and workers from a number of humanitarian organisations who, in various ways, came into contact with displaced persons and refugees. These volunteers had the task of entering into the most direct possible contact with the refugees, as people of good will offering neighbourly understanding. They got to know the people in the settlement and, having spent a certain amount of time in informal contact with them, signalled specialists in the network regarding the possible need for intervention. These volunteers helped in recognising problems that the team of specialists should respond to.

The second group of volunteers consisted of the members of various bodies made up of displaced persons and refugees themselves, such as the committees which were organised in almost every collective centre. Work with this group was more intensive, and communication between

<sup>1</sup> In one refugee settlement were housed nearly all the patients of a mental hospital, which had found itself caught up in the whirlwind of war in Bosnia and Herzegovina.

these bodies, as well as communication with people they encountered in their work, was facilitated. Some teams met regularly with this group, others only from time to time; yet in both cases there was an awareness that this group represented an important element in the social structure of the displaced person or refugee camp, and should be helped in developing its functions as successfully as possible, so that it might, in turn, aid development of the camp as an integral social structure.

- b) Social workers constituted the second level of the network. They operated at two levels. In the majority of teams, social workers divided their responsibilities in a given settlement on a “territorial” basis. In other words, they were most immediately responsible for the inhabitants of a certain part of the settlement, visiting them, socialising with them, and solving their problems to the extent allowed by their training and education. They were also that part of the team which would request the intervention of other specialists, based on their observations in the field among displaced persons and refugees. Those trained for group work led various group activities. Social workers who were trained in individual therapeutic techniques successfully participated in psychological assistance in the strict sense of the term.

- c) Psychologists provided special assistance to school teachers, so that the support offered to school children would be as comprehensive as possible. Their work focused on individual groups of children and resolving their problems stemming from war trauma, as well as from their current life situation in the collective centre. They offered support to other team members in carrying out their basic tasks.

- d) Psychiatrists worked with adults in the collective centres. Like other members of the team, they mainly provided psychological assistance to residents of the collective centres. In the case of families whose problems resulting from war trauma were more complex, they offered certain forms of family therapy directly in the settlements. This applied particularly to cases where individual family members were suffering from severe mental disturbances, in which case the entire family had to be given support in dealing with the very complex problems of psychological investment.

- e) Child psychiatrists provided ongoing psychological assistance to children suffering from more serious consequences of war trauma and daily-life trauma. Besides individual approaches, their work also covered the families of children with severe disturbances caused both by war-time events and current adaptive problems. They educated teaching staff about children’s problems and ways of offering assistance to children in schools and other types of educational institutions.

- f) Special education teachers focused particularly on problems related to progress in learning. Since the number of children with speech disorders had increased considerably, impeding their ordinary communication (especially in school situations), special attention was devoted to these children so that, by eliminating communication problems, the achievement of good results in school could be facilitated.

A few words about the population we were dealing with. Managing such a large and complex project was unusually demanding and complicated work. Not only was it necessary to respond to day-to-day changes occurring in the refugee settlements, but we also had to provide support to

team members in their enormous efforts to come to grips with the exceptionally complex situation in which they found themselves. For this reason, we considered it important to get to know the population we were working with in an appropriate manner; not just as individuals, as people we were helping, but also as a collective body, a community. Therefore, we undertook a highly comprehensive survey that included nearly 600 variables for each respondent; besides psychological variables, these also included a number of sociological and anthropological ones. In this part of the paper, we will present the data which we collected in two large refugee and displaced person settlements; these differed in a number of their characteristics. Altogether we interviewed 863 people.

In one collective centre were housed displaced persons from Vukovar and its vicinity. Vukovar is a city in the easternmost part of Croatia which, due to the sufferings experienced by its inhabitants, has become a symbol of this war. We interviewed 442 people from Vukovar in this settlement.

The other centre housed refugees from Kozarac and its surrounding villages. Kozarac is a small town in western Bosnia and Herzegovina, which was inhabited mainly by Muslims. In a certain sense, it served the aggressor as an example to other areas as to how its policy of “ethnic cleansing” would be carried out. We interviewed 421 people from this settlement. In both centres, our teams received great support from displaced persons and refugees, who accepted the team members’ work and tried to offer us the maximum assistance.

## Method

Data were obtained by means of structured interviews led by specialists working on the project for psychosocial assistance to displaced persons and refugees in collective centres. The interviews were completely structured. The protocol consisted of 88 questions. It was roughly divided into nine blocks: 1. general information (age, sex, level of education, characteristics of place of origin, etc.); 2. social origin and economic activity; 3. social status in immediate social environment prior to the war; 4. family relations; 5. traumatic events; 6. general health status before the war and at the time of the interview; 7. mental health status before the war and at the time of the interview; 8. consequences of traumatising experiences; 9. plans for the future.

The respondents were very well acquainted with their interviewers, as this instrument was applied a year and a half after the project for psychosocial support had been launched in the one collective centre, and after a little less than a year in the other, so that questions of trust and making contact did not arise here.

## Presentation of results

As shown in Table 1, the differences in individual traumatic experiences were enormous. Above all, the refugee population had experienced significantly more personal losses, i.e. the loss of loved ones<sup>2</sup>; they had been separated from their children to a greater degree; they had been taken prisoner to a greater degree; they had been exposed to direct attack, hunger and poor weather conditions to a much greater degree and over a longer period of time. Displaced persons had suffered greater

<sup>2</sup> Here we should point out that this refers to the loss of loved ones, not a demographic loss of inhabitants. Since the interview was carried out with each person residing in the collective centre, all the members of a family would mention the loss of a certain person. Therefore, demographic losses cannot be calculated based on the information presented here. The information at our disposal does, in fact, permit this, yet in a different way and not by means of this table.

material losses, and had been subject to interrogation by the enemy forces to a greater degree. Vukovar was the centre of a quite prosperous industrial and agricultural region, with a fair amount of inhabitants who, besides being employed in industry, also owned land and earned extra income from it. This region was certainly more prosperous than that from which the refugees came, and so losses were much greater. The land is highly fertile, and intensive farming enabled a prosperous urban lifestyle. This also meant, however, enormous involvement by the inhabitants, who were engaged both in industrial work in enterprises where they were employed and in industrial farming activities. The latter, due to the type of production involved, could not employ the entire family, as in traditional villages, but rather only those of its members able to drive tractors and operate machinery. Industry in Vukovar, or at least that part of it most important to the city, was based on industrial facilities with a high division of labour and assembly-line production, leading to a maximum degree of alienation among people in the production process. The reason for these respondents' greater level of exposure to the enemy is based on several facts. Before the war the city was a multi-ethnic one. Members of the Serbian army sought to obtain not only the usual military intelligence, but also information concerning the political affiliation of individual citizens.

**Table 1: Traumatic experiences**

		Displaced persons %	Refugees %
1.	Loss of relatives	18.3	34.2
2.	Injury or serious illness	8.8	6.4
3.	Injury or serious illness of a family member	16.7	16.7
4.	Loss or serious damage to real property	72.9	61.4
5.	Loss or serious damage to movable property	78.9	68.0
6.	Loss of very important personal effects	76.7	48.9
7.	Loss of ability to perform a gainful activity	23.3	22.8
8.	Relatives' involvement in armed conflict	30.0	26.5
9.	Separation from small children	8.5	4.8
10.	Separation from other children	11.4	21.5
11.	Separation from parents	12.9	16.7
12.	Separation from spouse	19.2	14.4
13.	Being taken prisoner	14.2	27.6
14.	Experiencing violence to other people	23.7	24.7
15.	Experiencing the death of other people	16.4	16.9
16.	Victim of rape or another form of sexual abuse	0.3	1.1
17.	Witnessing the rape of another person	1.3	4.6
18.	Experiencing direct enemy attack	35.6	46.8
19.	Lack of food over a long period of time	12.1	29.8
20.	Exposure to inhospitable weather conditions	16.5	26.8
21.	Interrogation by the enemy	16.8	9.3

In Table 2 we have presented the psychological problems of our respondents. As may be seen, such problems were found to a much lesser extent among refugees than among displaced persons. Although further investigation of this situation is quite clearly necessary, we believe the structure of a population and its way of life prior to the traumatic events to be the chief cause. The Vukovar population was a predominantly urban one, with a reduced network of social contacts even before the war, due to the manner in which people earned their living. The other group was a village population, which had deeper interpersonal ties before the war as well, and succeeded in preserving those elements of a stronger social network which could help it get through all these difficulties. This is also one explanation for the great difference in losses. When people were asked about the loss of a loved one, a greater frequency of positive answers could be expected in a broader, stronger social network. The next explanation proceeds from the previous one, and relates to the quite different conception of suffering in general and death in particular among a rural population. In the village, relatively far removed from large urban agglomerations, sickness and death are much closer to people than in the city. They occur in the same house where birth and other aspects of life unfold. They are part of a person's reality from the moment of birth, unalienated by medical technology, hospitals, ambulances and other elements of this system. What is much more important about such a conception in our situation is the help which strong social ties provide in the case of loss – immediate, direct, unconditional help. Likewise, the process of mourning is unencumbered by norms pertaining to “maturity”, “adulthood”, and the like. One further possible explanation for this great difference lies in the fact that the traumatic events were differently situated in time for each of the two social groups. Namely, the wartime experiences of refugees occurred nearly one year after those of displaced persons; in other words, displaced persons had had one more year to develop the symptomatology discussed here, but also one more year of this difficult and, for them, unknown and highly risky way of life in the collective centre, which most likely brought with it problems of another kind.

**Table 2: Problems reported by displaced persons and refugees**

		Displaced persons %	Refugees %
1.	Changes in mood during the day	20.8	7.8
2.	Inappropriate reactions (anger, crying, laughter)	10.4	4.3
3.	Loss of faith in others:		
a.	withdrawal	9.8	7.8
b.	rejecting personal contact	4.1	1.1
c.	neglecting personal appearance	0.6	0.9
d.	neglecting personal hygiene	0.3	0
e.	neglecting hygiene in one's living space	0.9	2.1
f.	neglecting family members (especially children)	0.3	1.8
g.	unease at going outside	2.5	2.4
h.	preventing family members from going outside	0.6	1.6
4.	Bodily functions:		
a.	weight loss	6.0	6.4
b.	excessive eating	0.6	3.0
c.	Constipation	2.2	0
d.	diarrhoea	1.3	0
e.	changes in sexual behaviour	0.6	0.5
f.	consumption of alcohol, cigarettes, drugs	8.8	3.4
g.	abuse of medications	7.3	5.3
5.	Sleep disorders:		
a.	insomnia	13.2	14.6
b.	waking up during the night	13.9	9.6
c.	Nightmares	8.5	2.5
d.	waking up unusually early	4.7	0.7
e.	unusually long sleep	1.6	0.5
6.	Changes in concentration:		
a.	preoccupation with one thought	5.7	6.4
b.	inability to concentrate	3.8	3.7
7.	Memory:		
a.	memory problems	4.7	2.3
b.	difficulty in recalling memories	5.0	1.1
8.	Preoccupation with bodily disorders (headaches, irregular heartbeat, pain in joints and throughout the body)	24.0	12.6

As may be seen in Table 3, the great majority of displaced persons were part of an urban population, roughly to the same degree as refugees belonged to a rural population. It should be particularly emphasised that a rather high number of refugees came from rural areas which, in terms of our usual preconceptions of city life, were considerably less developed; therefore, life in such settlements differed more significantly from that of displaced persons from the urban environment of Vukovar. According to the results of our interviews, no less than 26% of the refugee population

had lived in settlements without a sewage system, whereas only half as many displaced persons had lived in such settlements. As shown in the table, 11.6% of refugees had lived in settlements without either a water supply system or sewage system. Interestingly, a slightly higher number of displaced persons had lived in the same kind of settlements before the war. This information also speaks to another fact, namely, the process of social selection that began to unfold in wartime conditions. The data we are presenting here were gathered in a collective centre consisting of a group of wooden barracks, which had served as lodgings for construction workers before the war; that is, they were designed as places for working men to sleep at night. Living standards in these barracks were exceptionally low: the rooms had a maximum area of 16 m<sup>2</sup>, with only one washroom per 100 people; in the settlement where refugees from Bosnia and Herzegovina were housed, some of the barracks did not have their own washroom at all. The inhabitants of both settlements, refugees and displaced persons alike, represented the lowest social strata of the regions from which they had fled. Persons belonging to higher social strata left areas where fighting had broken out before any serious clashes took place, finding housing in urban centres in Croatia and, thanks to their material status, not ending up in collective centres. One sociologist has called this group of displaced persons *predbjeglice* (“prefugees”) (1).

Concerning the urban population and its somewhat greater vulnerability, it should be recalled that the urban milieu and way of life constitute in and of themselves a significant stressogenic factor across several generations. The urban milieu is encumbered by various aspects of social and personal pathology to a greater degree than in rural settings. Analysing risk factors, Breslau et al (4) found that persons in whose families anxiety, depression and asocial behaviour occurred were more exposed to the risk of PTSD than those in whose families such phenomena were not found prior to the traumatic experience.

**Table 3: Type of settlement in which displaced persons and refugees lived before the war**

		Displaced persons %	Refugees %
1.	Small village	0.6	4.6
2.	Village without water supply and sewage system	14.2	11.6
3.	Village with water supply, no sewage system	12.9	26.3
4.	Village with water supply and sewage system	5.7	33.8
5.	Town with less than 5,000 inhabitants	12.9	7.3
6.	Town with more than 5,000 inhabitants	35.3	11.4
7.	Suburb of a large town	7.6	1.6
8.	Regional or provincial capital	5.4	1.1
9.	Other	3.5	0
10.	Missing data	1.9	2.3
		100.0	100.0

No less interesting is the structure of qualifications among respondents. What is most strikingly apparent from Table 4 is the fact that, compared to displaced persons, nearly twice as many refugees had no qualifications, and were basically supported by others (housewives, students and the like). If we leave aside that part of the population made up of students and schoolchildren, which was at nearly the same level in both groups, we may conclude that refugees in our sample had a considerably lower level of education than displaced persons. This difference was especially pronounced at the secondary school level, with nearly five times fewer refugees having an education at this level than displaced persons. This information strongly indicates the rural character of the refugee population that came to Croatia from Bosnia and Herzegovina.

In general, where refugees are concerned, only the lowest social strata end up in forms of collective housing like refugee centres. The higher social strata find much more favourable solutions in such cases of existential difficulty. Lucia Ann McSpadden obtained highly interesting results when analysing the difficulties faced by Ethiopian refugees in the USA. Examining certain elements of their social status, she found that refugees were mainly from an urban background, and were relatively highly educated considering the environment from which they originated. Moreover, these young Ethiopian refugees in the USA primarily came from the families of public officials, professors, teachers and large landholders, while, for instance, only 6.9% of the sample came from farming families (5). We had the same impression before proceeding with this analysis, namely, that refugee camps in Croatia were populated mainly by the lower social strata, while members of higher strata had found better solutions; in the case of refugees from Bosnia and Herzegovina, this most often meant going to a third country.

**Table 4: Respondents' level of education**

		Displaced persons %	Refugees %
1.	Unskilled workers	11.4	6.4
2.	Semi-skilled workers	7.6	1.1
3.	Skilled workers	12.3	9.4
4.	Highly skilled workers	2.8	2.5
5.	Complete secondary education	13.2	2.5
6.	Incomplete secondary education	2.5	0.9
7.	Complete higher education	0.9	0.2
8.	Housewives	24.0	43.6
9.	Schoolchildren, students	22.4	27.4

Table 5 provides information concerning the respondents' occupation and source of income. A huge difference is especially apparent in the case of people who were supported, i.e. dependent on the income of another family member. As is evident from the table, twice as many respondents from the refugee group were supported, i.e. had no independent means of support. If we also include students and schoolchildren (i.e. that generation we expect to be supported) among such persons, then 36.6% of displaced persons fell into this category, while among refugees the percentage was no less than 54.6%.

This great difference was conditioned by the fact that 44.5% of displaced persons indicated regular employment as the main source of income in their families, while only 19.4% of refugees gave the same answer. This means that more than twice as many displaced persons had earned a living by working in a company, an office, or the like. Since such a position carries with it certain other dimensions of social status, particularly social security, this population had a certain advantage in this respect. At the same time, from the point of view of mental health, and especially of the ability to recover from stress, this population was, for that very same reason, more exposed to such problems. It is known that industrial work alienates one person from another to a great degree, diminishing and weakening a person's social contacts, reducing them to purely instrumental ones and thus increasing his or her vulnerability. This population was, however, typical of Slavonia in that, alongside regular employment, people maintained strong ties with the villages surrounding the urban centre. Most of the inhabitants either worked their own land together with their regular jobs, or helped out on farms owned by their parents or other close relatives who lived in the vicinity. However, agricultural production in the area where the displaced persons had lived was substantially different from that found among the refugees. In the former case, agricultural production was mechanised and industrialised, with manual labour playing a relatively small part, and with particularly little need for forming any ad hoc community to perform more extensive tasks. Refugees, on the other hand, came from an area with a more traditional kind of agricultural production, requiring greater manual labour and stronger ties in carrying out larger tasks. In this way, social networks in such areas are constantly strengthened, and these networks are then carried over into the refugee camp, retaining a much greater supportive capacity. Lindeman (6) found that stress reactions are tied to the demise of those institutionalised support functions which a person acquires in a certain society.

The most profound difference between these two populations proceeded from the great variance in their economic dependency. For it is this which created the basic differences in the lifestyle of each population. Most employed persons in the refugee population worked outside their family's place of residence. Many of the men had been employed by Croatian companies before the war, and a good many of them still are today; the majority of them, in fact, by the very company which owned the barracks in which the refugee camp was set up. Before the war these men returned home only occasionally, once or twice a month, to visit their families, staying with them for a longer time outside construction season (in winter). Some of them had worked like this for up to twenty years, and it is one of the paradoxes of the collective centre that certain families only began to learn to live together more intensively in this refugee settlement.

**Table 5: Pre-war means of livelihood of respondents or their families**

		Displaced persons %	Refugees %
0.	Unknown	2.8	2.9
1.	Regular employment	44.5	19.4
2.	Garden plot	1.3	1.6
3.	Field, vineyard	6.3	5.7
4.	Tourism, fishing	0.3	0
5.	Private enterprise	0	0.5
6.	Social welfare	1.9	0.9
7.	Pension	2.5	3.4
8.	"Funds from abroad", e.g. from children	0	1.4
9.	"Moonlighting", occasional work	0.6	0.7
10.	No income	3.2	8.9
11.	Supported by spouse, housewives	10.4	23.1
12.	Schoolchildren, students	26.2	31.5

The next three descriptions of the populations examined here likewise illustrate the differences between them quite well, in particular differences in their way of life, which certainly also profoundly affected their ability to cope with the problems brought by the war.

**Table 6: Did the respondents or their families own land?**

		Displaced persons %	Refugees %
1.	Arable land	59.3	96.8
2.	Orchard	52.1	36.1
3.	Vineyard	45.1	4.3
4.	Pasture	4.7	25.8
5.	Forest	48.9	38.4
6.	Garden plot	68.8	45.9

Table 6 gives us an answer to the question of whether the respondents or their family members owned land. A striking difference is evident here between the displaced persons from occupied parts of Croatia and the refugees from Bosnia and Herzegovina whom we worked with in the collective centre. Nearly 100% of the refugees gave a positive answer to this question, while somewhat less than 60% of displaced persons did so. This quite clearly points to a corresponding difference in lifestyle among these two populations prior to their traumatising experiences. Displaced persons more often owned garden plots suitable for small-scale cultivation and production, as a supplementary form of income for a population which, in the main, earned its living from industry.

**Table 7: Did the respondents or their families own livestock?**

		Displaced persons %	Refugees %
1.	Cows, oxen	23	77.2
2.	Small stock	30.9	34.1
3.	Poultry	35.3	76.3
4.	Horses	9.5	17.6

Table 7 informs us as to whether the respondents or their family members, with whom they lived together in a single household, owned domestic animals. We asked this question because ownership of domestic animals, particularly those which serve as a source of income through the sale of surplus products, strongly characterises the lifestyle of a given population. Here, too, there is a striking difference between displaced persons from Croatia and the refugees. In nearly 100% of all cases, refugees responded that either they themselves or the household they lived in had owned domestic animals. This difference is especially significant in the case of large stock such as cows, as such animals characterise a family's agricultural way of life. If we now recall the data concerning land ownership, the difference between the two populations again becomes apparent. The fact that 59.3% of displaced persons answered that they or the household in which they lived had owned land appears quite differently in this light. Since only 23% of them stated that they had owned livestock or lived in a household that owned livestock, this probably represents the dividing line which, in the case of displaced persons, separates the agricultural and non-agricultural parts of this population. For the type of agriculture predominantly practised in this region before the war, livestock was a necessary component of a farm household. Thus that other part of the population, which merely supplemented its household budget through income from farming, did not include all segments of the "farm household". Naturally, the "farm household" in the full sense of the term, meaning all the essential segments of life connected with agriculture, determines the basic differences in the lifestyle of a population.

**Table 8: What sort of equipment did the farm household own?**

		Displaced persons %	Refugees %
1.	Stable for livestock	30.0	74.2
2.	Storehouse for grain	23.7	54.1
3.	Storehouse for machinery	23.7	40.2
4.	Storehouse for hay	26.8	51.1
5.	Fishing equipment	13.2	4.6
6.	Tractor	14.8	14.4
7.	Tractor attachments	14.8	13.9
8.	Combine, thresher	1.9	3.0
9.	Tools	44.2	69.4
10.	Workshop	21.5	27.4

Table 8 provides information about the equipment of farm households. The level of use of tractors and tractor attachments is similar. Nearly the same percentage of people in both collective centres gave the same answer to the question about owning a tractor. There are several possible ways of interpreting this information. First of all, the actual number of tractors was smaller among the refugee population, as households in this population were substantially larger, so that a larger number of persons could give the same positive answer. This is only apparently in contradiction with what we stated earlier regarding the type of household. For a larger number of tractors and, especially, the difference in tractor attachments points, in fact, to the dual nature of households among displaced persons, who required more machinery in their agricultural activities. Moreover, the area from which displaced persons came was characterised by intensive industrial-type agriculture, with much less physical labour in the field, as well as much less intensive involvement by most or all members of the household.

The area of Bosnia and Herzegovina from which the refugees came had a very high pre-war rate of economic migration, with many people employed in Croatia and in other European countries. These people had purchased farm machinery with the aim of more intensive future development of their households. The process of acquisition was still under way; the process of return on such investment somewhat less so. In this process, the purchase of agricultural machinery had, apart from its economic function, a symbolic importance as well. The equipment found in farm households indicates that the refugee population had a predominantly agricultural orientation.

In this environment, women, as important factors in a family's economic activity, many of whom lived without support from an employed husband (whose place of work was often quite distant from his place of residence), had to create strong and highly specific social networks in order to realise their role as mother and chief producer in agriculture-based economic activities. When hostilities began, these women had to maintain their role as the factual head of the household, carrying responsibility for the entire family on their shoulders. Many of their husbands were not in their villages when the fighting started; a number of them, in fact, were residing in the very settlement where we carried out our survey. In our view, this specific situation was also one of the highly important factors which spared this population from a tragedy such as that which struck the urban population to which we have been comparing it here.

## 1.2. Observations from the Programme for Assistance to Pregnant Women and Mothers with Children up to the Age of 12 Months

Milivoj Jovančević

- In order to successfully implement the assistance programme, it is necessary to monitor the population's characteristics on an ongoing basis and adapt the modalities of the work as needed.
- In our programme, a population of 1,521 infants was studied to determine the impact of war trauma and refugee life on the early mother/child relationship and infants' corporeal and psychomotor development. The majority of this population came from villages and smaller towns in northern Bosnia and the Unsko-Sanski Canton. Here we present the most important observations, believing them to be of general significance and applicable to the mother/child relationship in other populations. The indicators presented form the basis for planning assistance programme activities.
  - 13.8% (or 210) of the children were housed in collective centres, while the rest were in one or another form of individual accommodation. A dysfunctional family environment was found in 8.3% of the families, while an atmosphere of tension was found in 4.3%, and 0.5% of the families were on the verge of break-up.
  - Compared to individual accommodation, staying in a refugee camp had a protective effect on the early mother/child relationship, probably due to the systematic care being provided by government and non-governmental organisations at the time.
  - The predominant psychological problems among mothers were emotional difficulties (47.4%), adaptive difficulties (12.7%), lack of self-confidence (12.2%), difficulties in becoming independent (8.3%), lack of self-respect (6.9%) and PTSD (6.5%). A tendency toward depression was found in 14.6% of mothers. In the period immediately following the traumatising events (1996) the percentage of mothers with PTSD was 8.9%.
  - Mothers who experienced personal injury or a serious illness in connection with wartime events more frequently interpreted the emotion shown on children's faces in the IFEEL test as fear, and considerably less often as anger or interest (7).
  - Mothers who had witnessed some form of violence against other persons, or had themselves been captured or interrogated by the enemy forces, less frequently interpreted the child's emotion as emotional passivity (7).
  - Mothers who were forcibly separated from their young children due to wartime events, and at the same time were exposed to extreme hunger over an extended period of time, more frequently evaluated the child's emotion as surprise and pain (7).

- Mothers were divided into three groups according to their wartime experiences: those who were injured themselves, those who witnessed violence against others, and those who were forcibly separated from their young children. The predominant emotions projected via interpretation of the IFEEL test were pain, fear and surprise. It may be said that, as a group, women whose life experience has been marked by violence will not choose passivity to describe the child's feelings (7).

- In examining the group of mothers with emotional difficulties connected with a lack of self-confidence and self-respect, more frequent expressions of joy and sadness could be noted. Emotional problems, combined with a lack of self-confidence, were frequently connected with an evaluation of the emotion as anger. Psychotic mothers and mothers with PTSD more frequently evaluated the emotion as fear, and considerably less often as interest.

- Mothers' relationship toward their children is already reflected during pregnancy. 19.5% of the respondents did not have a check-up, while another 54.6% had a check-up only once. The majority of mothers were more unworried than worried during pregnancy, and showed a greater tendency toward positive than negative feelings.

- Of the 492 mothers who had already stopped nursing their babies at the time of the survey, 42.3% stopped during the first month after birth, while three quarters of them (76.2%) stopped during the first three months. Adolescent mothers nursed their babies for a considerably shorter time.

- Anaemia during the nursing stage appeared most often among children who were nursed for 2 or 3 months, and least often among children who were nursed for 4 to 6 months. Statistically, the lowest frequency of Vitamin D prophylaxis was found among the group of children who were nursed for one month and the group nursed for 2 or 3 months. A longer nursing period and regular prophylaxis of anaemia and rickets reflect the quality of the early mother/child relationship; when these are present, the risk of neglect and other disorders in this relationship is reduced.

- With regard to harmony in interpersonal communication, it is important that a mother understand the messages a child is sending, that she understand and satisfy the needs expressed. Mothers with a higher level of formal education and greater knowledge of child development achieve more successful communication with their babies, and neglect them considerably less. In the survey population, 10.7% of mothers generally did not know why their baby was crying, while 15.6% stated that caring for their child was fairly difficult. 8.2% of mothers did not communicate spontaneously with their children at the time of the survey; rather, they behaved indifferently toward them.

- A low level of familiarity with the elementary facts of normal child development (when children begin to sit, speak and walk, what kind of milk is best for a child) was found in 27.5% of mothers. Adolescent mothers were significantly represented in this group. Mothers who tended to feel poorly or worried during their pregnancy had a lower level of knowledge about child development. Mothers residing in the collective centres had a considerably higher level of such knowledge. Mothers who came from small or underdeveloped villages had a lower level of knowledge about

child development. Mothers with a better knowledge of children's developmental needs understood better why their babies cried, and neglected their infants less.

- Adolescent mothers (up to the age of 19) represented one particular risk group, due to a considerably higher frequency of disorders in communication with their children, symptoms of neglect, a lower level of knowledge of children's developmental needs, failure to bring their children in for medical examinations and administration of Vitamin D, more frequent skin infections in their children, and poorer vaccination records. Such mothers represented 9.3% of the respondents.

- Mothers with pronounced symptoms of PTSD and a tendency toward depression tended to nurse their babies for a longer period of time. Conversely, children who were nursed for a shorter time showed more initiative in making contact with their mothers. Mothers who nursed their children for a shorter period of time also took their children in less often for regular Vitamin D prophylaxis of rickets and preventive check-ups.

- Compared to illness levels in peacetime, there were considerably more frequent incidents of skin infections and chronic diarrhoea among the infants surveyed. The frequency of respiratory inflammations, anaemia, and parasitic illnesses did not markedly differ from their incidence in peacetime conditions.

- Mothers who smoked more often neglected their personal hygiene, their children's hygiene, and hygiene in their living space; they also more frequently had husbands who likewise neglected their hygiene. Children of mothers who smoked suffered more frequently from respiratory illnesses. Considering all of this, smoking could be considered yet another indicator of a disturbance in the early mother/child relationship in the population surveyed.

- Infant neglect reflects a deep disturbance in early ties between a mother and her child. The most reliable indicators of this disturbance are neglected hygiene in the mother and/or child, overprotection of the child, failure to recognise the reason why a baby cries, and failure to ensure that the child receives regular medical examinations. Mothers in this group showed more frequent symptoms of PTSD, adaptive difficulties, difficulties in becoming independent, emotional problems, and a lack of self-respect and self-confidence. Adolescent mothers were frequently found in this group. They showed a considerably more frequent incidence of inadequate and poor communication with their babies, while their children had a poor vaccination record and no administration of Vitamin D, and suffered more often from anaemia, chronic diarrhoea, skin infections and respiratory inflammations. This confirms the practical value of these indicators of disturbances in the early mother/child relationship in everyday activity by specialists working with small children and their families. The presence of any of these easily identifiable indicators should serve as a clear warning that immediate attention must be given to the relationship between a mother and her child, in order to investigate the causes of the disorders indicated.

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# **Theory of the Early Parent-Child Relationship**

## 2.0. Theory of the Early Parent-Child Relationship

Milivoj Jovančević

### 2.1. Introduction

The special nature of early connections between mother and infant is described by Freud (1940) as “unique, without parallel, established unalterably for a whole lifetime as ... the prototype of all later love-relations” (1). However, it is only in the past thirty years that these relationships have become the subject of systematic research and it is in this period that the attachment theory has emerged. This theory has been one of the most significant steps forward in modern developmental psychology. In effect, it soon began to be reflected in the areas of child psychopathology (2), social policies connected to the care for the youngest of children (3), and legal sciences, whose aim is to achieve the greatest possible understanding of the child’s psyche and the satisfaction of her needs.

As we are dealing with processes which take place during a period when the cognitive abilities are extremely low (“the child understands nothing”) and which do not remain part of our permanent memory, it is not easy to understand how the events in this period have a pivotal role in the development of personality. These events take place almost exclusively on the affective level, at a time when the child is extremely sensitive and does not have any protective mechanisms in place; they take place at a time when the child’s existence depends on the love and assistance she receives from others. Any misbalance in the communication with the environment (with the person to whom the child is attached) leads to disturbances in the process of building self-awareness and awareness of others, in the process of becoming aware of the way to experience one’s own being and that of the people around, and in the process of becoming aware of what makes successful communication. The greater the number of illogicalities (misbalances) in communication, the deeper the disturbances in development.

Attachment can be defined as an ongoing emotional relationship which bonds two individuals. In the non-scientific context, this is called love. It is observed as the tendency to seek closeness and contact with another person, especially when the person is exposed to stress. Protection and providing a sense of security have deep roots in the earliest childhood and, according to scientists active in the field of evolutionary biology, they have an important role in the preservation of the species. That is why attachment can be discussed from the aspect of developmental psychology, evolution and object-relations theory.

## 2.2. Attachment theory: basic principles and theoretical development

### 2.2.1. Attachment

Most psychologists agree that attachment can certainly be observed at the age between 6 and 8 months. Although the process of attachment begins at the moment of birth itself, it is only at the mentioned age that the child produces responses to her mother which are different in terms of quality. As we have already mentioned above, ethologists have developed the most comprehensive attachment model. Bowlby concentrated on the phase following the 9-month milestone, when the child's attempts at remaining in physical contact with her mother become apparent (5). He introduces the term "attachment behavioural system", which describes the structure of behavioural patterns in attachment. Individual activities of the child and the mother, which on the surface might appear different, are all centred on the same purpose, which is to nurture the child's sense of security and protectedness. The appearance of attachment patterns in the third-quarter of the first year of life is closely connected to emotional and physical development.

During this period, the sense of fear prevails over all other emotions. With the development of memory and the child's cognitive functions, the child begins to recognise the unknown and the new, and the child's reaction is mostly negative. Around 8 months, a fear of strangers emerges, which is why the child cries and seeks her mother's protection (6). Separation from the mother causes separation protest in the form of crying and looking for the mother. Fear of strangers and the separation protest are indicators that attachment has been established. One of the most significant indicators of attachment is the way in which the child's distress lessens in the presence of her mother. A scared and quivering child soon calms down in the presence of her mother. As soon as the child feels the security the mother provides, she is ready for further exploration. Mother serves as a secure shelter to which the child may run should a new fear arise.

At 6 months, most infants begin to crawl. This progress marks a milestone, because the child is now able to better control the place where she is located. The progress is also reflected in the attachment process; the infant no longer depends on crying to seek the closeness of her mother, but is able to crawl to her and follow her around.

Fear of strangers, protests during the period of separation from mother, and bursts of audacity and the feeling of security while mother is present all indicate the full development of attachment.

### 2.2.2. Maternal bonding

The emotional relationship between mother and child does not develop simultaneously in both directions. Although the baby starts to show the first signs of attachment only after a few months, the mother becomes emotionally attached to the child at childbirth. Maternal bonding is mostly described as a process involving both biological factors and those based on experience. Immediately after childbirth and in the ensuing days, hormonal changes take place which make the mother very prone to the establishment of an emotional connection with the newborn. In this sensitive

period, (skin-to-skin) contact between the mother and the newborn triggers maternal bonding. This theory is confirmed by research showing that mothers whose newborns were in contact with their skin immediately after birth, or mothers whose children had more frequent contacts with them in the early postnatal period, show more emotions later when their children are in the infant period. Consequently, the conclusion is that a closer emotional connection was achieved later, in the infant period (7, 8, 9). Modern hospital programmes are being developed based on this knowledge (UNICEF's Baby Friendly Hospital programme is one of them). In these hospitals, physical contact between mother and child takes place immediately after birth and it is later possible for the child to stay with her mother. However, subsequent scientific publications contain methodological objections to the first study (10, 11). Most subsequent studies do not confirm the described importance of maternal bonding (12), because strong attachment can also develop in children who have not had such early contact with their mother, e.g., adopted children. Early contact is only one of many factors that contribute to the emotional reaction of the mother to the baby (13).

Following Bowlby's model, in 1969 Mary Ainsworth prepared an experimental model called the Strange Situation Procedure, which monitors the intensity and quality of attachment (14). It involved laboratory research of 12-month-old children and was based on the presumption that attachment can be evaluated best only when the child is in an unknown or stressful situation. The degree of attachment is evaluated by monitoring the reactions of the child who is exposed to a series of structured episodes involving the mother and a stranger.

The Strange Situation Procedure has 8 episodes. In the 1st episode, the observer introduces the mother and the child into a room in which there are several chairs and toys which should encourage the child to explore. The observer leaves the room. The observers are located behind a screen. Everything that happens is recorded with a camera for further analysis. In the 2nd episode, the mother is alone with the child, she is passive, and the child's interest in toys is monitored for a period of 3 minutes. If the child fails to show spontaneous interest in the toys within 2 minutes, the mother encourages her to do so. In the 3rd episode, a stranger enters the room. During the first minute, he is passive, during the second minute he communicates with the mother, and during the third he approaches the child and tries to engage the child in play. In the 4th episode, the first separation occurs; the mother leaves and the stranger stays with the child for 3 minutes. The duration of the 4th episode may be shorter if the child shows signs of severe distress. In the 5th episode, the mother returns; the stranger leaves. The reaction of the child to her mother's return provides observers with the greatest amount of information. The episode lasts at least 3 minutes, during which the mother comforts the child and tries to make her interested in the toys again. In the 6th episode, the second separation takes place; the mother leaves, the child remains alone for a period of up to 3 minutes, depending on the degree of distress. In the 7th episode, the stranger enters and tries to communicate with the baby for a period of up to 3 minutes. In the 8th episode, the mother appears once again, greets the child and then picks her up. At the same time, the stranger leaves the room unobtrusively. The 8th episode lasts 3 minutes.

By implementing the Strange Situation Procedure, Ainsworth and associates define 3 patterns of attachment in the way one-year-olds respond to short experimental separation from parent: 1) secure, 2) anxious-avoidant, and 3) anxious-ambivalent.

About 65% of the children were classified as securely attached. In the preparatory episodes, the children show interest in the toys and after their mother's departure show signs of distress, while on her return they show happiness. The parents are quite sensitive and responsive to the overall spectre of their child's affective signals and they have a more comprehensive view of the attachment they enjoyed in their own childhood. About 25% of the children were classified as anxious-avoidant. They showed mild signs of distress at separation and, when their mother returned, they tried to avoid her. The lack of distress at separation and the continued play (independence in behaviour) might seem positive at first glance, as well as the fact that their mother's departure did not seem stressful. However, here we are talking about a way of dealing with stress where the child diverts her attention from the information telling her that her mother has left (15). More frequently than others, the children from this group have bouts of anger (which they show by pressing their lips together) (16), while their mothers show hidden signs of non-acceptance (17, 18, 19). About 10% of the children were classified as anxious-ambivalent. These children show signs of distress throughout the testing process, especially during the separation period, and, after their mother's return, they show a mixed feeling of relief, because she is back, and anger aimed against her. The raised level of distress and anger can be explained as a strategy by which the child tries to obtain a response from a less sensitive parent through the excessive show of attachment patterns (20). The mothers of children who are anxious-ambivalent are less sensitive to the child's crying (21, 22, 23), they rarely initiate communication in a face-to-face position (24) and they are less likely to comfort the child by taking her in their arms, as they prefer to comfort her by speaking to her or by touching the child lightly (25). These mothers are often dissatisfied with their own parents, and they are preoccupied with these problems and with their conviction that they cannot live up to their parents' standards (26, 27).

A 4th subtype has been identified only recently - the disorganised/disoriented pattern of attachment (28). The children which belong to this style of attachment have no consistent response to the need to receive comfort and to the feeling of security while under stress. This pattern of attachment is characterised by different combinations of reactions from the first 3 types of attachment, as well as by atypical reactions (end of motor activity, slowed down movements). The families of these children have often experienced trauma, death or psychopathology (29, 30, 31). The parents also frequently suffer from unresolved trauma or loss accompanied by overwhelming emotions (32, 33, 34).

## 2.3. Mother-baby Interaction

Pregnancy and birth are the beginning of an ongoing interaction between mother and baby, which involves intersubject communication (Stern, 1985) and which develops in a way that is dependent on the perceptive, cognitive and motor abilities of the child (35). In most primates, the early postnatal period takes place in an environment which mostly consists of the mother's body. Clinging to the mother, the infant becomes acutely aware of tactile, kinaesthetic, auditory, visual and olfactory stimuli coming from her. The infant can respond to some of the stimuli immediately after birth. As the baby grows, the mother's body becomes her first toy and she spends a lot of her awake-time by examining it. The way in which the mother holds her makes it easy for the baby to come to know her. The mother likes to look at the child's face and she does her best to make the infant look at her. When the baby is pressed against her breasts, the mother's face is at an optimum distance for the child to see it clearly (let us remember that infants are near-sighted and that they can see clearly at a distance of about 25-30 cm). As far as the auditory stimuli are concerned, there is evidence that children who listen to the heartbeat gain weight more quickly. This could be an explanation for the parents' preference to carry their babies against their left side rather than against their right. Regarding mammals in general, and man in particular, the signs of distress are quite pronounced. One of the strongest signals which mobilises all maternal resources is the cry of the baby. In the case of hunger, it gradually progresses from arrhythmic, gentle cries to loud and rhythmic ones. In the case of anger, there is a similar pattern, but the gradual nature of the cries is less prominent, while in the case of pain there is a sudden scream which is followed, after a brief pause, by a series of shrilling cries accompanied by pained grimaces.

### 2.3.1. Affective development in the mother-child relationship

Ever since Winnicott made the already mentioned statement postulating the significance of the mother-child dyad as a distinctive whole, the development of the child has been increasingly monitored in the context of the family. Family is the basic unit where emotional development takes place. On the other hand, the child's emotional development has a central place in the infant's mental health, which is why it will now be discussed in the context of family relations.

Although there are great differences between families and the content of family life, certain common characteristics and rules can still be defined. What is common is the circle of life, the circle of death and birth. Although at first glance it could be concluded that it is a linear process (birth - ageing - death), the life of a family mostly consists of cyclic processes. In order for the processes to be fully covered, the family is defined as a community consisting of three generations (36). Although today it mostly consists of 2 generations, the first one, the oldest one, has a significant role in the dynamics of the child's development. The first generation (grandparents) transmit their family experiences from the past, set traditional family standards, talk about roots. At the same time, in addition to this kind of retrospective contribution, the parents (the 2nd generation) bring their vision of the future and begin a new time cycle in the life of the family. These projections cross paths frequently and, not rarely, are the source of conflict. The family model set in this way, in addition to transgenerational transmission, is a good framework for numerous processes that are called the content of family life.

### 2.3.2. Early affective connections between child and father

In many societies, it is traditionally considered that the care and feeding of the baby are the duty of the mother. Because of the quantity of time that the mother spends with the child, biological predisposition, as well as the closeness of contact, the mother and child form attachment. Even Winnicott (37) holds that the immediate influence of the father on the psycho-social development of the child develops well after the development of attachment with the mother. It was believed that at the earliest age of the child the father has an impact on the child only indirectly, by offering love and support to the mother. In comparison to mothers, fathers spend much less time with their baby, even in situations where both parents are at home (38). According to popular belief, men do not have enough skill and sensibility to care for the child (study on men from the USA) (39). According to these interpretations, the mother is the only stable object of attachment (40), thus confirming the opinion that the role of the father is relatively unimportant (41).

Further research has shown that the child attaches independently both to the mother and the father (42). Children who spend more time interacting with their father develop the secure type of attachment and have less likelihood of developing behavioural disorders (43). Children whose mothers spend more than 20 hours per week outside the home due to work are at an increased risk of developing the insecure pattern of attachment with the mother, but if the father takes care of them while the mother is away the secure type of attachment is the one to develop more frequently (44). The more time the father spends in close contact with the baby, the more signs of closeness and attachment the child will show (45). In the presence of both parents, only a little more than half of the babies show more inclination to the mother (46). Nonetheless, in stressful situations a large majority of children turn to their mothers (47). Consequently, the last few years have seen the development of programmes aimed at helping fathers to be more successful in adapting to the way children communicate and feel. The programmes endeavour to change the stereotypical role of the father in the process of care and upbringing. By verbalising their role, fathers who participate in the programmes increase awareness of their own psyche and of their ability to interact with the child. Psychologically, fathers become more flexible, thus reducing the possibility of the transgenerational transmission of negative patterns of attachment (48).

Fathers have more extensive interaction with the child at a later stage, less in activities involving care and feeding, but more in play and physical contact (they play more frequently with their male offspring) (49, 50). Most frequently, fathers play with babies whose age ranges from 2 weeks to 6 months by moving their extremities. This type of play can be found in 70% of the games involving the father, but in games involving the mother in only 4% of the games (51). The mother spends an equal amount of time with both her male and female children, while from the very moment of birth the father spends much more time with his baby boy. The older the child, the greater the divide. It is believed that in this way, based on social and cultural norms, children learn the patterns of behaviour for their gender (52). It also seems that fathers contribute more to the cognitive development of their sons than do mothers. Five- or six-month-old baby boys seem to be more cheerful, curious, alert and happy if they spend more time in contact with their father (53). The cognitive development of boys from fatherless families lags behind that of male children coming from families with both parents (even when the mothers have the same kind of approach to the

child) (54). However, the impact of negative social and economic factors that go along with single-parent families should also be borne in mind.

The father's pattern of interaction is quite different from the mother's. Data collected in longitudinal studies show that the matter at stake is not only an increased repertoire of stimuli available to the child, but also the specific contribution of the father, the contribution that babies recognise and need (they frequently request it directly, quite aggressively). Close connections with the father do not disturb the child's attachment to the mother (55).

### 2.3.3. Regulating emotions in the infant-parent relationship

Research of the early relations between child and parent, conducted in the 1970s and 1980s, shows the pivotal role of parental responsiveness to the signals sent by the child. Parental responsiveness is the foundation of parental influence on the cognitive, linguistic and social development of the child (56, 57). The capacity of the mother to receive signals and to provide adequate answers is a constant, although in the first three years of the child's development the complexity and the demanding nature of the signals increase dramatically (58, 59, 60, 61).

Fundamental knowledge about the role of responsiveness and the provision of adequate answers finds its place and further development in the organised structure of social interactions represented by attachment relationships (4, 62). The organisational model of the attachment theory (4, 63, 64) gives the most comprehensive overview of the functioning and development of relations between parent and child in the first three years of life. Another group of studies moves towards detailed monitoring of the dynamics and richness of the exchanged emotional contents between parent and child and their effects on the developmental changes which occur in the sphere of regulating the child's emotions. Turning to emotions and to processes of self-regulation gives the opportunity to detect early indicators of conflict, self-defence and disorders in the adjustment process in early social relations.

The psychobiological theory, which also deals intensively with the study of emotional interactions between parent and child, finds biological regulation in all close ties. Thus, in the mother-infant relationship there is mutual physiological regulation (meeting of physiological needs, adjustment of physiological functions, such as milk production and sleep patterns) (65, 66). The regular meeting of physiological needs and the achievement of harmony in the offer and demand process instils in the child a fundamental feeling of security and represents the earliest form of the secure type of attachment (67). Experimental work has proven the influence that the caregiver's responsiveness has on the organisation of functions (the establishment of the feeding and sleeping rhythm) in the very first days of life. Programmes whose aim is to help parents solve the problem of their babies not sleeping through the night and night-feedings (68) are founded on the basics of the responsiveness mechanism.

After 2 months of age, the infant reaches the level of development where she has substantially more intensive social communication. At this age, most contacts between mother and child take place "face to face" (feeding, changing, playing), thus opening new ways of communication. In these relations, it has been observed that both mother and child make efforts to adapt their behaviour to the behaviour of the other (69, 70). The better (or, rather, the more capable) the mother is at

adapting and responding to the behaviour of the baby, the more successful the baby is at responding to the mother's signals. Basically, this is affective attunement. From 3 to 9 months, the degree of attunement between mother and baby gradually grows (the adequacy of response to the signal). Frequently-repeated successful experiences become internalised, are remembered, and enable the anticipation of reactions at the next communication of the same type. Recognised and remembered experiences contribute to the development of the self and to the differentiation of one's own being from the environment (71). As the child makes advances in the sense of her psychomotor skills, and as the number of communication experiences increases (in both participants), the percentage of successful responses grows and the time for finding them diminishes. In the beginning, there are mostly inadequate answers, followed by a correction - a different answer. In this process, the child learns how to adapt her activities in order to find the desired answer. This introduces dynamics in interactive communication, and the child learns how to repair her mistakes and how to boost the efficiency of her signals (72).

The microanalysis method is used relatively frequently in analysing the development of early mother-child interaction. The method involves simultaneous video-recordings of both the mother's and the child's activities. A simultaneous projection of the two recordings (frame by frame) and a minute analysis disclose subtle ways of communication between mother and child (73, 74).

Although affective states can be expressed in several ways - such as by gesticulation and vocalisation - most knowledge about early emotional development is based on observing the baby's facial expressions (75). When still a newborn, the child has the motor skill to make almost all grimaces which characterise particular feelings (sorrow, anger, disgust, fear, happiness, interest, surprise) (76). However, the role of these grimaces is still unclear, considering that they are not related to the context of the environment. Meltzoff and Moore conducted a series of research studies in which, by analysing video-recordings, they showed that the newborn is able to mimic grimaces made by the parent (opening the mouth, sticking out the tongue, pressing lips together) (77). As expected, these observations have encouraged many other researchers to try to confirm and explain the origin of this strikingly discrepant result in view of the child's age. In trying to explain the nature of this phenomenon, ethologists conclude that this is not imitation *per se*, but a complex process of receiving and processing stimuli and creating a response. True imitation involves processes which appear only in later emotional and cognitive development. That is why imitation in the first days of one's life is regarded as an innate reflex where a particular movement by the parent triggers a similar movement in the child. Other newborn reflexes are also based on the same mechanism: a specific stimulus triggers a corresponding innate reflex. It has been observed that it is only after 2 months of age that the child begins to communicate as part of a context. It is presumed that the undeveloped cognitive functions do not permit recognition of external events and the manner in which they are reflected in one's own emotions (78). Immediately after birth, by firmly looking at her mother's face, the child may show her mother signs of being interested, which just illustrates how well the evolution has stimulated the development of social interaction between mother and child. With another innate expression, one of disgust, the child tries to inform her mother that something is wrong with the feeding process (79, 80). At the age of 3 or 4 months, there is a smile as the child's response to the mother's voice or movement. The smile may also be seen earlier, in

sleep, but this is not connected to outside stimuli (81). The expression of anger or sadness can be observed between 3 and 4 months (82, 83), and the expression of fear at 7 months. More complex patterns of showing emotions, such as shame and shyness, appear only after the first year of life.

According to Trevarthen (84), children from their very birth have the innate ability to show their emotions and the intrinsic motivation to establish affective communication. In line with this, Trevarthen calls the first few months after birth the period of “primary intersubjectivity”, thus trying to emphasise the processes of organising communication potentials (opening communication channels, the ability to recognise received emotions, their processing and rejection). The ability to connect individual emotions and to express them through an adequate differentiated movement, sound, look, and similar, develops gradually. After this mechanism is established, in the next phase of development (2-6 months), it is put at the service of interactive communication with the mother and with the gaining of adequate responses (satisfaction of the child’s own needs). At 6 months, the child already has plenty of experience and has installed in herself a number of communication (behaviour) patterns with her mother and developed the ability of anticipation when she encounters what has previously been experienced. The motor and cognitive capacities which put the child in a relationship with other people and experiences increase simultaneously; the child is led into a situation which involves unknown things and insecurity. In this phase of maturation, the child seeks an interpretation of the situation from those close to her (mother, father) and instructions on how to behave. This process is called social referencing (85). In the process of learning and interpreting certain events by social referencing, parents instruct the child in advance on how to act further. Since in the previous phase (2-6 months; face-to-face communication) the child has learnt the affective expressions of the mother quite well, she is now able to define herself towards the unknown in advance. In this way, she learns where danger or pleasure lies. The ability to interpret the facial expressions of people in the immediate vicinity when determining one’s own behaviour and expressing one’s own emotions is established at the end of the 9th month of life (86). The affective relationship of the parent to certain objects and situations must therefore be reflected in the child’s relationship to the same. When the parents mostly have a careful (apprehensive) outlook, the children approach new objects and situations less frequently. On the other hand, children whose parents have a positive, free approach, accept the new gladly. Past experiences remain permanently built into us and they emerge later in life when we encounter the object again (87). The next phase (between 9 and 12 months) is called the period of secondary intersubjectivity (88) and is characterised by the ability of the child to exchange an emotional experience with another person and to pay shared attention with such a person to a jointly observed object (joint attention to the object) and to determine her place and role in the outside world. The child’s desire to share some experiences may be seen in those moments where she seeks company in the contents that occupy her attention (play, cartoons, etc.).

These processes serve to build the capacity to recognise (understand) one’s own and other people’s emotions, express one’s emotions appropriately and at the right time. These qualities are part of emotional intelligence which later in life enables people to function and communicate successfully. Emotionally intelligent people can postpone the satisfaction of their own needs, be kind, cooperate with others and have a positive attitude (optimism). Research has shown that emotional intelligence is more important than cognitive intelligence for success in life.

Creative anticipation - the child's feeling for her developmental potential, her faith in her abilities and her future - is one of the basic drives (stimulators) of psychomotor development. The child has the feeling that she can do anything, the child is not aware of her limits or those imposed by the environment. Exploration of the surroundings and of the child's own abilities is still to follow.

At about one year of age, the child gradually detaches from her mother. Less dependant and more mobile, the child begins to investigate her surroundings and her own abilities. Moving away from the mother becomes increasingly longer and frequent, but the child knows the mother is always somewhere near. Even when she is not close (e.g., when the mother begins to work), the child knows that she takes care of her. At this age, children usually have an object which they always keep with them, which they take to bed with them and which they use for comfort (a toy, a piece of cloth, a pacifier). This is called a transitional object, a substitute of sorts for her mother. It is always there when needed and helps the child go through hard times when mother is not around.

The failure of the mother in affective attunement results in inadequate and unsynchronised responses to the child's messages (needs). Such failure disturbs the internal organisation deeply; it makes the creation of self and the interpretation of signals from the environment more difficult. Such children have disorganised behaviour, both towards the mother (89) and their peers (90, 91). Children who do not receive adequate responses from their mother and who consequently do not satisfy their affective needs use internal mechanisms of protection in order to subdue the feeling of unease. The infant can then activate several patterns of behaviour, such as self consolation (turning the head away from the sight that has caused discomfort, thumb sucking), auto-stimulation (rhythmic movements, monotonous and soothing sounds, superficial stimulation of certain parts of the body) and others.

Face-to-face communication takes place in the first half of the infant period and its effects on mental development may be observed even later, when the child is in the attachment phase. An experiment where the mother was instructed to be passive - no response to the child's signals (still-face procedure) shows that children who frequently try to provoke their mother's response at a later stage develop more frequently the secure type of attachment. Those infants who seek their mother's response to a lesser extent develop much more frequently the insecure type of attachment at the age of 12 months (92, 93). A gradual increase in the frequency of smiles in a baby at the age from two and a half to seven months also points to an increased likelihood of developing the secure type of attachment at the age of 12 months. In contrast, a decreasing frequency of smiles in the given period leads more frequently to the insecure type of attachment (94). Obtrusiveness or excessive restraint in the mother's approach causes the child to avoid eye-contact at an early phase (face-to-face communication), and, in the phase of developed attachment, the most frequent response to brief separation is the anxious-avoidant type of response (95, 96, 97, 98, 99, 100). Later, we shall talk about the effect of mental disorders (depression, psychosis, posttraumatic stress disorder) on emotional communication and the child's development.

### 2.3.4. Parental contribution in transgenerational transmission

The birth of the first child signifies the beginning of parental care. Although that is the first time parents face the complexity of the task, overwhelmed with new experiences, they do not begin their relationship with the baby by learning from day to day, gathering one experience at a time. Part of the preparations takes place at the time of pregnancy when parents prepare themselves both emotionally and practically for their new roles. Marital relations before the birth have an important role to play. Dissatisfaction with marriage, with themselves, or with the job of one of the spouses often results in dissatisfaction with their role as parent, and caring for the baby is felt as a nuisance, burden or stress (101).

Characteristic or family-specific patterns of parental care and communication with the child can be observed through several generations. Thus, in some families there is child abuse that can be traced back several generations (abused children later abuse their own children) (102, 103, 104), there are the personal characteristics of the parents, marital disagreements and certain styles of upbringing (105). These factors mark the stages between which there are complex processes of growing up and which are indisputably imprinted on the child's behaviour. Children born to conflictive and unstable parents, brought up amidst marital strife, are often irritable and explosive by nature. If the marriage of such parents does not suffer from external manifestations of the problems (marital fights), children have much less difficulties in their behaviour. Personal experiences in childhood project themselves on the parental role of the adult. Studies of attachment have found elements which are transmitted from one generation to another. Affective communication creates internal working models which are specific to the given individual and have the tendency to be repeated in the generations to come (unless the external influences change substantially) (106). War inflicts deep wounds on the existing cycles of transmission: it is disastrous to the psyche and results in the creation of completely new patterns. Trauma caused by war is transmitted to following generations. Because of the depth and unsolved nature of the problems it brings with it, war trauma continues to generate mental disturbances (there are centres which provide psychological assistance to the 4th generation of prisoners of the concentration camps of World War Two). The preservation of the cultural heritage has an effect on preserving the identity of a group, which is achieved by cherishing, presenting (teaching) and repeating the traditional patterns of behaviour, thinking and affective approaches.

People who have negative childhood experiences frequently repeat them when they become parents themselves. People who openly face their painful problem originating in childhood and who work it out are able to put an end to the transmission cycle. This termination can be made easier by a good experience from the past (107) or by the spouse's support (108).

### 2.3.5. The impact of temperament on early affective bonds

Temperament is an aspect of personality which denotes emotional expressiveness and responsiveness to external stimulation. The temperament of both mother and child has an important impact on the dyad. The mother will react differently to the behaviour of a satisfied, calm child ready for cuddling than she would to that of a restless and crying child. Different approaches will also have an impact on the interaction with the child, on the development of interaction patterns, and on the child's overall development. As there are no components of personality in the infant stage,

such as beliefs, attitudes and a system of values, at this stage studies of personality are restricted to observing the child's emotional expressiveness and reaction to stimuli from the environment. These components of personality are referred to as temperament. Temperament defines more "how something is done" rather than "what is done". Just as children have different weights and lengths at birth, and a different physical constitution, they are also differentiated by their general way of responding to the world surrounding them.

Most researchers of temperament acknowledge that temperament is conditioned by heritage, and that it is stable and observable from the earliest age.

The role of inherited factors in the formation of temperament is evident in studies which show an increased frequency of similarities in the temperament of monozygotic twins rather than in heterozygote twins (109, 110, 111). However, temperament is also moulded by external factors. Differences that exist in the temperament of twins are less pronounced at birth than at a later stage. This is explained by the fact that the living conditions before birth were mostly the same for both twins, while the conditions after birth differed to a greater extent, resulting in the formation of different temperaments (112).

The stability of temperament or its continuity may in certain parameters (negativism towards new people and situations and activity levels) be monitored from birth to death (113, 114, 115, 116). Geneticists explain the continuity of these parameters through heritage, and environmentalists through the continuity of conditions in the environment (117, 118). Geneticists explain the discontinuity of certain characteristics of temperament by the fact that some genes cease to be active in the course of life (119, 120).

A third characteristic which defines temperament – its early appearance – is not a generally accepted characteristic. Still, research shows that there are some differences in the temperament of newborns which may be observed even after several years. Most frequently, these are negative responses and signs of irritability, and less frequently responses to pleasurable stimulation (121, 122, 123, 124).

In a well-known, quite extensive study on temperament (New York Longitudinal Study), two American paediatricians, Alexander Thomas and Stella Chess, created a generally accepted classification of temperament (125, 126, 127, 128). They define 9 categories of temperament:

- 1. Activity Level (daily proportion of motor activity in everyday life)
- 2. Rhythm (Regularity) (Predictability includes the timing of feeding patterns, sleep/wake cycle, elimination schedule)
- 3. Approach or Withdrawal (The nature of the initial response of the child to a new stimulus, including mood expression and behaviour)
- 4. Adaptability
- 5. Intensity of Reaction
- 6. Threshold of Responsiveness (The intensity level of stimulation necessary to elicit a response from the child)
- 7. Predominant Mood
- 8. Persistence
- 9. Distractibility

Based on these categories, it is possible to define 3 of the most frequent types of neonatal temperamental constellations: the “Easy Child”, the “Difficult Child”, and the “Slow-To-Warm-Up Child”. The “Easy Child” is categorised by regularity of rhythm, predictability, adaptability, positive approach to the unknown, good mood and mild intensity of expressing emotions. The “Difficult Child” is categorised by irregularity, non-adaptability, negative withdrawal response to the unknown, negativism and intense mood expressions. The “Slow-To-Warm-Up Child” is categorised by reduced activity, withdrawal in new situations, slow adaptability, mild expressions of emotions and a negativistic mood.

Studies that focus on the parental evaluation of their child’s temperament show that a great part of the perception of the child’s temperament arises from the parent’s own temperament, which further stresses the complexity of the process of the child’s affective development (129, 130, 131, 132, 133, 134).

## 2.4. Negative impacts on the development of early affective bonds

The relations between parent and infant have a strong impact on the physical, psychological and social development of the child. Disturbances in these relations caused by separation from the parent or traumatic and painful experiences with the parents have a deep-rooted negative impact on the child's development.

The devastating impact of no parental care was first observed in children who were placed in institutions (children's homes) due to the loss of both parents or because of the parents' incapacity to take care of them. In his work dating back to 1945 (135), Spitz describes a high infant mortality rate in such institutions and the psychological problems of children who would spend long periods of time in children's homes. In such homes, one person would take care of a group of up to 8 children (and such caregivers would also frequently leave and be replaced by new ones). The time each child spent interacting with the caregiver was very brief and there was no opportunity to establish deeper emotional bonds. As there were curtains between beds, there was no peer communication and children grew in isolation, almost without any outside stimuli. The children were prone to infections - frequently with fatal results. The average weight and height was below the lower level of normal, and development quotients would gradually deteriorate (from 124 at the commencement of stay, 75 at the age of 12 months, to 45 at two years) (136, 137). Homes which provide a lot of support for the child (in the form of nutrition, creative work) reduce the negative effects of institutionalisation on the development of intelligence, but there are still problems of social deprivation resulting from the absence of the opportunity to establish deeper emotional bonds - attachment (a high turnover of caregiver staff). Stagnation which occurs during the stay of children in institutions can very soon be repaired by placing children in families (138, 139). These insights have resulted in the growing propagation of adoptions.

Hospitalisation is also a traumatic experience. Separation from the parent is traumatic enough, but hospitals also involve medical procedures to which the child is exposed. Bowlby described 3 phases of separation anxiety: 1) Protest - where the child tries to have her mother return by shaking the rail of the bed and throwing herself against the bed, 2) Despair - where the child withdraws and becomes inactive, occasionally crying monotonously. As they are mostly silent and quiet, one could gain the impression that they have accepted the situation. 3) Detachment - where the child accepts the nurse, begins to take food, play, smile and communicate with others, but when the mother arrives, the child remains apathetic and turns the head away from her. Such traumatic experiences can be mitigated if one of the parents stays in hospital with the child, if other family members come to visit, if the familiar patterns of daily routine are maintained (by the parent staying with the child) and if the number of persons who take care of the daily routine is reduced (140). Children who have frequently stayed with grandparents (or the babysitter) when the parents were away, and children who occasionally stayed with familiar persons, find it easier to adapt to hospital conditions (141, 142).

### 2.4.1. Mother's emotional problems

Parenthood (parental care and love) is vital for the normal overall development of the child. Psychological or psychiatric problems of one or both parents have a deep-rooted effect on the child's health. As it is the mother who has most contact with the baby during the first year of her life, research of this problem focuses mainly on the mother's problems. In view of the complexity of the issue, literature describes various approaches to the problem of maternal mental illness, from the study of genetic factors which cause problems in the child, social factors which frequently come along with mentally sick mothers (poverty, marital problems), to the study of disturbances in the intersubjective relations between mother and child. The first condition for the building of early bonds is that the mother is available to the child. It is difficult to imagine a situation where there is no possibility for the intersubjective exchange of emotions (communication). In this situation, the individual (in this case the infant) is completely isolated, without any possibility for emotional and cognitive development. In real life, this happens in the case of psychotic mothers or, at the beginning of the 20th century, in the case of children who were placed in institutions because their mothers had abandoned them or were sick. It is important to know that in this kind of situation the clinical picture of the child need not be obvious - the children may seem well-groomed and the mother caring. However, after careful analysis, it can be observed that the suitable content of early bonds between mother and child is missing: everything remains an outer form, while at the content level there is void or disharmony between the needs of the child and the responses of the mother (non-attunement) (143). After countless unsuccessful attempts at communicating with the mother, the child becomes reticent, stops sending signals and begins to comfort herself by sucking and by rhythmic movements of either the head or body. After some time, the baby will try to make contact with the mother again, but after new failures she will seek comfort in the same defence mechanisms. In time, this behavioural pattern becomes a habit and creates a deep-rooted feeling of inability to elicit other people's responses, as well as the feeling that the mother is unreliable and the world around her worthless. The baby becomes depressed, not as a reflection of her mother's depression, but because of her own impotence in the face of her inability to interact with her surroundings.

When the mother is emotionally unavailable (depressive, uninterested, excessively scared, pre-occupied with other problems, etc.), the child cannot obtain a response from her and the child becomes depressed and, as a result, an overwhelming sense of inability to establish communication with the outside world is born. A mother with emotional problems is not able to recognise the child's message, so she is also not able to respond adequately. Usually, the mother sends a wrong response or no response at all. The child becomes neglected. Sometimes, such mothers can sense that the child wants something and offers many unnecessary things. Such children seem overprotected, and on the surface they may seem overwhelmed with love and affection. However, their needs are basically left unsatisfied and at their signal (demand) they receive a huge quantity of unnecessary things. Such children are also basically neglected.

For a long time it was believed that postpartum depression was one of the most important pathogens (stressor) for the development of the child (144). Epidemiological research has shown

that about 10% of women suffer from non-psychotic postpartum depression in the first 3 months following childbirth (145). Clinically, this is characterised by irritability, anxiety, poor concentration, and depressive moods and thoughts. The symptoms may have a deep effect on interpersonal relations, including the relationship with one's own child. The highest incidence happens in the first 3 months after childbirth, which coincides with the period which Winnicott defines as the primary phase of maternal preoccupation, when the mother's physiology adjusts to the external conditions of life and parental care and when she is extremely sensitive to the quality of their interpersonal contacts. This is also confirmed by observations that in the case of the experimental termination of communication with the mother, the child succumbs to distress and avoidance (146, 147, 148). The high frequency of postpartum depression and problems in early bonding with the child become even more significant considering that in most cultures the mother has the role of primary caregiver and constitutes the primary surroundings of the child. On the other hand, substantially less frequently, only about 2%–3% of mothers have serious forms of postpartum psychosis (149). In view of the high incidence of postpartum depression, the fact that the mother is the dominant factor for the baby and considering the sensitivity of the child to the quality of interpersonal relations, the question arises of possible negative influences on the growth and development of the child. In the last twenty years, there has been a great deal of research showing that children of depressed mothers have behavioural disorders, some have depressive forms, others conduct disorders, and others are hyperactive (150, 151). Because of insufficient reciprocal cognitive stimulation, the children of depressed mothers lag behind in cognitive development (152, 153). The babies of depressed mothers are more frequently born with low weight (which contributes to the development of their mother's depression), they sleep more during the infant phase, they cry more frequently, they are more restless and they arch their backs (opisthotonus) (154, 155). Because of the long-term nature of the monitoring and the difficulties in obtaining a longitudinal insight into the health of the mother, it is not quite clear to what extent there is a difference in the permanent consequences on children whose mothers are permanently depressed or on those whose mothers had an episode of depression at the time of testing (the first few postpartum months). However, it seems that the negative consequences are visible for a long time after remission. In 58% of children at the age of 8 years, there are still behavioural disorders that have been present from the age of 3, although the mother no longer suffers from the symptoms of depression (156). By monitoring mother and child, it has been observed that communicate with their child less frequently and that they participate less in the positive stimulation of the child during play. As for the children of depressed mothers, they engage less frequently in affective communication (smiling, showing toys to the mother, vocalisation during joint play) and show stronger signs of distress when the mother leaves (157). Such mothers are preoccupied with their own problems and are consequently less sensitive to the needs of the child (158, 159, 160, 161, 162). It is believed that about 20% of children have certain problems if just the mother has emotional problems, but this number rises to 43% for children whose both parents have emotional problems (156).

Efficient treatment of postpartum depression by early intervention in the form of support and counselling (164) requires the early detection of mothers who are at an increased risk of developing depression. Marital problems observed before the birth of the baby, an extremely poor social

and economic status, the lack of a close and reliable person, and previous psychiatric diseases are regarded as reliable indicators of an increased risk of postpartum depression (145). In addition, in the early postnatal period, a negative response to the newborn (164), feeding problems (145), poor moods and crying (165), lack of family support (no visits or superficial communication during the visits) all point to an increased possibility of developing postpartum depression.

In the case of psychiatric illness in parents, there is also the issue of genetic transmission of the illness and disorders to children. Extensive research has been conducted in this direction. The research has shown that there is no solid connection between the illness of the parents and psychiatric disorders in their children (166). Such research has shown that the illness of the parents precedes (provokes) disorders in children. Thus, the children of sick parents develop normally in the case of adoption. On the other hand, the children of healthy parents show disturbed development if their adoptive parents have a psychiatric illness. Family relations have a much greater role in the occurrence of difficulties in the development of children than the type of illness borne by the parents. Thus, aggressive behaviour in the family has a much stronger negative impact (17% of boys of non-aggressive parents compared to 40% of boys of aggressive mothers and 70% of boys of aggressive fathers) than the presence of a mental illness in the parent (167).

Literature has not provided any information on the influence of posttraumatic stress disorder on the early relationship between mother and child and the child's growth and development.

In conclusion, the following may be established with certainty (168):

- 1. Children whose parents suffer from mental illness are at an increased risk of developing mental problems
- 2. Depression and schizophrenia in the mother frequently come hand in hand with some other risk factors (psychosocial stress, poverty, marital problems); the said factors increase the risk of disorders in child development
- 3. Depressed mothers are more negative and less positive in contact with their children
- 4. The children of depressed mothers are more frequently negative and more seldom positive in interaction with their mothers, and probably in interaction with other adults, as well
- 5. The children of parents with mental illnesses develop more frequently the insecure type of attachment
- 6. Conflicts between parents and children are more frequent in families with sick parents
- 7. The children of depressed mothers have impulsive reactions more frequently and they have more difficulties in relations with their peers
- 8. Depressed mothers give their children negative assessments much more frequently, but this may be caused by the fact that more frequently than others they indeed have children who show "more difficult" patterns of behaviour.

### 2.4.2. Poverty, single parenting, work

Although the negative impact of poverty on the life of a family is easily detected and is very complex, in literature there is not much information on this ever-present problem of the modern day. The complexity of living in poverty is reflected in its side-effects, such as social pathology, poor family relations, social deprivation of the family, barely meeting basic needs (healthy nutrition, hygiene, health concerns), lower level of education of the parents, specific health problems in children and parents, and the burden the parents have to bear in fighting for the family's survival. The problem of poverty can be viewed from the aspect of extremely poor families who live on the brink of survival, as well as from the aspect of those families who put much more effort in staying outside the category of poverty. Within the said scope, there are various, mostly negative, effects on family life and on the early mother-child relationship.

Poverty and inequality are the two most important factors that contribute to poor living conditions and poor health. On the global level, based on the World Health Organisation database (WHO reports, WHO Global Database), poverty is on the rise. In 1970, 20% of the richest segment of humanity had 30 times more income than 20% of the poorest. Today, the richest fifth receives about 60 times more than the poorest fifth. The total wealth of the 358 richest people is greater than the total annual income of 45% of the poorest inhabitants of planet Earth (2.3 billion). Inequality can also be observed according to geographic distribution, gender and race (nationality).

About 3 billion people live on less than 2 US dollars per day. In other words, half of the population of planet Earth live below the "level of dignity"; they do not have adequate housing, health care and education for their children. Almost half of them live on less than 1 US dollar per day. This segment of the population, about one billion, are starving and are at constant risk of being undernourished. Of 1.3 billion of the poorest, 70% are women, which is a direct reflection of their position in the family and in society. Women from the poorest of families die in childbirth 100 times more frequently than richer women. According to the WHO Global Database on Child Growth, about 30% of children in the world are undernourished, and the last few years have seen a gradual deterioration in the condition in 30 countries. The average African family spends 20% less than 25 years ago. About 43% of children up to 5 years of age (230 million) who live in developing countries are undernourished.

In order to maintain their living standard and avoid poverty, in an increasing number of families both parents work. In the USA, the percentage of such families has grown from 38% to 48% in the last 25 years. At the same time, the number of families where only the woman works has increased from 10% to 18% (169). If mothers have to work for a living, there is the problem of who will take care of the children, so the number of children who are placed in nurseries is on the rise. Depending on its economic power and policies, the state grants rights to maternity leave and prescribes standards for pre-school institutions. Specific problems related to the stay in child collectives (separation, frequent respiratory infections and sick-leave taken on account of children who are poorly) raise questions about the medical and economic justifiability of the early placement of children in nurseries (in some countries, children are sent to nurseries at the age of 3 months).

In the past forty years, the problem of single mothers has been particularly emphasised. In the period from 1900 to 1960, about 9% of children in the USA lived with a lone parent. This pe-

riod was followed by a substantial rise in the number of single-parent families, and in 1985 they amounted to 20%. Most children from these families live with their mother. The real numbers are probably much higher because the figures were obtained by gathering data based on the current status, while the likely number of mothers who were single mothers at one point in their life is probably much higher. It is estimated that three-quarters of the total number of poor families are single-mother families, and that about 54% of them live in poverty (170).

Poverty and its side-effects have an impact on the health of the child from the moment of conception. In their case history, more frequently than others, poor mothers have risk factors (illnesses, detrimental habits), poorer antenatal care (in the wider sense of the term), they show more signs of stress during pregnancy, as well as habits detrimental to health. It is estimated that in the USA one in four poor mothers take narcotics during pregnancy (168). Under such conditions, the child is exposed to acute or chronic stress in the womb; premature childbirth is more frequent, as is inadequate foetal growth (premature babies). The same factors are also present after birth, so there is a misbalance between the increased demands imposed by the baby and the physically and emotionally limited capabilities of the mother. Mothers of restless, crying premature babies, who are overwhelmed by stress, frequently leave aside their babies if they fail to react to their attempts at comforting them (171). Such negative patterns of communication are difficult to break and they act as a permanent disruptive factor in the growth and development of the child. Apart from the fact that poor children are frequently born more vulnerable because of the influence of prenatal factors, healthy children born into poor families also more frequently and easily become vulnerable due to inadequate care and nutrition. More frequently than others, they succumb to deficit-related illnesses (anaemia, rickets, undernourishment), lead poisoning (old buildings painted in colours with up to 50% lead content, lead water pipes) (172, 173), they get sick and die from respiratory diseases, diarrhoea, malaria and AIDS (WHO Global Database) and they are more likely to be the victim of injuries and poisoning (174, 175). Precisely because of their vulnerability, poor children need better health care, but because of their status, it is less available to them (176, 177). The consequence of poverty is higher post-neonatal mortality caused by poor living conditions and by the specific problems of the parents (National Commission to Prevent Infant Mortality, 1988). According to a study conducted in Washington, the post-neonatal mortality rate of the population receiving social welfare was 10.1%, while in the rest of the population it was 1.4‰ (178). It is estimated that in the USA about 10% of the poorest children live on the street and that about 35% of homeless women in the study had been pregnant in the previous year, and that 26% of the homeless women had given birth (179). That is why it is perfectly clear that children without shelter are at particular risk of developing health and developmental problems (180).

Life under such conditions has an impact on the parental role, interpersonal relations within the family, as well as on the everyday care and upbringing of the child. Irregular patterns (sometimes chaotic) in sleeping, waking, feeding and changing schedules, frequent changes of caregivers, as well as frequent changes of the place where the child sleeps, are all part of the life of chronically poor families (181, 182). Premature babies born into poor families spend more time with relatives or friends than the children of richer parents (183). In such situations, the child becomes frequently attached to persons who are not part of the household. A larger percentage of

poor families do not have their marital status regulated. On the other hand, it is estimated that about 80% of single fathers do not live in the household with their child. The role of the father in such situations has not been sufficiently explored, but it seems that only a fraction of such fathers have the capacity to take over full responsibility, while most accept the role of the father only partially, under certain conditions in which they participate in family life (they dedicate their time to the woman and little ones who call him “daddy”), but without jeopardising their freedom (184). In such families, the grandmother frequently takes the mother’s role, where more or less consciously she tries to make up for everything she failed to do as a mother herself (185). The absence of structure in their daily routine and in the continuity of the primary figure in their lives indubitably have a disturbing effect on the emotional development of the child.

In a way, every child creates her parent. Every child tests the empathic capacity of the parent afresh and thus less demanding children can do well even when they have a parent with less empathic and physical capacity, while “difficult” children can completely exhaust even a parent with plenty of capacity (186). Poverty increases the probability that the child will be demanding. At the same time, poverty reveals and intensifies the effects of parental vulnerability (abuse in their own childhood (187), psychiatric illnesses in the family (188)). Poverty produces new stressors, such as unpleasant neighbourhoods, neglected and overcrowded households, and dehumanisation, loss of control over one’s own destiny and dependence on social welfare. All together, these factors weigh the parents down and divert attention from the child; these factors consume the parents’ physical and emotional energy, they test their patience, their sense of competence and control over their destiny. This results in the paralysing sensations of anger, irritability, fatigue, helplessness and despair, which in combination with exhaustion undermines their capacity to communicate with their own baby (189). Recognising the affective needs and signals of the child and providing an adequate response (attunement) are substantially inhibited. There are also frequent mood swings in the mother, caused by crises, but which are also sometimes unprovoked. Their children also show mood swings, so one day it is anger, the next happiness, and on the third there are no emotions whatsoever (190). In mothers who are aware of the needs of the child, it can still be noted that in the case of crisis they put the needs of the child in second place and dedicate their attention to the acute problems (191). It seems that parents mostly expect the child to adjust to their own organisation of everyday life, rather than for them to adjust to the needs of the child. It has been noted that children born into poor families frequently receive a lot of love from their parents, grandparents and other relatives, but this mostly happens when the grown-ups have time and when they feel like communicating with the child. The child is not able to communicate when and how she wants (192). Preoccupation with the daily routine of caring, feeding and providing for the physical health of the child frequently leads to the neglect of play and empathic responsiveness. Mothers are frequently burdened by memories of their own poor childhood, so they put the provision of food, diapers, clothes and other things, which generally the poor lack, in first place. Fun and play with the child is often regarded as an unaffordable luxury (193). Such mothers do not enjoy play with their child so much (194) and try to control (dictate) the terms of interaction. They are aware of their reduced capacity to adapt to the child’s way of playing, but because they lack physical and mental energy they are not able to be more efficient and creative (190, 195). In

some interpretations, attempts at controlling the behaviour of the child come from attempts to compensate for one's own inability to control the overall situation and to boost one's own sense of importance.

A group at particular risk are poor adolescent parents who frequently have traumatic experience from their own childhood. This is not only material deprivation, but discontinuation of adequate care at the earliest age, family violence, rejection by the parents and the sense of overall failure. Residues of such events in combination with further problems arising from poverty make these young people unprepared for their own role as parents (196, 197, 198). The way they see themselves and the way other people see them, as well as what can be expected of them, including their understanding of parenthood, have an impact on future relations with their own child (199, 200). Deeply buried experiences from their own childhood rear their ugly head with the birth of their child and it frequently happens that the mother has a feeling of emptiness and impotence, a feeling that she cannot (does not know how to) respond adequately to the baby's demands. Consequently, she begins to avoid her own child, who becomes the source of painful memories and emotions. This is how history repeats itself.

### 2.4.3. Adolescent motherhood under normal living conditions

- Reports by the National Centre for Health Statistics of 1991 emphasised the problem that in the USA  $\frac{1}{4}$  of young girls below the age of 19 become pregnant. Adolescent pregnancy means adolescent parenthood which forces young women, still children themselves, to assume the great responsibilities that come with motherhood.

- Research of the Croatian adolescent population conducted by Džepina et al. in 1990 showed that more than half of interviewees did not use any protection in sexual intercourse, so that 4.5% of sexually active female adolescents became pregnant, while 1% of that number gave birth.

- Even under regular living conditions, adolescent parents face numerous problems. Young, sexually mature, insufficiently grown-up, cognitively and psychologically immature, with only few statutory rights, they mostly find it very difficult to face the responsibilities of parenthood.

The cognitive immaturity of adolescents and other developmental factors cause them to focus attention on themselves. That is precisely the reason why they may pay less attention to their child, why they may find it more difficult to recognise the needs of their child or to neglect her if these needs are opposed to their own needs, which all results in the poorer quality of such parenthood.

- The basic problem of adolescent parenthood is the adolescents' development in the biological, cognitive, psychological and social sense in an environment of chronic stress, especially marked by poverty, limited opportunities for education, and family instability. In most cases, adolescent mothers suffer from permanent and/or temporary psychological, social and economic consequences. Osofsky and Hann (202) show that, in comparison with adult mothers, adolescent mothers have a more pronounced dispersed identity, less independence, more frequent depressions, less self-esteem and difficulties in trusting people.

- There are quite clear and significant indications that mothers in depression are emotionally more distant and undedicated to their children, and even that many of them are at an increased risk of carrying out physical aggression against the child (203), which definitely implies an increased risk of such children having affective problems (204, 205, 206).

- Poverty and misery are an important contributor to the problems faced by the adolescent mother. They heighten the risk of a large number of circumstances, including, frequently, life on the brink of the law, frequent changes of residence, difficulties in maintaining a daily routine, difficulties in raising children and lack of emotional and social support.

- Apart from the mentioned high-risk social and emotional environment in which adolescent parents live with their child, there are also indicators of problems in the cognitive area.

- Many adolescent mothers talk little to their children and it is to be expected that such children are poor at verbalisation. Because of their life in poor cognitive environments, there is no doubt that such children are at an increased risk of developing behavioural and/or learning disorders, especially when they enter the organised systems of education.

- In many studies, in comparison with older mothers, adolescent mothers are described as having less knowledge about the developmental needs and the developmental orientation of their children (207). The latest research by Fusrtenberg, Baranowski, Schilmoeller and Higgins (208) shows that teaching about parenthood can substantially reduce the risk of developmental problems in children.

- Despite the problems pertaining to adolescent parenthood, it seems that some young mothers and their children do just fine. The key to successful adolescent parenthood can be found in many factors, of which definitively one of the most important is support provided by the family, friends and others, assistance and alternative care provided by some other person in the house, as well as an opportunity to continue education, and fertility control.

- Self-esteem is another very important factor in successful adolescent parenthood. The better the young mother feels about herself, the better her mood while interacting with her child. It has been found that there are more problems in parenthood if the mother shows signs of highly pronounced depression and a low level of self-esteem (209, 210).

- Despite theoretical differences in attempts to conceptualise the parent-child relationship, there is accord that the main component of successful parenting is parental sensitivity. Parental sensitivity includes the ability to apply appropriate responses to the child's signals, especially the most important of them - crying. The parent has to become aware of a particular need, interpret it correctly and give a suitably efficient response.

- Emotionally mature adolescent couples who have a child are mostly successful in overcoming problems that are primarily connected with adolescence and the stressful events that accompany a young person at this stage. Nevertheless, adolescents who are in the full swing of their own physical, mental and social development frequently represent a problem in themselves, which arises

from difficulties which are mostly psychosocial in nature. As such, they might have a reduced ability to be “sensitive parents”, which certainly results in far-reaching consequences for the development of the child.

- In our research of adolescent mothers during the war in the Republic of Croatia and Bosnia and Herzegovina, in comparison with other mothers, we observed the following: 1) poorer rudimentary knowledge about the development and needs of the child (what kind of milk is the best, when the child begins to sit, walk and talk), which shows a lower level of interest (emotional orientation) towards the child; 2) a higher frequency of emotional difficulties and a lower incidence of depression; 3) a lower rate of establishing contact with the child (eye contact, smiles, gentle touches, or play); 4) a lower frequency of attempts to establish contact on the part of the child; 5) a shorter period of breast-feeding; 6) a lower level of recognising the child’s signals (recognising the reason why the child cries); 7) a lower level of self-esteem and self-respect, and 8) a higher frequency of the feeling that caring for the child is a particularly heavy burden. It should be stated that such mothers received special attention and increased care in the programme of psychosocial assistance.

#### **2.4.4. Effect of premature birth and serious illness of the child on the early mother-child relationship**

Around 50,000 children are born in Croatia every year, and 5.6% of them have low birth weight (from 500 to 2,499 grams). Of this percentage, 0.2% have an extremely low birth weight (500-999 grams), 0.6% have a very low birth weight (1,000-1,499 grams) and 4.8% have a low birth weight (1,500-2,499 grams). The group with an extremely low birth weight has a mortality rate of 64.5%, those with a very low birth weight have a mortality rate of 31.6%, and the group of children with a low birth weight has a mortality rate of 3.9% (211). Taking into consideration the prenatal mortality of this group of children, it is estimated that annually 2,500 children require longer hospitalisation after birth, as well as special care after arrival home. Apart from these clearly defined criteria and data on premature babies, there are also other factors (multiple pregnancies, lower social and economic status, specific emotional reactions of the parents, etc.) to denote the complexity of the problems associated with premature birth. There are a number of works that describe the biological and emotional consequences for this group of children and their parents.

In comparison with full-term babies, premature babies who have extremely low and very low birth weights more frequently suffer from diseases of the central nervous system (212). Although the development of medical technology has reduced the frequency of such disorders, about 10-15% of children still have some signs of neurological or intellectual disorders (213, 214, 215). In the group of children who weigh below 1,000 grams at birth, 17-27% have cerebral palsy and have an IQ lower than 70 (216, 217), while 10-20% have less serious neurological problems such as epilepsy or an IQ between 70 and 85 (218). Despite the said decline in the number of unwanted consequences of premature birth, there is still a 10-40 times greater prevalence of cerebral palsy in this group of children than in full-term babies (219).

Premature birth halts the natural processes of emotional and social adjustment to birth, since there is no time to develop attachment and prepare for birth (classes for pregnant women). Quite

the opposite, there is a period of stress, fear of losing one's child, the stay of the child in an intensive care unit and the fear of permanent consequences for the health of the child (220, 221). Frequently, relatives criticise the mother for not having succeeded in her duty – to give birth to a healthy baby. This augments the mother's feeling of guilt and incompetence (222). In the first days of the child's stay in the intensive care unit, it is mostly the father who has contact with the staff (while the mother recuperates after childbirth). Most fathers are very protective of their wife and choose what to tell her. They tell her what they know she wants to hear, and keep secret such information that they presume needs to be told later, when the wife is ready (223).

Parents predominantly have a negative attitude towards premature babies with a low birth weight. Concerned about their baby's health and fearing for her life, they are frequently afraid of attaching to the baby emotionally (224). For this reason, they have a different approach to the baby, they touch her less and express a feeling of unease when they meet the baby (225). More frequent visits enable the parents to get a realistic view of the baby's progress and to be more optimistic. In addition, babies who get frequent visits recuperate and make progress faster and they leave hospital earlier (226). Still, there are two types of mothers who differ through the quantity of interactions with the child while in hospital. Mothers who communicate with their baby less, also visit the baby in hospital less frequently, and, at the adjusted age of 3 months (the age the child would be if born full-term), when the baby is at home, they also show less engagement and a narrower range of interactions (227). Parents who in this period receive additional support and counselling cope better later in the process of care and upbringing after the baby is discharged from hospital (228). Programmes aimed at the parents of premature babies tend to deal with the normal growth and development of children, with nutrition, and provide instructions on the activities and games with the objective to stimulate cognitive, verbal and social development. In 1990, the Infant Health & Development Programme was launched. It involved 985 babies who weighed less than 2,500 grams at birth. The children were divided into two groups: the treatment group, which included children whose parents had been involved in an education programme, and who, after the age of 1, were included in the nursery education programme; the others were observed as the control group. After the age of 3, their overall development was assessed. The children in the treatment group had better IQ results (on average, the children who weighed 2,000–2,500 grams at birth had 13.2 more points; the children who weighed below 2,000 grams at birth had 6.6 more points than the control group), while the children in the control group had a 3-times higher incidence of mental retardation. The children in the treatment group show substantially fewer behaviour problems. Other research also emphasises the importance of tactile stimulation of the child for growth and development, the organisation of behaviour, motor activity and alertness (229, 230). Regarding parents, there is a sense of insecurity and there are fears for the entire first year of life. It is believed that the causes can be traced to the specific patterns of interaction between mother and child which are observed in the first few weeks of life. It is held that premature newborns have difficulties in processing information coming from their surroundings and thus become very easily generally disorganised (231, 232). As the disorganisation causes the hyporeactivity of the child to everyday usual stimuli, mothers frequently over-stimulate their child. Thus, unintentionally, they cause further disorganisation, leading to sudden changes from hyporeactiv-

ity to hyperactivity, which provokes further insecurity of the parents in terms of the adequacy of their actions (233, 234).

By comparing the group of children who stayed in the unit for a shorter period of time (less than 17 days) and the group who stayed for more than 35 days, it was seen that there is a connection between the seriousness of the illness of the newborn and the relationship between mother and child. In the dyad with a seriously sick child, the baby shows continuously poorer motor activity and insufficient awake time, while it can be observed in the mother that she smiles less and touches the child less frequently both during the stay in hospital and after 6 and 12 weeks after discharge from hospital. In the group of children with shorter hospitalisation and a less serious illness, the overall dynamics of interaction is richer, and becomes normal soon after recovery and discharge. In the case of children with long hospitalisation, although the child might have recovered completely, her interaction is poorer, which can be noted even several months after discharge. This is explained by the mother's perception of the child as a very fragile being, which is why she has less interaction with the baby. Consequently, the baby communicates less, which not infrequently makes the mother conclude that the possible cause of the child's hypoactivity is brain damage (235).

In general, following the study of a number of works, it can be concluded that a substantial percentage of children with birth weights less than 1,500 grams show difficulties in behaviour and socialisation at a later period (24-43%, depending on the source of data) (236, 237). However, it is important to point out that prematurity is not connected with a higher incidence of psychiatric diseases later in life (238).

Children born with congenital diseases (heart defects, cystic fibrosis, atresion of bile ducts, orthopaedic anomalies, malignant diseases, and others) which require frequent and lengthy hospitalisation, as well as traumatic medical procedures, in a large number of cases also suffer from lifelong biological consequences and specific needs.

In children, hospitalisation indisputably causes emotional stress. The primary cause of stress is the ruptured development of attachment to the parent and a parallel change of surroundings and usual daily activities (feeding, changing, bathing, playing) which normally help the child organise her experiences. The sense of protectedness, as well as continuous care and love, has gone. According to some research, in family surroundings a 36-month old baby meets an average of 6.6 different persons per day (8.4 per week), while in hospital the child meets more than 40 different persons per day (239). Nurses undertake care and feeding as a part of their routine, and the whole wealth of interaction that the child is used to is missing. At the same time, nurses also perform very traumatising diagnostic and therapeutic procedures, which additionally confuses and agitates the child. The child needs regularity in the events surrounding her in order to develop the ability to anticipate events and to feel control over her own life. However, the hospital provides very little useful regularity: the lights in the room sometimes stay on throughout the night, healthy children go, new children are admitted, sometimes it is not permitted to have a toy for comfort (for hygienic reasons), the bed is used for sleeping, feeding and playing... Having observed the specific needs and difficulties of hospitalised children, in 1959 the British government, in cooperation with the Department of Health, adopted instructions on procedures concerning the hospitalisation of children

following the instructions provided by certain paediatricians and early psychoanalysts (including Ana Freud and John Bowlby). In 1980, twenty-one years later, the programme was evaluated. Positive steps were noted, but in most hospitals the mother could still not stay with her child (although technically it was possible), in over 50% of hospitals siblings were not permitted to visit, and 30% of hospitals did not offer the possibility of continuous services to parents (food in the cafeteria at night or weekends). Nurses did not ask the parents any questions about the specific needs and habits of the child or inform parents about behaviour problems while the child was in hospital. At the time, similar data could also be gathered in the USA.

Chronic diseases and frequent hospitalisation have an extremely negative effect on the emotional and physical health of both children and parents. After discovering the nature and seriousness of the disease, which requires a special process of adjustment (shock, disbelief, denial, anger, despair, guilt, acceptance), parents try to adjust to the disease and to the child's needs and establish a normal way of life (240). In view of the complexity of the problem, parents need a great amount of support both from hospital staff and from paediatricians in primary health care in the process of the successful integration of the child in normal activities (tertiary prevention). It is the primary level paediatrician who has the duty to maintain continuous communication with specialised services, parents, the sick child (at the appropriate level), social welfare services, schools and other elements in the local community which provide assistance to the sick child. At the same time, parents have been observed to take on an increasing amount of both responsibility and care for the health of the child. Naturally, this is possible only with adequate education and support (241).

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## 3.0. Early Mother-Child Relationship: Separation from the Parent - Separation Phase

Mirjana Šprajc Bilen

**S**eparation from those we love is always painful. For a small child, though, it is particularly painful when she has to undergo separation from her parents. At the same time, however, separation is necessary to propel the independence and development of the child's personality. It is an unavoidable and important part of the normal process of growing up.

In order to understand why separation in the first years of life is so painful and accompanied by fear, it is necessary to explain the nature of the emotional connections that exist between parents and children.

### 3.1. How to explain the appearance of the fear of separation

Neither an infant nor a small child can survive on their own. They need help from those around them. That is why they are biologically "programmed" to cling to the solid connection they have formed with the one person who has demonstrated the ability to satisfy their basic needs as a child, which means to survive and thrive. When such a close person (the mother or the person caring for and raising the child in the first years of life) disappears from the child's vicinity, in the eyes of the child her very existence seems threatened and fear, accompanied by all the signals that suggest the highest level of alarm, is activated. Therefore, this fear, just like all other fears, has the basic function of protection, this time of survival, and that is why it is so strong.

**The fear of separation appears at the age from 6 to 8 months.** In most children, it lasts until the child turns 4 years of age, and it is most intense between 6 months and two years.

**The child experiences separation even when the mother is physically present, but cannot take care of the child's needs.** This is emotional separation, i.e., neglect. It takes place in situations where the mother is physically present, but for various reasons (long-term depression or illness, as well as marital, family, economic problems or personality disorders) she cannot take care of the physical or emotional needs of the child.

### 3.2. Family inclination

It has been noted that children from some families accept separation relatively quickly and easily, while children from other families are significantly weaker in that respect, that is, there is a family inclination in the manner of reacting to separation at an early age.

The parent's attitude to separation mostly depends on the personality of the parent:

- Most parents know the needs of their child quite well and, with the help of parental intuition, they are able to decide correctly when their child needs protection and when it would be a good moment to encourage her towards separation.
- Some parents are "too caring". Mothers who are afraid from the very first day that something is going to happen to their child, who feel insecure when the child is not around, mostly provide too much protection for their child. The child, on the other hand, experiences the world around herself in the same way as her mother does, that is, as a dangerous place, and that is why she becomes insecure and scared, distrustful of her peers, even grown-ups. For such a child, it is difficult to fit in. Sometimes it happens that the child becomes so insecure that she cannot be separated from the mother at all. Both mother and child are trapped in their excessively close relationship, which prevents the child from becoming independent and growing up. It is necessary that the father or a third person take over responsibility and spend more time with the child.
- On the other hand, some parents, although they mean well, allow the child to be separated from themselves too early, when the child is not ready, because they do not want to spoil the child and because they want to prepare her for hard times ahead. That is wrong and the child does not become stronger, but weaker, because she is exposed to something that is far beyond her level of development.

### 3.3. First reactions of the child to separation

Although there are substantial individual differences, most children at an age from 6 months to 4 years react similarly to separation. If the child has to stay in hospital or if the child has to go to a nursery or kindergarten, quite explosive reactions can be expected. Such reactions take place in several time-specific and characteristic modes of behaviour and experiences of the child:

- Protest (lasts about 7 days). The child cries vehemently, refuses all other contact, although perturbed, and keeps seeking visual contact with the mother. The child does not accept help from the grown-ups who approach her. She refuses both food and play.
- Despair (lasts from one week to three months). The child's motor reactions become calmer, the child no longer refuses interaction by actively protesting, but becomes reticent and apathetic, sad. She has night-time fears and nightmares. Regression in behaviour is also possible (loss of the already-achieved control over the elimination process, baby-talk, sucking the finger, etc.). The child has strong reactions when she meets her parents, the child protests and cries, so it is often felt that it is better for the parents not to come to visit. The reverse is true. The most important thing is that the child continues to see the parents regularly so that the fear of abandonment can be appeased.

- Apparent adjustment, where the child only appears to have adjusted. The child no longer cries, she communicates with those around her and becomes attached to people, but the situation is even worse for the child now. The child has given up the struggle, she is sad and equanimous, although the way she feels inside is not so manifestly obvious on the "outside" any more. However, when the mother appears the child might behave as if the mother does not interest her or as if she does not know her. For parents, this is an unexpected and painful experience; they feel the child has forgotten them. It is possible to frequently see stereotypical movements by which the child comforts herself (head or body shaking, thumb sucking, etc.). All these are expected reactions to separation, although they are very unpleasant and painful both for the child and for the parent.

### 3.4. Feeling of guilt in working parents

Many parents who work have the feeling of guilt, because they have to leave their young children in care. They are also often tired, so they do not have either the time or the strength to spend quality time with the child. Children are sometimes all alone at home, and the house is also not always in perfect order. The feeling of guilt causes nervousness and depression and, as a result, the parent changes his or her behaviour towards the children: the parents become overprotective or help the children too much (write homework for them), they do not encourage independence, they are too tolerant of the child's inappropriate behaviour, they have the need to fulfil all the child's wishes, they buy too many toys or pity the child in her presence. Children raised in this way easily become egocentric and self-absorbed, they have a low frustration tolerance, which is why they find the blows of life quite hard to bear. When they become adults, such people try to mould the environment around them, which is why they are often in conflict.

### 3.5. The working mother

Experience shows that working mothers are no worse educators than non-working ones. Employment or non-employment is not a solution in itself. What matters is how the mother feels in her role, whether she is happy with it or not. If the mother is satisfied, regardless of whether she works or not, she will be a patient mother who will have more understanding for her children and will be a better educator. What matters to the child of working parents is good care for the child while the parents are at work, a good mother surrogate. As far as the quantity of time that the parent spends with the child is concerned, most people agree that it is much better to spend less time with the child, but make it "quality time", with full attention paid to the child and her needs. This means to be in a good mood, play, work together, to engage in an activity which appeals to both the child and the parent. Nonetheless, this comforting sentence does not change the sad but evident fact that we do not spend enough time with our children. The circumstances are such that we raise our children in a hurry, accidentally almost. Even when we do have time, we "take" them to various activities and pay other people to spend time with them.

### 3.6. For how long can a child bear separation from parents without consequences?

Research shows that the child's reactions to separation mostly depend on the age of the child, her personality, personal experiences and the circumstances surrounding the separation. As a rule, children up to four years take separation from parents badly, especially if they are exposed to separation and then left in a new and strange place where they also do not have a good mother surrogate. The smaller the child, the harder she takes the separation. Common everyday separation under normal circumstances should not bear significant negative consequences on the further mental development of a healthy child who has had good experiences. Although reactions to separation can be stormy and dramatic, mostly they are passing disturbances which take the form of: behavioural disturbances (irritability, defiance, tantrums, unsociability, cruelty, and destructivity), sleeping and feeding disorders, loss of control of the elimination process, stomach pains, headaches, nausea, feeling of tiredness and exhaustion, speech disorders, and intensified fear of separation. The intensified fear of separation manifests itself in the child's unwillingness to be separated from the mother even for an instant. It is as if the child has lost all trust and lives in constant fear that the mother will abandon her again... She keeps repeating demands incessantly and gets very angry if the mother does not fulfil her every whim. The child is insatiable in this, and as a result the mother becomes exhausted and angry, because she feels haunted. When the child senses the anger, the child feels rejected again and demands even more proof of her mummy's love. This is the beginning of a vicious circle where the relations are full of love, and intolerance.

The increased risk of mental disorders later in life is connected with multiple and protracted separations, especially if the child is too sensitive, separated under bad conditions (sickness, war) and if the relations between the child and the parent were insecure and tense. In such cases, separation can be a traumatic experience that leaves permanent consequences. After such an experience, the child can become permanently insecure and distrustful of all new experiences and keep expecting new disappointments. In the most severe of cases, serious personality disorders also appear.

It is believed that separation for a duration of 5 months (without contacts in the meantime) can cause permanent personality changes in the child. The ability of the child to face the separation depends on the quality of the emotional bonds that have been formed between mother and child, and between the child and other people in her life. Insecure and unhappy children take separation badly. Separation which lasts several years, even when the child has the best possible mother surrogate, frequently provokes difficulties in parent-child relations. The experiences of families who had to be separated for economic reasons (parents going to work abroad) testify to this. Family reunions in improved economic conditions are frequently marked by a pronounced lack of understanding between generations. Such misunderstanding is mostly connected with the conscious or subconscious fantasies of the child who believes that the parents had not loved her enough when they left her. Let us remember that the child thinks egocentrically. Everything revolves around the child. Had the child merited it, the parents would have loved her and would not have left.

### 3.7. How to mitigate reactions to separation?

- Primarily, take care that the child is not separated at the earliest age, unless necessary.
- In situations where the infant and the small child (up to 3 years) is separated from both parents, it would be ideal to make the separation as brief as possible and to have one person known to the child take care of her in a familiar environment.
  - When the mother is not with the child, the child needs a good mother surrogate. If possible, the mother surrogate should be a calm, stable and emotionally warm person. The most important thing is to have only one person so that the child can grow emotionally attached.
  - If the child becomes completely separated, e.g., in hospital, separation stress diminishes if the parents visit regularly or if they can spend part of the day with the child in the hospital. The child will most frequently cry and protest when the parents leave. One should know that this is normal. In this way, the child eases separation suffering, which is inevitable. Therefore, although it is painful for the parents to see their child crying, and not be able to soothe the pain, the parents should accept the crying and protests calmly, because this makes things easier for the child.

The separation of the child when the entire family is in a stressful situation is especially risky. Separation from both parents caused by catastrophes, war, traffic accidents or family conflict causes the child to experience the fear of threat to her existence, abandonment and punishment. In the first years of development, the child cannot cope with all these extremely strong emotions; the protection mechanisms (emotional maturity, cognitive capacity) are undeveloped, and the result is permanent consequences for the child's emotional (and, not rarely, physical) growth and development. Therefore, the child should receive special care and attention, both at the individual and collective level. In times of peace, most attention is paid to the study of the debilitating effect that the stay in children's homes has on the infant, and which is marked by the absence of the development of attachment, and disruptions in emotional and cognitive development, with permanent consequences for the formation of a mature adult personality.

## 4.0. Trauma in Infants and Small Children

Mirjana Šprajc Bilen

There is a misconception which says that children up to the age of three do not experience trauma, since they are shielded by their immaturity and lack of understanding. This corresponds more to our wishes than to reality. Experience shows that even infants and small children “remember” their traumas. While they are unable to understand and analyse dangerous situations intellectually, they possess natural, biological reflexes and defence mechanisms that come into play to ensure survival when their existence is threatened. For example, a newborn baby whose nose becomes blocked while breast-feeding, and who thus experiences a feeling of suffocation (a traumatic experience), will thereafter refuse several new attempts to nurse it. Having experienced a threat to its life, the infant’s brain registers this as a situation to avoid, on its own and without its parents’ help. This demonstrates that children can, immediately after birth, generalise their experience and avoid situations which remind them of a trauma. Children have a great capacity for generalisation. This is very important in helping them organise their memories and establish some sort of order and system by means of which they perceive themselves and the world around them. Thus they gradually construct their inner psychic life. Unfortunately, this generalisation of traumatic experiences leads children to be wary not only of harmful experiences, but also of those which are beneficial and important for their further development. Defence mechanisms are transformed into rigid patterns of behaviour that limit children’s lives, their relationship toward their parents, and their exploration of themselves and the world around them, becoming an obstacle to further growth and development.

### 4.1. What can be a traumatic experience for an infant?

Due to its inability to analyse intellectually, it is not possible to predict with certainty what might be a traumatic experience for an infant. It could be physical pain, bodily injury, or an everyday experience that overtaxes the baby’s sensory system (excessive sonic or auditory stimulation, e.g. an explosion). In such cases, children react with fear and alter their behaviour. The comfort offered by parents is not always sufficient at such times.

### 4.2. What impact do overwhelming emotional experiences have on infants?

An overwhelming feeling can have a strong impact on a child and threaten its future development. It is important to recognise the child’s reaction to such an experience, so as to make use of children’s great capacity for change. Parents are usually ready to help the child, and the child reacts quickly to changes.

A child constantly watches its mother, and regresses or stagnates in its development depending on her

A child who has undergone an overwhelming experience, an experience of threat to its existence, will be constantly on guard, in a continual state of alarm and hypervigilance, completely determined not to allow that terrible thing to happen again. It is as if the child “reasoned” thus: if you are always on guard, nothing unexpected or dangerous can happen. Children will try to defend themselves against all situations which in any way recall their trauma. The continual tension of this “state of alarm” influences a child’s attentiveness, exploration, and acquirement of new experiences. A fear of new situations arises. The child explores less, and this decreased exploration of the outside world deprives it of experiences. The child withdraws into itself in a psychological sense, and ceases to be able to utilise its abilities and develop its independence, becoming overdependent on its mother. The final result is that the evolution of play and the symbolisation of internal psychic structures are impaired, and this slows the child’s development, as these represent the basis for overall development.

### 4.3. Traumatic experiences can be direct or indirect

Direct trauma is a child’s reaction to a traumatic experience it has undergone (while, at the same time, the child’s relationship with its parents may be satisfactory).

Indirect trauma means that the child’s reaction is also a symptom of difficulties proceeding from the relationship between the child and its mother, who has experienced a trauma. A traumatised mother is emotionally unprepared to offer her child security and satisfy its psychic and physical need for safety, protection and love. In this case, the child has a dual perception of its mother: as a source of protection and love, but also a source of anxiety and frustration.

### 4.4. What happens to children’s feelings in such an environment?

The mother is overwhelmed by her feelings, and “does not see” the child; she does not recognise its needs, and thus cannot satisfy them, either. Children require a reflection or echo from their parents – that they see them just as they are, with their feelings and needs, that they call them by name and give them affirmation, that they feel joy and wonder toward them just as they are, that they take them seriously. By means of this, children come to accept themselves and their own feelings, gain an awareness of themselves, and acquire self-respect. If this is lacking, the child will have no connection to its own feelings, no perception of itself and its true worth – and this is depression. For good mental health it is important to experience one’s own true worth.

In situations where parents do not satisfy children’s needs a turnabout occurs, and children begin to satisfy the needs of parents. They neglect themselves and their needs and feelings, experiencing emptiness, a sense of futility, and depression. We all experience these things even as adults when we focus on satisfying the needs of others. We no longer know or feel what we need, what our true worth is. A person is spared from depression when his sense of self-respect is based on the authenticity of his own feelings, not on the possession of certain qualities. When we do not feel

worthy enough as human beings – in and of ourselves, just as we are, regardless of our success – we feel bad and become depressed.

The most severe consequence of emotional neglect is fantasised attachment. A child deprived of the formation of a true connection with its own feelings will, at first consciously and later unconsciously (through inner identification with its parents), become dependent on its parents and unable to separate from them. Later, this person will become dependent on his or her partner, group of friends, and particularly children, lacking his or her own identity for establishing ties with other people.

## 4.5. How to help traumatised children up to the age of 3

- Ensure a secure environment without traumatic experiences for children and their parents, so that parents are able to give children a feeling of security.
- Support for parents as crisis intervention and support in raising children (give parents the chance to talk about their experiences and children's reactions).
- Rebuild children's confidence in parents, by helping parents to accept their children at their current level and support them in becoming independent by maintaining certain limits. Help parents to see the whole child and not just the problem.
- Give parents hope that a change will occur.
- Build children's renewed confidence in the world and help them to broaden their experience and face frightening situations, which may lead to a temporary increase in anxiety.
- Play with children and encourage them in their own play.



## **Practical Instructions on How to Organise Work in the Field**

***Before any work begins, it is necessary to take the following steps:***

- 1.** Find out the number, structure and conditions under which the victims are accommodated
- 2.** Investigate the local resources – experts, state and non-governmental resources that would participate in the programme
- 3.** Form an interdisciplinary team (holistic approach) consisting of the best experts who live and work at the location affected by the crisis
- 4.** Organise initial training, in which it is necessary to cover the topics of the infant's mental health, the methodology of work with victims and with government and non-governmental institutions
- 5.** Set up the supervision of the work of the teams in the field in terms of organisation, coordination and expert supervision (occasional meetings and continuously by phone or the Internet)
- 6.** Organise the collection and evaluation of the data on persons injured and the assistance provided
- 7.** In collective centres, coordinate the victims (selection of their representatives and coordinators who are to organise the basic living activities in the centre) and work on cooperation with them
- 8.** Provide for the basic living needs of the victims – food, drink, hygiene, take care of emergencies in terms of physical, mental and social health and evaluate the epidemiological situation and the need to set up any counter-epidemic measures. Government and non-governmental organisations in the field have to be engaged in this part of the job
- 9.** Start working on an active approach (visits to the afflicted families) and interdisciplinarity (the team has to consist of at least one doctor – if possible a paediatrician, senior nurse and psychologist, and a social worker has to be available to the teams)
- 10.** If possible, form a clinic (centre) where assistance may be requested at specific times
- 11.** Provide for efficient evacuation and transport of victims whose condition requires that they be taken to higher-ranking health institutions
- 12.** Achieve cooperation with state and non-governmental institutions in the field
- 13.** Represent the interests of victims in the mass media and by including other non-governmental organisations and volunteers in complementary activities (such as Lamaze classes, play-rooms, spatial planning, working activities for adults such as agriculture, production of goods which yield additional income for the families, and other activities)
- 14.** Based on the continuing monitoring of the needs and possibilities at the location, adjust the methodology of work quickly and efficiently.



**Methodology of Stimulating  
the Early Relationship  
between Parent (Caregiver) and Infant**

## 5.0. How to Stimulate Communication between Parent and infant; How to Boost the Development of Attachment - Instructions for Parents

Milivoj Jovančević

The programme has the following components: psychological support (child psychologist) – through group education about the basics of the early mother-child relationship and through individual work; encouragement of communication with the child through massage, medical developmental gymnastics and voice communication. The main tasks of the programme are as follows:

- 1. To make sure that the mother feels protected
- 2. To boost the mother's budding sense of self-confidence and self-respect
- 3. To instruct the mother about the basic needs and development of the child
- 4. To instruct the mother to communicate with the child (breast-feeding as a way of communication, massage, developmental gymnastics – “Baby Fitness”, stimulation of voice communication – “Voice Fitness”, playing with the infant), where it is necessary to demonstrate the techniques of doing the exercises and to show the reward represented by a happy and pleased child.

## 5.1. Communication with the infant: breast-feeding and care

Breast-feeding is a very good way of communication between mother and child. Several levels of communication can be recognised in this act. The first is a message to the child – here it is warm, safe and comfortable, here there is food. Nature has balanced this relationship very wisely; first of all, the child is born with the sucking reflex – the child tries to put in his mouth anything that happens to be near the mouth or on the cheek and starts to suck; and secondly, children are in the oral phase, which means that the biggest pleasure and comfort comes through the mouth. On the second level of communication during breast-feeding, mother and child get to know (recognise) each other through touch, in the same way as they do during changing and bathing. The more they touch each other, the more talk and grimaces there are, and the better the communication. Naturally, there is also the sense of smell, which infallibly identifies the mother. During breast-feeding, the child experiences all the pleasures of this world: the sense of warmth, gentleness, safety, pleasant taste, the satisfaction of his hunger and the need to feel loved. On the other hand, the mother has the closest possible contact with the baby, in a connection which in a way resembles the days of pregnancy when she felt every move the child made and experienced it as part of herself, as part of her body. The mother feels the warmth of the child and the child's movements, the mother feels that she is playing the role given to her by Mother Nature – she is successfully feeding and caring for her child. Finally, she has the feeling that she has done her biological duty – to produce offspring and to make sure the child grows up.

Sometimes the child is too agitated to begin to feed peacefully. You should then try to soothe the baby in a quiet, rhythmic voice. Try to use vowels by starting in a higher and ending in a lower pitch (e.g., a “downward“ long “a“). In contrast, if the child is sleepy, you can awaken her by more intense touching, louder baby-talk and by using “upward“ vowels. Observe your baby: when she is full, she will turn her head away from the breast for an instant, stretch her body backwards and then extend her little arms along her body. That is a message – I am full and happy, now I'm going to sleep.

Your baby is able to imitate grimaces and voices from the earliest age. Do try, and you will stimulate the development of communication and, indirectly, the psychomotor development of the child (sticking out the tongue, closing and opening the mouth, pressing lips together, closing and opening the eyes).

## 5.2. Communication with the infant: Baby Fitness

### 5.2.1. Massage

Andrea Čalopek Butković

## I FACIAL MASSAGE

### 1. FOREHEAD

Place both thumbs on the baby's forehead vertically. You should not cover the baby's eyes, because babies feel insecure if their eyes are covered. Start at the centre of your baby's forehead and slowly caress his skin outwards.



### 2. NOSE, CHEEKS

With your thumbs alongside his nose, move your hands from the nose and ever so lightly across his cheeks. This massage is beneficial if the baby has a clogged nose because it serves to drain mucus from the nose, and the air passages become clear.



### 3. CHIN

Place your thumbs at the centre of the chin. The movement starts from the centre and slowly progresses across the chin.



## II HAND MASSAGE

### 4.

Place both hands on the baby's shoulders. By slowly massaging the shoulders, descend down the upper arm and then to the lower arm. With the palms of your hands, you should try to cover as much of the arm surface as possible.



**5.**

We now massage only one arm. We use both our hands to take hold of the baby's arm in the upper arm area. We slowly descend down to the lower arm and hand. We must use the whole palm, as if you are pulling on something lightly. You should not use the tips of your fingers, because that would not be comfortable for the baby. Do this several times with one arm, and then proceed with the other arm.



**6.**

We massage only one arm. With one hand we take hold of the baby's hand and wrist. With the other hand we do the massage by encircling the baby's arm, in the form of a ring. The movement starts in the upper arm area, descends down the lower arm, and ends at the hand. Do this several times, first on one arm, and then start with the massage on the other.



**7.**

**We massage only one arm. Press the fingers of both hands together and place them on either side of the baby's upper arm. Roll your hands from the upper arm, down the lower arm, all the way to the hand. Do this several times, first on one arm, and then on the other.**



**8.**

**If the baby's hand is clasped into a fist, put the palm of your hand under the baby's palm. With the fingers of your other hand, stroke the upper side of the baby's fist. The movement starts on the baby's fingers and continues to the wrist. After several repetitions, the baby should open up her hand and you achieve contact, "palm-on-palm" touch.**



### III CHEST MASSAGE

9.

Place both hands on the centre of the chest area. The movement, light strokes, proceeds to the shoulders, and then down the sides of the chest to the centre of the chest again. The movement is not interrupted, but proceeds in continuous circles. You should do 6-7 circles in a row.



## IV STOMACH MASSAGE

### 10.

Place your hand on your baby's navel. If you are right handed, then use your left hand. With your right hand you should apply light pressure and move your right hand clockwise, in a circular motion, from left to right. When you reach the position where your hands are side by side, you lift your right hand away from the tummy and proceed with a new cycle of motions. You should not lift off the hand on the baby's navel. This direction is recommended because our alimentary tract works in that direction.



### 11.

The tummy can be massaged in a way that you press the fingers of your hand together and caress the tummy with the palms of your hands. The tummy is massaged by moving your hand from the upper tummy area downwards to the lower tummy area. When you reach the lower part with your hand, use the other hand to start the massage on the upper part of the tummy. Your hands alternate. Do 6-7 alternations in a single massage cycle.



## V LEG MASSAGE

12.

Place both hands on the baby's hip and upper leg. The stroking movement starts at the knee and proceeds to the lower leg and foot. Try to cover as much of the leg surface as possible with your palms.



13.

We massage one leg at a time. We use both hands to hold the baby's leg in the upper leg area. Use the whole hand to hold the leg, not just the fingers. The movement starts at the upper leg and proceeds to the lower leg and foot as if you were pulling on something lightly. Take care that you do not use the tips of your fingers, because that is not comfortable for the baby. Repeat the massage on one leg several times, and then start massaging the other leg.



**14.**

We massage one leg at a time. With one hand we hold the baby's leg in the ankle area. With the other we do the massage by encircling the baby's leg, in the form of a ring. The movement starts at the upper leg and proceeds to the lower leg and ankle.



**15.**

We massage one leg at a time. Press the fingers of your hands together and place them on either side of the baby's leg. Roll your baby's leg between your hands from the upper leg down the lower leg all the way to the foot. Do this several times, first on one leg, then start rolling the other.



**16.**

Place your thumbs at the centre of the baby's foot. The thumbs have to lie on the foot, with the thumb nails in the same direction as the baby's toe nails. Stroke the foot from the centre outwards. Be sure that the thumbs are pressed against the foot. There are a number of nerve endings in the foot, so with each touch we stimulate a large number of nerve cells. That is why it is good to include the baby's feet in the massage, so that the baby gets as many stimuli as possible. Do this several times, first on one foot, and then on the other.



**17.**

The feet can also be massaged horizontally. Place your thumb crossways on the lower part of the sole. Move the thumb from the lower part of the foot to the upper part near the toes. When you finish the movement on the upper part of the foot, start the same movement with the other thumb on the lower part of the foot. The thumbs alternate. Do this several times first on one foot, then on the other.

Do not forget the pressure pads on the underside of the toes. Be sure to massage them; you will improve the circulation in the baby's feet.



**18.**

The whole hands can also be used to massage the baby's feet. With one hand, hold the leg in the lower leg region for stability. Place the palm of your other hand on the foot and apply soft pressure on the foot. Remove the palm from the foot and repeat this several times..



## VI BACK MASSAGE

**19.**

The baby should lie on her tummy for this massage. The massage is divided into three parts: you first massage the top, then the middle, and in the end the small of the back and the bottom. Place your hands at the centre of your baby's back and make outward strokes. You first repeat this several times on one part of the back and then move on to the next.



## 20.

A back massage may also be done when the baby is lying in her mother's lap. One hand is placed on the baby's bottom, and the other hand does the horizontal stroking movements. The stroking movement begins on the shoulders and ends on the bottom, where the hands meet. It is important to point out that the hand should be shaped to follow the contours of the baby's back.



## 21.

The position of the baby is the same as in the previous massage. One hand is placed on the baby's feet, and the other is used to make horizontal stroking movements. The stroking movement begins on the shoulders and ends on the bottom. The hand should be shaped to follow the contours of the baby's back.



**22.**

If you do the massage in the described order, it is proposed that you finish the massage with this exercise. The baby is on her tummy. You move your hand from the top of the back to the lower back. When you reach the small of the back with the palm of your hand, you use the other hand to begin the massage on the top of the back. The hands alternate.

**5.2.2. Literature**

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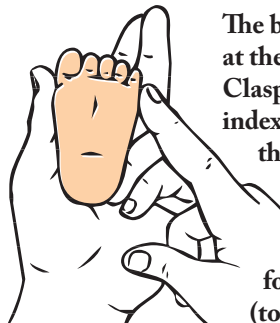
### 5.2.3. Medical developmental gymnastics


Milivoj Jovančević, Andrea Čalopek Butković

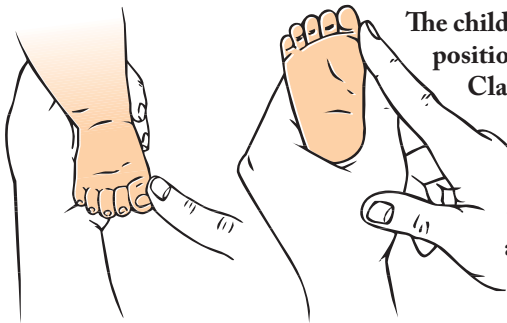
The exercises below have multiple benefits. The child is born, but the brain is still developing. Millions of nerve cells are created which travel to their destinations and establish connections with other brain cells. By exercising, we stimulate the central nervous system and accelerate this process. We may observe how the brain works, and thus the effects of our activities, through the psychomotor and emotional development of the child. It is recommended to do these exercises twice a day for some twenty minutes, and only when the child is in a good mood.

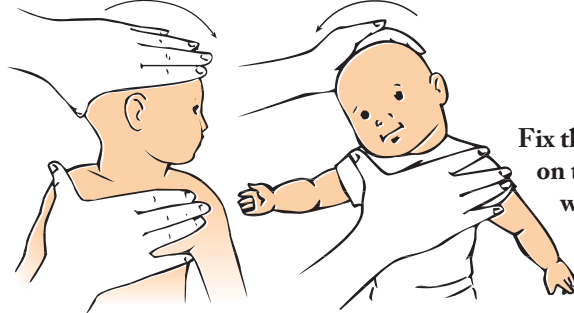
So many times have we experienced the pleasure of exercising with our infant and the abundance of warm feelings that are born and shared through this experience. Exercise creates a closeness surpassed only by the intimacy of nursing your baby. The mother familiarises the child with her touch, she gets to know her baby's soft and warm hands, she becomes familiar with the scent of her child, and the sounds and emotions that the baby uses in response to her expressions of love and attention.

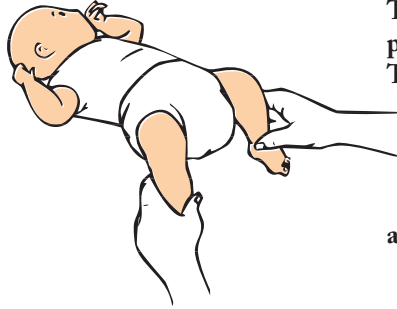
In some cases, due to difficulties in their own lives, mothers have difficulties accepting their newborn child. Exercising with the baby is such a powerful and motivating experience that it mobilises all the mother's senses and feelings, soon establishing a normal relationship, and the communication that is necessary for the healthy growth and development of the child. It removes the mother's fears and insecurities and opens up space for enjoyment and expressions of love. Therefore, we recommend that in doing each exercise you let your feelings and the exchange of messages flow freely. Gently touch the baby's skin over the entire body, coo, sing, smile and kiss... You have a unique opportunity to experience, perhaps, the happiest moments in your life – take it, and enjoy.


No.	FROM THE	DESCRIPTION OF THE EXERCISE
1	1 <sup>st</sup> month	<p><b>Very often, the position in the uterus causes the feet to turn inwards (the soles “stare” at one another).</b></p>  <p><b>The baby is lying on her back. Bend the leg at the hip and the knee. Clasp the baby's ankle with the thumb and index finger (as if between scissor blades), the palm facing upward and outward. With the other hand, stimulate the outer border of the foot from the toes towards the heel. By reflex, the foot will turn towards its outer border (towards the finger that is stimulating it).</b></p>

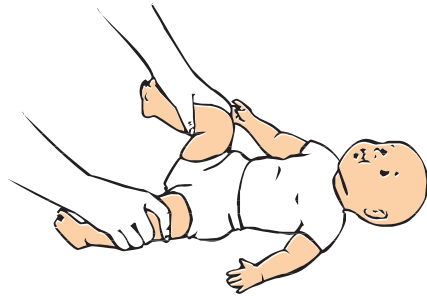
No.	FROM THE	DESCRIPTION OF THE EXERCISE
2	1 <sup>st</sup> month	<p>On some occasions, the pressure of the uterine wall causes the foot to turn upwards, so that the instep nearly touches the shin, while the heel bone very prominently sticks downwards.</p>  <p>The child is in the same position as in Exercise 1. With one hand, clasp the child's foot around the ankle ("scissors"). The palm or the fingers of the other hand are placed on the top of the foot and the foot is pressed downwards.</p>

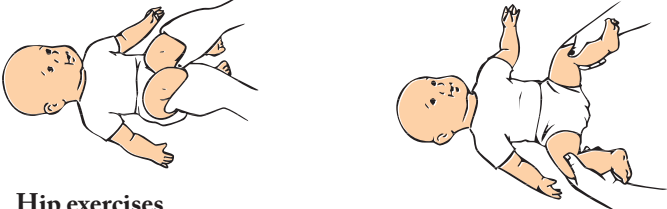
No.	FROM THE	DESCRIPTION OF THE EXERCISE
3	1 <sup>st</sup> month	<p>Sometimes only the front part of the foot was pressed against the uterine wall, so that the baby's foot seen from the bottom looks like a banana (the front part of the foot looks inwards).</p>  <p>The child is in the same position as in Exercise 1. Clasp the heel with one hand (the pictures show 2 ways of holding the heel fixed), and push the front part of the foot outwards with the other hand.</p>

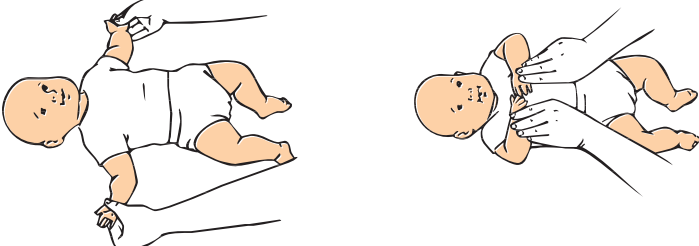
3a		<p>The infant's head might be "flat" on one side and there might be an injury to the neck muscles (positional torticollis).</p>  <p>Fix the shoulders on the surface with one hand and rotate the head left and right as far as it goes. Then, with the baby facing you, flex the head towards the left and right shoulder.</p>
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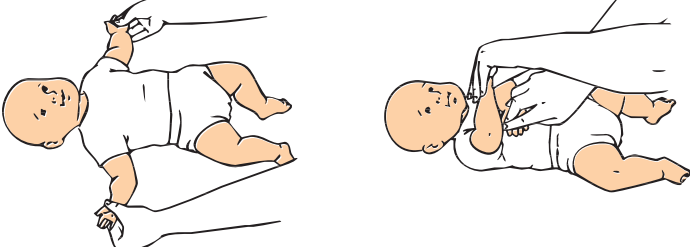
No.	FROM THE	DESCRIPTION OF THE EXERCISE
4	1 <sup>st</sup> month	 <p>The child is in the same position as in Exercise 1. The soles are pressed on the surface. Clasp the baby's shins and feet. Lower the soles onto the surface and lift them up again.</p>

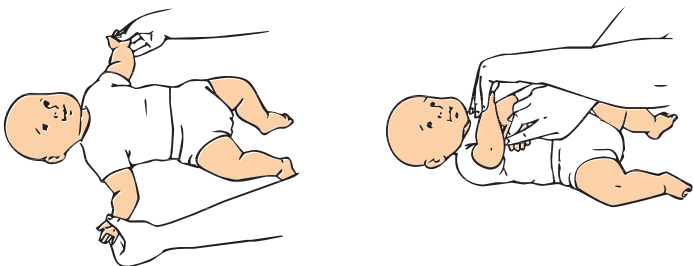
No.	FROM THE	DESCRIPTION OF THE EXERCISE
5	1 <sup>st</sup> month	 <p>The child is lying on the back. Clasp the legs in the area around the knees and press the child's knees towards the tummy, then stretch the legs out on the surface.</p>

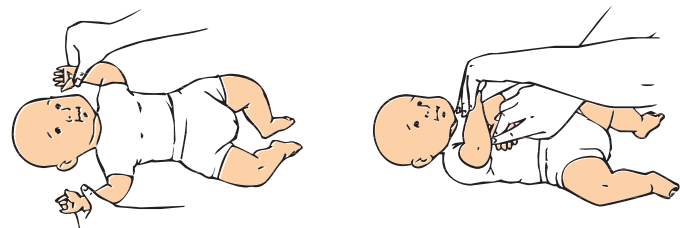
No.	FROM THE	DESCRIPTION OF THE EXERCISE
6	1 <sup>st</sup> month	 <p>The same as Exercise 5, but performed with alternate legs; one leg is bent while the other is simultaneously stretched out on the surface (asymmetrically).</p>

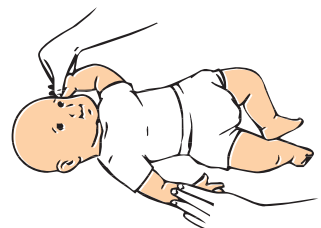
No.	FROM THE	DESCRIPTION OF THE EXERCISE
7	1 <sup>st</sup> month	 <p><b>Hip exercises</b></p> <p>The child is lying on the back. The legs are bent at the hips and knees. Clasp the knees and shins and stretch them out to opposite sides. When the legs are stretched to the sides, try keeping the knees up at the level of the hips, and press the knees downwards as far as possible towards the surface!</p>

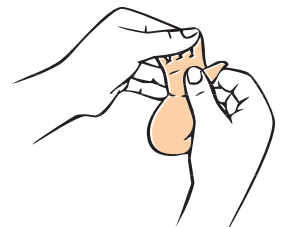
No.	FROM THE	DESCRIPTION OF THE EXERCISE
8	1 <sup>st</sup> month	 <p>The child is lying on the back. Try keeping the baby's upper arms horizontal to the surface. Hold the baby's palms and move the forearms up to the elbows: bend (hands go towards the chest) and then stretch, that is, return the hands to the initial position on the surface.</p>

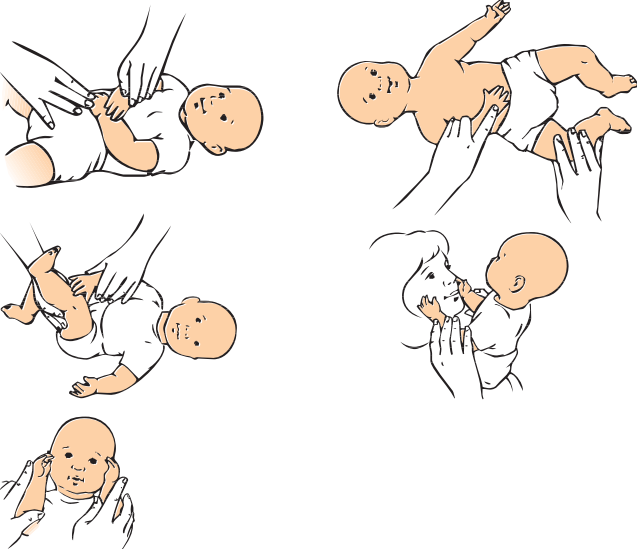

No.	FROM THE	DESCRIPTION OF THE EXERCISE
9	1 <sup>st</sup> month	 <p>The child is lying on the back. The arms are in a horizontal position, stretched out from the body. Cross the arms on the chest (left hand on right shoulder, right hand on left shoulder), then return to initial position.</p>

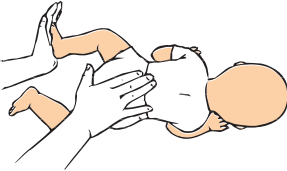
No.	FROM THE	DESCRIPTION OF THE EXERCISE
9	1 <sup>st</sup> month	 <p>The child is lying on the back. The arms are in a horizontal position, stretched out from the body. Cross the arms on the chest (left hand on right shoulder, right hand on left shoulder), then return to initial position.</p>

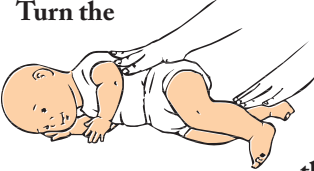
No.	FROM THE	DESCRIPTION OF THE EXERCISE
10	1 <sup>st</sup> month	 <p>The child is lying on the back, with her arms beside the body. Lift both arms stretched above the head, and return to the initial position on the surface.</p>

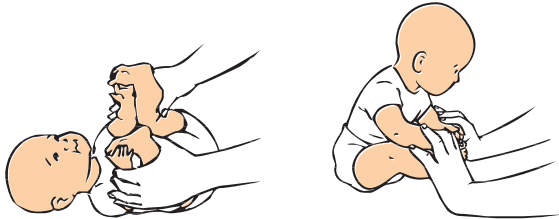
No.	FROM THE	DESCRIPTION OF THE EXERCISE
11	1 <sup>st</sup> month	 <p>The same as Exercise 10, but with alternate arms; while one arm is above the head, the other is lying parallel to the body.</p>

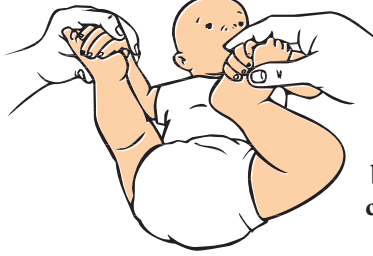
No.	FROM THE	DESCRIPTION OF THE EXERCISE
12	1 <sup>st</sup> month	 <p>Open the child's palm with the thumb of one hand. Hold the child's fingers with your thumb to keep the palm open, and use the thumb of your other hand to rub (stroke) the baby's palm.</p>


No.	FROM THE	DESCRIPTION OF THE EXERCISE
13	1 <sup>st</sup> month	<p data-bbox="419 249 1091 310">Use the child's palm to go over her forearms, tummy, one leg then the other leg, her own face and then the mother's face.</p>  <p data-bbox="419 891 784 919">Position the child on the tummy.</p>  <p data-bbox="419 1087 1072 1148">Open the palm on a smooth and tight surface that will not bring on the baby's grasp reflex.</p>

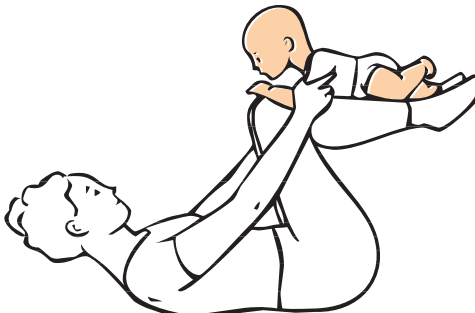
No.	FROM THE	DESCRIPTION OF THE EXERCISE
14	2 <sup>nd</sup> month	<p data-bbox="419 1262 1103 1323">Position the child on the tummy. Place the forearms under the chest, close to the body.</p> <p data-bbox="419 1328 1110 1424">Bend one leg at the hip and knee and place it under the tummy. Also bend the other leg, but place it lower down from the first leg. Alternate the legs as if the child was crawling.</p>  <p data-bbox="419 1633 1076 1694">If the child tries to push, support the foot with the palm of your hand.</p>


No.	FROM THE	DESCRIPTION OF THE EXERCISE
15	2 <sup>nd</sup> month	<p>Turn the child from the position on her tummy to her back, and then again to her tummy. Bring the child to lie on her side in a balancing position, leaning on the lower arm.</p>  <p>Try to encourage the baby to turn (tummy – back, back – tummy). Help with your hand, and by calling to the baby so that she turns her head, and through this, the entire body.</p>

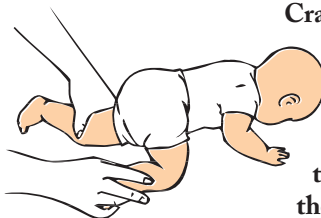
No.	FROM THE	DESCRIPTION OF THE EXERCISE
16	3 <sup>rd</sup> month	 <p>The baby is lying on her back. Clasp together the shin and forearm of the child and bring the child to a sitting position rotating her sideways. When in the sitting position, gently tilt the baby in all directions to exercise control of the head (Buddha position). It may also be performed by holding the child by the shoulders while you raise her into the sitting position.</p>

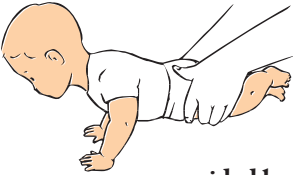
No.	FROM THE	DESCRIPTION OF THE EXERCISE
17	4 <sup>th</sup> month	 <p>The baby is lying on the back. Take the child's hands and make them touch her feet. When she grasps the feet, bring them both towards the child's face.</p>

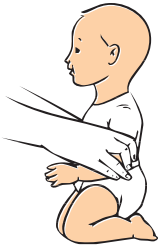
No.	FROM THE	DESCRIPTION OF THE EXERCISE
18	5 <sup>th</sup> month	 <p>The child is lying on the back. Take the child by both thighs and lift from the surface (the child hangs head down). Let the child press with her hands on the surface or gently lean her head on the surface; later you may perform a full turn until the child lies on her chest.</p>


No.	FROM THE	DESCRIPTION OF THE EXERCISE
19	5 <sup>th</sup> month	 <p>“Airplane” The parent is lying on her back with her legs bent at the hips and knees, and the shins parallel to the floor. The child lies on her tummy on the parent’s shins (as if flying).</p>

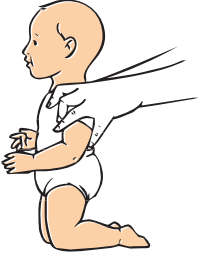
No.	FROM THE	DESCRIPTION OF THE EXERCISE
20	6 <sup>th</sup> month	 <p>The child is lying on the side. The leg she is lying on is bent upwards towards the tummy, and the other leg is placed over it with the sole of the foot on the surface. Pull the child by the top arm until the baby leans on the bottom forearm.</p>

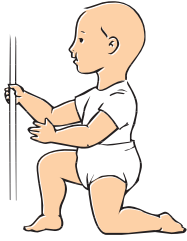
No.	FROM THE	DESCRIPTION OF THE EXERCISE
21	6 <sup>th</sup> month	 <p>Crawling, position on all fours. This is performed by a stronger rotation of the body to the side. Hold the knees under the body, that is, under the pelvis; do not let them go sideways as in a frog.</p>


No.	FROM THE	DESCRIPTION OF THE EXERCISE
22	7 <sup>th</sup> month	 <p><b>Position on all fours.</b> Lift the pelvis from the surface, place the knees under the body, simultaneously making sure that the arms are under the chest. In the beginning, support will be provided by the forearms, and later just by the hands.</p> <p><b>Position on all fours.</b> Let the baby support herself with her arms (forearms or hands), and simultaneously lift both stretched legs (as if playing “wheelbarrow”).</p>

No.	FROM THE	DESCRIPTION OF THE EXERCISE
23	8 <sup>th</sup> month	 <p><b>Sitting on heels supported by your hands at the front.</b></p> <p>Slightly raise the baby’s bottom and rock left and right (stimulate rotations of the body by putting objects on the sides).</p>

No.	FROM THE	DESCRIPTION OF THE EXERCISE
24	8 <sup>th</sup> month	 <p><b>The child is in a sitting position. Spread her legs to give broader support for stable sitting.</b></p>

No.	FROM THE	DESCRIPTION OF THE EXERCISE
25	10 <sup>th</sup> month	 <p><b>Place the child from a sitting to a standing and kneeling position.</b></p>

No.	FROM THE	DESCRIPTION OF THE EXERCISE
26	11 <sup>th</sup> month	 <p>Place the child from a standing/kneeling position into a stride while she holds herself up.</p>

No.	FROM THE	DESCRIPTION OF THE EXERCISE
27	12 <sup>th</sup> month	

#### 5.2.4. Stimulating speech and language development: voice fitness

Mirjana Lasan

Speech and language represent a kind of foundation for development. Language is needed for communication and for expressing thoughts, and it is widely known that good-quality and efficient communication has an impact on an individual's social and emotional wellbeing. In the same way, the combination and mutual influence of environmental and birth factors affect the development of speech and language, in other words, communication.

Speech development does not begin with the first word – around the first birthday – but much before that. Some believe that it begins immediately after the child is born, with her first cry, and when the child begins to breathe independently. However, many people believe that it begins even earlier, in the prenatal period, when the internal ear has developed, and, with it, the ability to hear. Vocalisation is the main precondition for speech, and in the first year of life, the child produces a range of vocal sounds that are crucial for the later development of speech. We often tend to ignore these sounds, by describing them as “just babble”, not thinking that these very sounds may provide a lot of information about a child's development.

Hearing, listening and paying attention are important prerogatives for the development of speech and language. Right after they are born, children will react with fear to very loud sounds. The attention span in the first weeks is very limited, but, soon after, babies will begin to listen when someone talks to them, and they will react with a glance and a smile. They will begin to show interest in the movement of the lips of the person talking to them; they will quieten down when they hear the voice of a parent, and turn their heads towards its source. As the weeks go by, children will be able to listen, observe and differentiate among the increasingly complex and fine sounds and activities in general.

The interaction between the infant and the mother is to the greatest extent an emotional one. It has also been proven that babies show the greatest interest in faces and voices from the earliest age. Besides being interested, children are also very sensitive to voices and adjust to them easily, especially to the mother's voice or to the voice of the person who cares for her the most. Precisely for this reason, children will more readily react to human communication by imitating the expressions of the faces and the sounds or voices. However, the main precondition for imitation is motivation, or the wish to communicate with others. There are many games to help this process, such as hiding the face between the hands, or a tickling game, because it is well known that children learn best and most easily thorough play and experience.

Through games, or another type of interaction, we develop communication skills that go beyond verbal expression. Thus, for example, eye contact and pauses in communication that give the child time to respond represent important non-verbal communication skills. At the same time, they enable the parents to monitor the child's abilities and speech development as a whole.

Children also react to the intonation of the voice of the person talking to them. Grown-ups often talk to a small child in a prominently high-pitched voice to attract and keep her attention. After that, they will make a pause which allows the child to respond with a glance, a smile or by making vocal sounds.

The sounds that the child can produce are closely related to the anatomical structures that develop over time. With the growth of the child's head and neck, over a period of several weeks and months, the child will be able to produce various kinds of sounds.

Most newborn babies use their voice to cry, but also to produce a few other sounds. In the first eight weeks, they sigh, sob, moan when they feel uncomfortable, they produce short squeals and sounds that resemble the vowels "a", "e" and "o". In the beginning, these sounds are mostly an introduction to crying, but as the child matures, they increasingly become associated with pleasure. At about 8 weeks, babies begin to coo, which is the most frequent reaction to friendly voices and faces. At about 2-3 months they are able to vocalise two to three syllables, for example "aah-caa", etc. At around 4 months babies begin to experiment with their speech organs, and so, during that period, the consonants "b", "p", "t" and "d" can also be heard. With the development of their motor skills, some time around the 6<sup>th</sup> month of age, the baby begins to babble, and syllables such as "mamama", "dududu" or "papapa" are not unusual. In this period, the imitation game between child and adult also helps the further speech-language development. When they are about

7 months old, children are able to vary the pitch and loudness of their voice, so that at 8 months they produce sounds related to a game. At around 9 months, children begin to combine different consonants and vowels, but also to produce some new consonants. Then, the children begin to use these combinations with a specific purpose and meaning, which will lead to the first words that grown-ups understand.

So, communication skills begin to develop at birth, and, as children get older, and their motor readiness develops, these skills grow more complex. Besides encouraging them, it is very important to pay attention and observe what sounds children produce and how they do it, which will allow for the timely identification of possible warning signs.

Taken from “Children’s communication skills”, B. Buckley (2003)

Communication skills of a 3-month-old baby	Warning signs
<ul style="list-style-type: none"> <li>• Cries</li> <li>• Smiles at people, toys</li> <li>• Looks at people, toys</li> <li>• Makes eye contact</li> <li>• Makes vowel-type sounds</li> <li>• Coos and gurgles</li> <li>• Startles in response to loud, sudden noises</li> <li>• Responds to speech by looking at the speaker’s face</li> </ul>	<ul style="list-style-type: none"> <li>• Does not smile</li> <li>• Does not vocalise</li> <li>• Does not cry when hungry or in pain</li> <li>• Never turns head towards the source of sound</li> </ul>

Communication skills of a 6-month-old baby	Warning signs
<ul style="list-style-type: none"> <li>• Appears to understand tones of warning, anger and friendliness in voices</li> <li>• Recognises own name</li> <li>• Seems to recognise names of family members</li> <li>• Produces some consonants</li> <li>• Participates in turn-taking games and “question and answer” games</li> <li>• Looks at what an adult is looking at</li> </ul>	<ul style="list-style-type: none"> <li>• Does not look at the speaker</li> <li>• Does not follow moving object with eyes</li> <li>• Does not babble by using consonants and vowels (for example, ma, boo, go)</li> <li>• Mostly silent apart from crying.</li> </ul>

Communication skills of a 9-month-old baby	Warning signs
<ul style="list-style-type: none"> <li>• Stops an activity when her name is called</li> <li>• Looks towards speaker who calls her name</li> <li>• Stops activity in response to “no”</li> <li>• Babbles by combining different vowels, varying pitch and loudness</li> <li>• Points and vocalises to request things</li> <li>• Performs routine activities on request (for example, waves “bye-bye”)</li> </ul>	<ul style="list-style-type: none"> <li>• Not interested in socially interactive games</li> <li>• Does not recognise own name</li> <li>• Does not produce many sounds</li> <li>• Does not produce a range of syllables (for example, mamama, bababa)</li> <li>• Not interested in sound-making toys</li> </ul>

Communication skills of a 12-month-old baby	Warning signs
<ul style="list-style-type: none"> <li>• Responds appropriately to some verbal requests</li> <li>• Makes appropriate verbal responses to some requests (for example, says “bye-bye”)</li> <li>• “Talks” to people and toys by combining a few syllables that vary in pitch and intensity of voice</li> <li>• Vocalises in response to being spoken to</li> <li>• Combines looking, gesture and vocalisation to make requests or to protest</li> </ul>	<ul style="list-style-type: none"> <li>• Does not recognise familiar objects when named</li> <li>• Does not turn her head towards a person calling her name</li> <li>• Does not produce many different syllables</li> <li>• Does not look towards the place where the finger points</li> </ul>

Some exercises are listed below for adults to encourage, and at the same time monitor, the speech-language development of the child. It is important to mention that it is best to perform the exercises in the position that is most comfortable for the child, but it is essential that eye contact is maintained. It is also desirable to pause after each exercise to allow the child to respond, thus helping you to monitor the child’s answers and her development.

- 1. Alternate opening wide and closing the mouth
- 2. Alternate opening the mouth wide and stretching it into a smile
- 3. Pursing the lips
- 4. Giving kisses that might be both loud and quiet, one or several in a row
- 5. Sticking the tongue out and pulling it in
- 6. Whistling from loud to quiet, from high-pitched tones to lower ones, in fast and slow rhythm
- 7. Sighing by producing the vowel “aah” which may also be louder or softer, high or low pitched, and slower or faster
- 8. Moaning accompanied by the vowel “e” which can also be varied as in point 7
- 9. Brief squeaking, accompanied by the vowel “o” (vary as in points 7 and 8)
- 10. Gurgling
- 11. Cooing (caa, coo, cor, kii, etc.)

- 12. Babbling (baa, po, ma, nu, etc.)
- 13. Cooing by producing a row of syllables (cacaca, cococo, cucucu, later gagaga, gugugu, ghighighi)
- 14. Babbling by producing a row of syllables (bababa, bobobo, pupupu, papapa, mememe, nenene, etc.)
- 15. Imitating the child by using the same sounds as the child and a normal speech intonation.

These exercises may be done relatively frequently, depending on how often the child “allows” it. Regardless of how many times they are performed, children love the attention of grown-ups, either through singing, playing or any kind of interaction.

### 5.2.5. Literature

1. Buckley B. Children’s communication skills: from birth to five. New York: Routledge; 2003.
2. Stančić V, Ljubešić M. Jezik, govor, spoznaja (Language, speech, cognition). Zagreb: Hrvatska sveučilišna naklada; 1994.

### 5.2.6. Play with your children

Mirjana Šprajc Bilen

## ENJOY THE GAME AND THE CHILD REMEMBER, YOU WERE A CHILD YOURSELF

**In the same way in which a baby needs food and care, she also needs someone to gently touch her and talk to her, she needs to enjoy playing with her parents, and all this from the earliest age. Do not wait for the baby to grow up and become an “equal” partner in the game.**

**Both you and your baby will benefit from playing together. You will enjoy seeing your child learn new things, you will look forward to the togetherness and intimacy, because it is widely known that enjoying things together makes people feel closer. The child will grow up with confidence and trust in you and those around her, which will help her grow into a happy child.**

**Children who get more attention from their parents show better progress in their psychomotor development.**

**Playing with your child is a clear sign of care and love, and this is a sign that the child will always interpret as love. And love is the most important ingredient of growing up. If you do not have time for your child, she will think that you do not love her, because she will notice that you do have time and patience for things that you care about.**

## GAMES FROM BIRTH TO 12 MONTHS

When a baby is awake she needs a pastime and encouragement. This is why we surround her with rattles, mobiles and other toys. The younger the baby, the faster she becomes bored with one game and seeks new pastimes. Playing with mum and dad is much more interesting for her.

In the first months, too much noise should be avoided, since loud laughs and sudden gestures may upset the child. Children of that age prefer observation games, they want to communicate with their parents face to face, and see the response in their parents' faces. When talking to a baby, the parent must be careful not to do it for too long, not to talk without stopping and thus irritate the baby.

The mother and the baby are having a dialogue: the mother says something and the baby looks and listens. After that, the roles change: the baby coos, but also tries to express herself with her arms, legs and the entire body. Then it is the mother's turn again. It is from this first dialogue that the communication of the child with her surrounding begins. If the child has learned to "wait her turn" here, she will also know how to do it later on.

### Energetic games

- 1. Give an opportunity to your child to become aware of her body; blow on her tummy several times in a row, "walk" with your finger along the entire length of her arms, count her fingers and gently tickle her.
- 2. You can place a baby who is older than one month on her chest for a few minutes. This is a good exercise to strengthen the neck and shoulders and gives you the opportunity to position yourself with your face in front of the baby's and have a brief "conversation" with her. (Never leave the baby alone in this position!).
- 3. When the baby is a bit stronger, put her in your lap. Let her "stand" on her feet while you hold her arms, or let her "fly" in your lap while you hold her firmly. (The baby is standing or kneeling in the parent's lap. Holding the child firmly by the hands, the parent moves his or her thighs left and right giving the impression that the child is "flying" or dancing).
- 4. Exercise together. While the baby is lying on her back on the floor, gently raise her shoulders one by one towards the baby's head; then allow the baby to press her soles into your hands, or gently "ride a bicycle" with her legs.
- 5. Enhance physical skills with toys that she can squash, shake, press or turn, which will stimulate control of the hands; give the baby toys that roll, which will encourage her to crawl (try to have a crawling competition). If possible, arrange the furniture in such a way that the child can walk around the whole room by holding herself up.
- 6. Let the baby "swim" in the tub, both on her chest and her back (always support her head and shoulders with your forearm). Or take a shower together, and let the baby feel the water on her head. Never, not even for a moment, leave the baby out of sight when she is in the water!
- 7. In the park, pass the baby a ball while she is sitting down; swing her on a swing.

## Creative games

- 8. Talk gently to your newborn baby and look her in the eyes. Try some early games, such as sticking out your tongue and laughing, and see whether the baby responds.
- 9. Sit the baby on your knee and gently sing lively, rhythmical songs, which will stimulate speech development.
- 10. Provide new stimulating experiences. A newborn infant likes to watch moving objects (for example, mobiles), while an older baby likes to bang toys on a surface and explore different objects and materials.
- 11. Play games that require specific actions from your baby. Observe whether your one-month-old baby can follow a slowly moving object with her eyes, or if your 9-month-old baby can find a toy if you hide it under a piece of paper, or if a 12-month-old can give you a toy if you ask for it.
- 12. Help the baby to gain a feeling of identity and to experience herself as a person, by giving her a chance to see herself in the mirror, to look at pictures of other babies, and, when she is bigger, teach her to point to different parts of the body.

## Popular games

- 13. Throwing. All babies throw their toys. Turn this into a game, and let her throw the toys onto different surfaces, such as sand or leaves to produce different sounds.
- 14. Hide and seek. Hide so that the baby can see only part of you, or hide a teddy bear under a pillow and let the baby look for it.
- 15. Emptying. Place a few toys into an old handbag and allow the baby to take them out. Or let the baby explore the kitchen cupboard which you have filled with plastic bottles, strainers and sponges.
- 16. Pushing and banging. Give the baby a cardboard box that she can fill with objects and push around. Let her bang on a frying pan with a wooden spoon.
- 17. Early construction games. Make a tower out of two or three blocks (first soft ones, and later wooden ones) and let the baby strike it down. Then teach her how to build it up again.
- 18. Place the baby on a towel. Take some pleasant warm oil (such as wheat-germ oil) and gently massage the baby, starting from the centre of her body. Avoid the area around the navel in newborns.
- 19. Leaf through books together. In the beginning, books made of cloth are best, and after the baby turns 6 months, simple cardboard books which can even be wiped with a wet cloth.
- 20. Describe to the baby what happened during the day, or listen to some relaxing music together and rock the baby to the rhythm of the music.

## FROM 1 - 2 YEARS

- 21. Put on some nice music and dance with your baby. When the baby is tired, put on some quiet music and gently “slide” around the room.
- 22. Touch your nose and let the baby touch hers, shake your shoulders and let the baby do the same, tap your feet and let the baby imitate you. Then see if the baby can follow you doing all three activities in a row.
- 23. Be “funny”. Use “funny” steps to walk around the room, waddle around the kitchen, turn around three times, touch the tips of your toes and, finally, run back to the sitting room.
- 24. Ask your baby to move her shoulders until you say “Stop!” If the child can already say “stop”, exchange roles. (This skill in responding to “stop” is useful to avoid danger when you are out of the house).
- 25. Go over and through a simple course of hurdles. Arrange cushions around the room, for the baby to climb over, cardboard boxes to crawl through, and a table to crawl under (first check that the child cannot hurt herself). You can also let her crawl down and under your knees.
- 26. Sing as many lively and rhythmic songs as possible.
- 27. In the park, give the child toys and objects to push and pull, encourage her to walk (later on to run) from you to your partner, gradually increasing the distance. Partially hide behind a tree and let the child look for you, feed pigeons and other animals.

### Creative games

- 28. Put some lukewarm water in a bowl and let the child experiment by pouring water in and out of different containers. One container may have a large hole, and the other several small ones. Add some ping-pong balls for the child to push. (Never leave the child alone near water or in the water!)
- 29. Fill a container with clean sand and let the child pass it through a sieve and through a funnel. Add some water so that she can make mud pies. (Be careful that she does not put sand in her mouth!)
- 30. Show the child how to make plasticine sausages, or balls, cakes or other shapes.
- 31. Let the child draw on paper with coloured crayons, washable paints, or finger paints. Children like to make colourful footprints or handprints. Different shapes can be made out of vegetables, such as potatoes, which can be dipped in paint and used as stamps. Do not give a child a pencil or pen with a sharp point!

### Popular games

- 32. Hide and seek. This is an ever popular game and can be made even more interesting if, for example, you hide a toy under a plastic bowl and place another two bowls beside it. Ask the child to tell you under which bowl the toy is hidden.
- 33. Sorting game. Play the game of finding objects, the “find me” game. When the child finds an object you have named (let us say it is an apple) ask the child to find another apple. Con-

tinue with questions: “Can you find the cow, bus, doll, etc. The objective of the game is to sort objects into groups, for example, animals, fruit, dolls, etc.

- 34. Acting. Pretend that you are drinking tea with your child, or that you are treating a small teddy bear by putting a plaster on its knee.
- 35. Fetching. Give the child a small basket or bag and ask her to fetch you different things. Start with one thing in the same room, such as a plastic cup, and then ask her to fetch a sponge, a plastic plate, etc., from different rooms in the house.
- 36. A small child learns to speak by listening to the same words again and again. Therefore, hug your child and start the following game: show, for example, a table and say: “This is a table”, then point at a chair and say “This is...” encouraging the child to finish the sentence if she is able to. If you know that the child knows the word, say something wrong on purpose to give her the chance to enjoy correcting you.
- 37. Act out well-known stories and rhymes using rag dolls, or draw the characters on your fingers. You can also act out an everyday event such as bathing or going to bed by putting the dolls to bed and asking the child to be quiet and to avoid waking them up.
- 38. Enjoy “quiet” activities. Help the child do simple jigsaw puzzles, construct a simple “building” from blocks, or just open up an old toy to explore what is inside. When you are showing the child what to do, keep your voice calm and create a peaceful mood.
- 39. Leaf through books in the evening before going to bed and use them to stimulate a conversation about the child’s own experiences. Allow the child to help you hold the book and turn the pages.

## WINTER GAMES

### INDOORS

“Jump” into the bathtub with the baby at any time of day. This is against all rules, and is good for creating a feeling of closeness. Explore the water by splashing, or use plastic cups, bottles and other objects suitable for water games.

Sit in front of the mirror with your baby and look at “the other baby” in the mirror; bring the baby close to the mirror and let her touch the other baby with her nose, or give her a kiss. Or, first move either yourself or the child, or both of you, to the side of the mirror and then slowly appear. Your baby will rejoice every time her new “friend” appears.

Cut out pieces of old clothes of different texture (denim, corduroy, cloth, etc.). Make sure the pieces are big enough so that the baby cannot swallow them, that there are no buttons and that the pieces are clean. Explore these various materials by touching them with the child’s hands and face.

Hide and seek. When the child starts to walk, vary the peek-a-boo game. Hide under the bed, and, when the child comes near, come out. Or hide a favourite toy and congratulate her when she finds it.

## OUTDOORS

In a restaurant, sit the child so that she can watch people in the street and the other part of the room.

Socialise with other mothers in the neighbourhood.

In shopping centres, you do not always have to spend money. Nowadays, there are shopping centres with children's playrooms.

Swimming is ideal if you have the opportunity.

**FINALLY, FOR CHILDREN OF ALL AGES:  
DO NOT FORGET, FOR YOUR CHILD YOU ARE ALWAYS THE MOST POPULAR, THE  
MOST IMPORTANT, AND THE MOST INTERESTING GAME.**

### 5.2.7. How to choose a good toy

Mirjana Šprajc Bilen

A toy must be appropriate for the child in terms of her psychological and physical development. When selecting a toy, think about the child's health, motor skills, intelligence, temperament and, primarily, about her age.

A good toy is one that the child likes playing with, which she can use in different ways, and which she always goes back to. Adults are usually disappointed if they buy an expensive toy that they like, but which the child does not accept and will not play with. This can happen if the child is not mature enough for such a toy, such as the case of a father buying an electric train set (which he wanted and did not have when he was little) for his three-year-old, while the son wants a bucket and spade.

If the toy is so precious that grown-ups restrain the child from playing with it ("Careful not to break it, or dirty it!"), it would be better not to have bought it, because, in such a case, the child cannot put it to use. When buying a toy, you must remember that the child does not care about its material value, as is the case with grown-ups. A child needs a toy that she can play with when she wants to, and in the way she finds suitable. This may sometimes imply that a curious child will take apart even the most expensive toy to explore what is inside, and after that she will show no more interest in it. Adults must know that this represents normal childlike curiosity and the child does not deserve to be told off for it.

It may often happen that a cheap, plain toy, for instance a stuffed bear, bunny or doll, becomes a favourite toy. The child becomes faithful and emotionally attached to it and keeps it throughout her childhood, until she reaches adulthood. Such a toy becomes precious to her. In such a case, it becomes more than a toy; it is regarded as a friend and life companion.

## What is important when selecting a toy

The general rule here is that the toy must be appropriate for the child, her degree of psychological and physical development, which is most often proportionate to the child's age. Thus, the age of the child is a satisfactory criterion to bear in mind when selecting a toy. Besides the age, some other circumstances in the life of the child must also be taken into account, such as, for instance, the child's health (a healthier child will have more energy for games and sports), motor skills (good motor control allows for more active play), intelligence (at all ages, brighter children are more creative and entrepreneurial, and their interest in games is more balanced), temperament, etc. Many children like movement and sports, so that sport accessories, such as a racquet or a ball will always come in handy, while a quiet child who, for example, enjoys drawing will be happy to receive a box of coloured pencils or some other drawing supplies.

When choosing a toy, it is good to know what the child has already got. Some children are so well equipped with toys that it is impossible to buy them something they do not already have. In that case, building blocks could be a good choice because they can be easily combined with existing blocks.

## What a good toy should look like

**Shape:** The most important thing is for the toy to be shaped so that the child cannot hurt herself. There should be no sharp or hard edges, and all the parts must be well fastened. Besides, it is important for the toy to be pleasing to the eye in order to develop a feeling for aesthetics from an early age.

**Colours:** clear, bright colours, paints that are resistant to dampness and flaking, and entirely non-toxic.

**Type of material:** various materials are possible: smooth wood or plastics, but also soft, stuffed shapes and dolls that do not shed hair (teddy bear, bunny, etc.).

**Dimensions:** large enough for the child not to swallow it or stuff it up the nose.

## The right toy at the right time

During the first year of life, toys must be simple, light, soft, brightly coloured, big enough and made of material that can be easily washed or disinfected. These are, for instance, rattles, small rubber dolls or animals that produce sounds when pressed, different mobiles – colourful shapes hanging within the child's view and which move with the air currents – or rubber rings that children like to bite when they are teething. In the second half of their first year, appropriate toys are those that may be stacked or nested (blocks or plastic cups), cups, spoons, soft cloth or rubber balls with a slightly rough surface, various animals that float in the water, etc.

In the period from the first to the second year there is a great need to move around and explore the environment. Therefore, children particularly enjoy toys that allow them to do so. They like toys that they can push or pull along on a string, or those that they can ride (rocking horses) and thus develop nimbleness. They enjoy playing in the sand, so they need accessories such as buckets, spades, and other containers. At this age, they already like to build and construct with various

blocks which may be solid or hollow, and with which they will certainly like to play when they are older, but in different ways. While at this age they will just move the blocks around and stack them, later on they will construct tunnels and towers, and finally, entire buildings, houses, garages and cars.

From the second to the fourth year, children are attracted by tricycles and sledges, but also by all the toys they can use in the sand. Children usually like to draw and colour using large pencils, felt-tip pens and chalk. They can use scissors with a rounded tip. They like Lego bricks of larger dimensions, simple jigsaw puzzles, blocks with numbers and letters, simple musical instruments, abacuses with large balls, peg boards, simple card games and other society games, toys that can be wound up and cars of all makes and sizes. At this age, children increasingly play with other children, they begin to fantasise and imitate, and they show their imagination by playing different roles, such as mum and dad, a shop assistant, doctor, etc. For this, they need doctors' or hairdressers' equipment, dolls' accessories, etc.

# IV

## **Educational Guidelines for Caregivers and Parents**

## 6.0. How To Be A Good Parent

Mirjana Šprajc Bilen

In bringing up a child, parents often start from themselves and their own wishes, and not from the child and her feelings, needs, capacities and abilities. Think for a moment: do you accept your child with all her virtues and faults, do you give her enough space to express her individuality, or are you too demanding, too strict, or perhaps too lenient, or inconsistent? What is your educational attitude to the child?

The most important feature of any family is the warmth of emotional relationships between parents and children, the emotional climate that reigns in the family. It has a strong effect on the children's development, on their experience of relationships between people in general, as well as on their ability to bring up their own children when they become parents. The quality of the parent-child relationship depends of the characteristics of the parents, but also of the child who has an active role in this relationship from as early as birth.

Children differ among themselves, and some differences are largely innate, and cannot be changed through upbringing. Thus, parents with two or more children often wonder why they always have problems with one child, when they have brought up the others with no great effort, or why something that produces good results in one child, has no effect, or even the opposite effect, in the other.

Differences in children's characteristics, such as physical appearance, temperament, gender, health, ability to adjust, etc., lead the parents to have a different relationship towards each child. Some children are "easy" to bring up right from birth; they eat well, sleep well, are healthy and have a friendly disposition, while others might be irritable, whiny, have their own eating and sleeping rhythm that the mother cannot "grasp", and behave in an obstinate way. The mothers of such children quickly become tired, disappointed and irritable, they begin to doubt whether they are good mothers, which is often reinforced by the lack of understanding of the people around them ("Your child is always crying!").

There is no recipe on how to be a perfect parent, and your child does not need a perfect parent. Children need parents who love them, but also who guide them, who show them that they are "in charge" of the relationship, who decide and take responsibility for the children, in the same way that the children take responsibility for tasks they are mature enough to do. If parents are consistent and patient, they win the child's trust, which will be the source from which the child develops self-confidence and confidence in her qualities, and later on, in other people. This is an important precondition for the children's development into mature and responsible adults.

How do we know if we are good parents? If the child has no significant problems in her development and in growing up.

## Do you accept your child?

The most important thing is to show love to children and to accept them “as they are”. For example, it is not a good idea to expect a lively child to be calm, or a shy and cautious one to be open and quick.

Insufficient emotional interest in the child, a cold attitude and one where the child is ignored can derive from sentiments ranging from indifference to aversion. It is difficult for any child to stand the lack of parental love. Children experience this absence even when the parents love them, but are not able to show love. This may happen in the situation when parents love their children, but are too busy and do not have time for the children, when they are overburdened with troubles and problems, and although they care about the children, the children always have the feeling that the parents’ thoughts are somewhere else and that their parents are not really interested in what is going on.

Sometimes, parents will do anything to please their children, but they keep their distance: unfamiliar people look after the children, and the children spend their weekends and holidays with relatives. Often, even without a pressing need, a child might be left with her grandparents for years. If this long-term separation occurs in the first years of life, when the child returns home there is little chance for the necessary closeness and trust between child and parent to be established. An emotional contact can no longer be formed. During the separation, the child experiences parental rejection. In such a situation, children do not feel loved and sense they are to blame for the lack of parental love, since they feel they do not deserve it (they are not good enough, successful enough, obedient, clever or beautiful enough). In this way, children form a bad image of themselves and their abilities, they become insecure and develop the urge to “fight for” parental love, drawing attention to themselves through different forms of maladjusted behaviour (tantrums, aggression, refusing food, refusing to talk, etc.). If this does not help, they often either become extremely aggressive or they withdraw and isolate themselves. From the parents’ perspective, there may be various causes for them not to accept their children, and it is believed that they are not aware of most of these causes:

- parents imitate their own parents who did not accept them
- the animosity and anger towards their own parents is transferred onto their children
- they recognise their own faults in the children
- a parent may show hostility to a child in order to hurt the other parent, which is often the case with divorced parents.

### **Inconsistency in education: “Let her do whatever she wants, I’m tired!”**

Educational inconsistencies often occur with mothers who are too busy and continuously tired, who have neither the patience nor the time for the child, and whose mood fluctuates. Sometimes they will punish their children for behaviours which would otherwise not be punished, and at another time they will let them do whatever they like, even things that they would not otherwise get away with, in order for the mother to be able to rest or do a task undisturbed. Some fathers, preoccupied with their work, let children do whatever they like, until they overstep the mark. On some occasions, they often severely punish their children for next to nothing. Based on such behaviour, it is difficult for children to know and learn what they can and what they cannot do; so, they become confused and insecure, afraid because they do not know whether they are loved. Children protect themselves from such feelings and insecurities in different ways, often through disruptive behaviour and neurotic reactions.

No one is always consistent. A child will understand some parental inconsistency and the sporadic unfair treatment if the parent admits it and does not blame the child for his or her own mistakes.

An inconsistent attitude may also be related to the conflicting attitudes of the mother and the father about bringing up their children. Children can adjust to this, too, if the parents admit their differences. What disturbs children is that the parents get into a conflict over these differences, rather than the fact that their parents have different views.

If one parent does not let a child do something, and the other allows her to, it is understandable that the children will favour the more lenient parent, but at the same time, she will lose confidence in both parents. This is the most frequent consequence of conflicting educational positions.

### **Unrealistic parental expectations: “He will be the best!”**

Some parents expect their children to be successful in everything, to be the best and to develop in conformity with their set plan.

Such parents continuously advise their children, they direct them and make demands, and if the children do not meet their demands or expectations, they punish them. The parents’ plan must be implemented, and any resistance or negativism is not tolerated. Parents specify when the children have to eat, when they have to sleep, when they play, what they will put on, and who they should have as friends. High demands are set in terms of cleanliness, tidiness and it is expected for the child to have a high readiness to meet the parents’ demands. The parents consider that it is important for the child to be obedient and abide to the parents’ plan. Such children generally start early with language, music, ballet and other classes.

These demands are generally set higher than children can bear, since there is constant pressure on them to be perfect in everything they undertake. If they fail, the children will feel frustrated because they cannot meet their parents’ expectations, and this may result in a feeling of inadequacy

and guilt in later life. Such parental expectations create great pressure. In most cases, these expectations are unfulfilled.

### **Critical parents**

Critical parents are those who criticise and are never satisfied with what the children do, and when they are satisfied, they are afraid to show it so as “not to spoil the child”. But, on the other hand, they are not afraid of criticising, warning and comparing their child with other children who are “smarter, more successful, better”. They do not even refrain from mocking and laughing at the child. Children thus lose self-confidence and security and begin to feel less worthy in comparison with others. They are consequently filled with dissatisfaction.

### **Excessive protectiveness: “Mummy will do it for you!”**

The excessively protective attitude of some parents helps them to be good parents when children are very little and completely dependent. Later on, when children need to gradually become autonomous, such a manner becomes harmful. This applies, for instance, to a child who wants to eat by herself, put on her shoes by herself, reach something, and parents prevent her from doing so by saying, “You are little; you don’t know how to; careful, you’ll fall; you’ll make a mess; mummy will do it”. Faced with such over carefulness, children cannot become autonomous, they remain dependent on their parents, insecure, they lack confidence and become excessively shy.

Children sometimes react to such parental behaviour by throwing tantrums, having excessive demands, being disobedient at home, while outside the home they may be quiet and obedient, shy and insecure.

Overly protected children may have the feeling that the mother is always present, that she does not allow them to grow and take any risks, or that she will always see them as small children. Such children can often be demanding and selfish; they do not have friends, and even later on have difficulties in communicating with other people.

How do we become overly protective? The reasons vary, but there is always a special reason why a particular child has a special place in the parents’ life. This may have been triggered by an illness or some other condition of the child, sometimes this is a “long-awaited” child due to fertility problems, or a difficult, monitored pregnancy.

Sometimes there were serious marital problems preceding the child’s birth which might lead the mothers to experience the birth of a child as a reward for all the earlier difficulties and unfulfilled expectations. Overprotective mothers very often have an acute sense of responsibility, a close connection to the family and a prominent maternal instinct. The fathers in the family, in such cases, usually fall in the shadow, and do not have a sufficient sense of authority towards the mother and the child.

Some overprotected children behave in a rebellious, spiteful manner and can often act tyrannically towards their mothers who are extremely lenient and who appear helpless. Some typical situations can be witnessed in shops where small children demand that something be bought for them, and when they do not get their way, they start creating a performance to get what they want.

### **Excessive strictness: “You have to listen and behave!”**

If the parents are strict, this usually means that they require excessive obedience, and regularly restrain their children in their small and normal pranks or aggressive play (screaming, jumping, running, banging), which children need, but which is very irritating for grown-ups. They often expect the kind of behaviour that is beyond the level of maturity of the children. For example, they expect a three-year-old boy to tidy up his toys himself, or they expect a child who is naturally frisky and playful to be calm when visiting someone, not to touch anything, not to throw things around, to be calm and well behaved in an instant. Such demands are excessive and inopportune.

Parents use loads of energy to mould their children in their own image, and they consider their strictness to be the best way to prepare their children for the future, because they do not want to spoil them. They take their child to a psychologist because she is disobedient or too lively. They try to achieve complete obedience through punishments or constant “nagging”. In so doing, the parents do not realise that their offspring do not understand most of these torturous “lectures”, which make them confused and afraid. Due to this excessive external control, these children do not develop their independence and self-initiative, and, with these elements, the ability to become involved in groups of peers as equals. They are usually very “refined and well-behaved”, and adults praise them to the sky, as opposed to their peers who reject them.

If punishment is applied, especially strict and physical punishment, children might be very calm and obedient at home, but in the company of their peers, in kindergarten or school, they could be very aggressive, rough, and wanting to be “in charge” at all costs. All this shows that these children have not developed their internal behavioural control mechanisms.

Consequently, the result is similar to that in the case of excessively lenient parents. Since they lack sufficient control and understanding from their parents, these children do not develop their own control mechanism.

Children are afraid to openly confront strict parents, and thus try different, more or less concealed, ways of avoiding them. Such children may behave negligently, they do not hear what they are told, they forget, or, if they are forced to eat, they conceal the food. Sometimes, they have bodily reactions which give rise to psychosomatic conditions, such as headaches, stomach aches, pain around the heart, etc.

If your child is, in one way or another, “less successful, slower in acquiring certain skills” than other children, it does not at all mean that she is less clever or lazier than others. This might mean that she is afraid or insecure.

According to psychologist J. Mascoll, some suggestions have to be followed to help your child achieve what both of you expect:

- 1. Build a feeling of self-respect by showing your children that they are precious. If children have a good opinion of themselves, they will be better prepared to both acquire skills and deal with situations they will later be faced with.
- 2. Prompt good and positive efforts, work or aptitudes, instead of criticising negative attempts and lack of aptitude. Do not overburden children with demands or duties. This might cause stress that will hinder success.
- 3. Do not help your children too much, because they will never acquire self-confidence, but do not let them “agonise” over difficult tasks alone, either. Ideally, a balance should be struck between giving an initial push, where you can help children, and then letting them complete the task alone.
- 4. Set expectations for your children, but do not set them too high. If the standards you set are higher than children can realistically achieve, they might gain the feeling that their performance will never be satisfactory. Gradually increase your demands.
- 5. Use a ratio of 5 rewards to 1 punishment.

This is considered to be the most effective combination. The reward may be praise, encouragement, or a warm smile, and punishment includes reproach, criticism, indifference, even a frown.

- 6. First, it is important to comment on the positive sides of children’s efforts, even if they are more difficult to find. Then, something interesting has to be found in their work or behaviour, for instance an original idea, while the negative sides, which require constructive criticism, may be dealt with at the end. For several days, write down all the praise and punishments that you have given the child. If it turns out that there were fewer than 5 instances of praise to one punishment, it is high time you changed the way you are bringing up your child. If you continue to do the same, the child may have the impression that it can never fulfil expectations, and this depletes self-respect and produces anxiety.

- 7. It is not advisable to excessively praise your children, either. They might gain the impression that everything apart from what you praise is a failure. A child is in greater need to be seen and heard than to be praised. We can look at a drawing, and simply make a comment like: “This house is blue. You drew clouds, too”, or ask, “And what is this here?”

## 7.0. Emotional Intelligence

Mirjana Šprajc Bilen

*“Anyone can become angry – that is easy. But to be angry with the right person to the right degree, at the right time, for the right purpose, and in the right way – that is not easy”*

*(Aristotle)*

*“It is only with the heart that one can see rightly. What is essential is invisible to the eye*

*(Antoine de Saint-Exupéry: The Little Prince)*

Experience shows that the IQ (cognitive ability measured by IQ tests) of new generations of children has been increasing, while, on the other hand, their “emotional intelligence” has been decreasing. This means that children are becoming less capable of cooperating with others in resolving problems; of behaving in a friendly and kind manner; of respecting other people and empathising with them; of postponing gratification (reward); of being persistent, that is, self-motivating, so that they pull through in spite of difficulties; of understanding their own feelings and expressing them so that others also understand them, without being hurtful to themselves or others; of fostering a “positive attitude”; of being hopeful; and of having confidence in themselves and other people. These are all characteristics of an emotionally intelligent person.

Why is there a decline in the emotional competence and intelligence of the new generation?

For the simple reason that we do not sufficiently teach this to our children, and children are even less able to learn this spontaneously by imitating the adults they see, both in private and public life. Besides, we tend to imply that today kindness, understanding for other people, and integrity do not “pay off”, which sends a clear message to children about the type of behaviour we expect from them.

Since their earliest age, we have been teaching our children foreign languages, music, sports, computer skills and other skills that we think will improve their lives, make them happier and more successful. However, in the last few decades, there has been a growing awareness that rational knowledge and skills are not sufficient, and that emotional intelligence is, in fact, extremely important. Not only to make “better people”, but also to achieve what we call “success in life”. Some people hold that emotional intelligence is even more important than cognitive intelligence.

Emotional intelligence can be influenced more easily than cognitive intelligence, through learning and other educational processes, especially in childhood when the child is most capable of learning. It is in this period that some changes occur in the functioning of the brain, and the paths are set for behaviours and experiences which later remain fixed. Little by little, children in this way create a collection of methods that they will use later in life to face various difficulties. The outcome of such learning is not only a successful child, but also a satisfied and healthy one.

In everyday life we do not encourage, but rather we prevent, the development of our children's emotional intelligence. How?

- The child receives the ability to experience feelings/emotions at birth. If this ability is not stimulated in time, if the parents and the surroundings do not react to the child's emotions at the earliest age, if they do not identify them, acknowledge them, if they do not respond to them, or name them, if they do not support the child in experiencing and appropriately expressing her feelings, there is the chance that the child will "give up" some emotions, learn to suppress and negate them. This is why a child needs so much attention and care in the first years of life.
- Children learn to hide their feelings to avoid a reaction from the surroundings.

However, "in good faith", we do not always accept our children's emotions or take them seriously... They upset us to the extent that we try to prevent them or behave as if they were not there... Grown-ups ask their children from the earliest age not to get angry, not to be sad, they persuade their children that it does not hurt, that they are not tired, thirsty, hungry, etc... Anger, hate, envy, jealousy or despair are not desirable, and sometimes neither are positive emotions, such as joy or being in love. Parents sometimes say things like "Stop it, you can dance and sing later", "You can't be afraid, there's nothing to be afraid of". As if fear needed a rationale! We say, "You love your baby brother, don't you?" when the child is so jealous that she wishes the brother had never been born. When children hurt themselves or get an injection, we try to persuade them that this does not hurt, or we suggest, "It's not that terrible, don't exaggerate!" Try to imagine how you would feel if you were in pain and someone you loved and trusted was trying to persuade you that you were making it up. Or if he wanted you to love your obnoxious boss because "he is so good and loves you".

### How do children understand these messages?

- In this way, we give children the message that their feelings are not important or desirable, that they are even unacceptable. Consequently, children feel that they themselves are unacceptable, too. They must not be as they are, they should be different in order for grown-ups to accept and love them.
- So, children build a poor image of themselves and develop an inferiority complex ("I am not good enough to be loved"). Such children are not aware of their virtues. The way they feel about themselves prevents them from believing that they also have good characteristics and abilities, and so they do not make use of them, they do not even make the effort, and consequently, they cannot experience success. Or, at the other extreme, in order to compensate for their feeling of inferiority, they make a lot of effort and achieve brilliant results, but, in spite of this, the feeling of depression and the bad self-image remain.

## Children also care how we grown-ups feel

- Are we aware of ourselves and our emotions? If we do not recognise our feelings and do not know how to express them, or verbalise them, we cannot control them, or we control them sufficiently, which causes psychosomatic conditions and depression (“Those who cannot recognise their feelings, become their slaves”).
- Do we accept our feelings as they are, or do we suppress them?
- Can we relate our feelings to thoughts and behaviour?
- Are we aware how much we can affect our own mood?

Successful people consciously manage their emotions. They carefully observe their own moods, consciously channel them, and use them for their own benefit. Feelings are our source of energy, just as fuel is to a car. Feelings do not have us, we have feelings.

- There is always a choice, even with the most intense emotions. We can, for example, express strong anger either by crying and shouting, or by attacking or withdrawing.

## How children perceive their parents (grown-ups)

Parents and other grown-ups sometimes forget that children have the capacity to perceive their parents’ (adults’) behaviour, even when parents try to hide their real feelings. Parents do this in good faith to protect their children from their bad mood. However, children recognise their parents’ mood, but due to their lack of maturity and their ignorance, they interpret it wrongly. At preschool age, children are generally egocentric: “All this is my fault. Mummy (or the kindergarten teacher, or daddy) is angry or sad because I am bad. This is why they cannot love me. It would have been better if I wasn’t here, if I hadn’t been born at all”. Sometimes they might say something like this aloud, which causes consternation in the parents and other adults. Children may often maintain such an internal dialogue which can grow into a “life script”: “It would be best if I died”, and which accompanies them thought their lives.

This is why it is important to tell children when we are in a bad mood, when we are angry or sad, and explain to them that it is not their fault and that we love them. If it is, indeed, their fault, we should tell them so immediately, and accompany it with an appropriate consequence (punishment) to relieve the child from a feeling of guilt and to make her angry at us and not only at herself.

Many parents cannot stand the fact that their children are angry at them, that they are obstinate, angry or sad. This is the normal reaction of a parent or other caregiver. Some parents may even think in this situation that they are not good parents. However, the opposite is true. The fact that the parents do not let the children do whatever they like is a good indicator that the parents are actually trying to fulfil their role. If we required from children only what they themselves want, what use would we be? In order to be good educators, we sometimes need to be both demanding and “strict”, but also persistent and patient.

This does not apply to the situation where we are constantly in a bad mood and if we often “take it out” on the child. In such a case, there is no way to convince the child that we love her and that she is worthy of love and respect.

## The educational style affects emotional intelligence

Authoritative education, where the roles of the parent and the child are clearly set, has proven to be better for the development of a child's emotional intelligence. In such a relationship, it is clear which decisions are made by the parents, and which are the child's responsibilities, and who listens to whom. For the development of emotional intelligence, it is better to be too strict but consistent, than too lenient and giving.

Emotional intelligence develops through the systematic teaching of children in all the areas mentioned above, such as the development of morality, encouragement towards cooperation and empathy, creation of trust, confidence, optimism, care for self and others, realistic thinking and resolving of problems, social skills, communication skills, sense of humour, acquiring friends, functioning in a group, good behaviour, success, the strength and control of emotions, non-verbal communication, the emotional strengthening of body and spirit, etc.

## Conclusion

How can we stimulate the development of emotional intelligence and enable the child to be successful in the first years of life?

- By developing our own emotional intelligence
- By systematically teaching, not only through words, but also through experience.

The entire handbook suggests how to stimulate the psychomotor and emotional development of babies and small children in the first years of their lives and create the preconditions for a healthy life. The chapters on play, massage, educational procedures, and the stress of parenting all suggest simple ways of caring for your children, providing support and understanding, and participating in their emotional life. All these are methods to show our children, in a way that is acceptable to them, that we love them and that they are important to us. The way we treat them is the way they will later treat us, but also all the other people around them. When we develop their self-confidence and trust through play, socialising and understanding, we also stimulate psychomotor development, and we create what is necessary for children to exploit their capacities and to be successful. At the same time, we prevent later disruptions which are the plagues of today, such as depression (the most widespread illness of our time), aggressive behaviour, addictions, crime and illness.

## Some suggestions on how to stimulate the development of preschool and school children's emotional intelligence

- Be sincere with your children and require the same from them.

Children often lie, with the "good intention" of protecting both parents and themselves. Therefore, they often lie about their school grades in order not to upset or disappoint their parents. If a child tells a lie, it does not mean that the child is (or will be) a liar, as parents often so perceive, but in most cases the child cannot bear your reaction to the truth. Usually, a parent's reaction is excessive. It must be borne in mind that children of preschool age often do not know the difference between truth and their imagination, so it can be said that they do not lie, but invent.

- Do not hide problems from your children. If you explain about the life situations around you, children will learn something from this. Do not keep it a secret that you do not get along with your spouse or that you are getting a divorce. Children will notice this anyway, and this will scare them even more. It is best to tell them that this is your problem, that you are sorry for that, but that you will resolve it, and that this is not their fault, and that they cannot do anything to help. Do not hide the fact that you have lost a job, or that someone in the family has died. Nevertheless, this does not mean that you should inform your children about all your intimate events.

- A child should be encouraged to make and keep friendships with other children (invite them to birthday parties or other parties, and do not be too critical towards your children's choice of friends).

- Demand friendly and polite behaviour towards other people.

- Encourage them to do something for people or children who are weaker, poorer, or ill. Involve them in community work.

- Be authoritative. Today's education is, in most cases, too lenient. We do not have time for our children, so the easiest thing is to give in, and give them everything they want just to "be rid of them" for a while. Do not give in when what is at stake is important.

- Teach children to be persistent. Do not let them give up immediately after the first attempts. Patiently encourage them to keep trying.

- Do not resolve your children's problems if they can resolve them themselves (do not write their homework, do not meddle in their conflicts with other children, except if the latter are stronger, and when bullying is involved). Doing things for your children gives them the message that they are not capable of doing these things alone, and leads to them ceasing to make any effort. It is better for the children's self-confidence to get a bad mark for their own homework than a good mark for someone else's.

- It is also necessary to talk about your own weaknesses in front of your children, and not about your being better at everything. This will produce closeness and will increase your authority. But we should not tolerate our children's faults just because they are our faults, too.

- Do not allow children to spend too much time in front of the television (not more than 12 hours a week). The violence often seen on TV reduces the children's sensitivity to other people's suffering.

- In contrast, it is thought that many computers and computer games stimulate the development of emotional skills.

- Find at least some time to play, socialise and talk to your children every day.

- Encourage the children to express freely what they feel, and do not explain to them that they should not feel that way. Because we do not choose our feelings. But we can choose a way to express these feelings. It is the parent's role to help their children to recognise and express their feelings without hurting themselves and others.

- Foster humour.

- Teach yourself and your children how to pursue a healthy lifestyle, as far as this is possible: a healthy diet and physical exercise, relaxation techniques and how to deal with anxiety and stress.

- Develop a positive, optimistic attitude to life and its problems. Optimism is learned from the parents. There is a solution for every problem.

# V

## Evaluation and Supervision

### Supervision should be implemented in two ways:

- 1. As organisational-coordination supervision where the manner of work and programme activities are supervised and modified as needed. This part of the work is conducted by the programme leaders in close cooperation with the supervisors of the expert part of the work. The leaders must also have a high level of expertise. They must exploit all the advantages in terms of locality and resources, and encourage the individual abilities and initiatives of the team members.
  
- 2. As expert supervision in the course of providing assistance, where work is conducted in terms of continuous training based on case studies which were originally part of the work of the teams, and where opportunity is provided for consultations. Professional supervision is conducted by the best experts in the area of early growth and development who can be found in the region caught up in the crisis. It is advantageous if the experts to be engaged have not been personally hit by the crisis, so that they can have a more objective and comprehensive insight into the very complex processes that are part of the programme, such as needs assessment, and the assessment of the method of work with the affected persons, as well as the way helpers are taken care of.

The best way to evaluate the situation and assess the needs of the affected persons is to systematically collect data and to continuously monitor these data, so that the programme can be adjusted to the current situation and to current needs. Very often, such data point to needs and problems that cannot be identified through traditional supervision meetings. Besides, the collected data represent a basis for documenting the conducted activities (for the needs of the financiers), they provide a background for further scientific research, and they constitute a historical document of the events related to the crisis.

The scope and type of data that are collected depend on the expert and organisational capacities of the programme leader.

At the very least, the following data must be collected:

- 1. general data (age, gender, education, characteristics of the place of origin, etc.);
- 2. social origin and economic activity;
- 3. social position in the narrow social environment, before displacement;
- 4. family relationships;
- 5. traumatic events;
- 6. health – general health status before the war and at the time of the interview;
- 7. health – psychological health status before the war, and at the time of the interview;
- 8. consequences of the traumatic experiences;
- 9. evaluation of the early relationship between caregiver and infant (for example, the regularity of monitoring the pregnancy; basic knowledge about the development and needs of the

child; length of nursing; knowledge of why a baby cries; whether it is difficult for the mother to take care of the baby; whether she provides for suitable medical care; whether the child has any chronic conditions; spontaneous communication with the child; spontaneous communication of the child with the mother; appearance and tidiness of the child, the living space and the family);

- 10. records of interventions conducted in each individual family.

As part of the programme, the collection, entry, and, where possible, electronic processing of data must be arranged.



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**Providing assistance in crisis situations to families with babies or toddlers**

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