ABOUT THE EVALUATION OF THE ICDP PROGRAM

ICDP international working group 2010

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I INTRODUCTION

How can the ICDP program be evaluated in a sensible way?

As this is not an external package program of a behavioural nature, but a sensitising program where consciousness-raising of personal interaction with one's child and facilitation of existing positive behavioural patterns is the key issue, then the evaluation of this intention may be slightly different from the traditional approach within this field.

It has to make sense and be in line with the naive theories of those who implement it otherwise it will not be sustainable.

Some points to consider:

1. It is naive to believe that facilitation of caregivers' positive patterns of care will release long-term changes in the children. At best this can be one of many factors influencing a child's life-career or life-path. Such issues are necessarily multi-causal, and it is naive to think that simple facilitation or consciousness-raising of the caregivers' positive interaction patterns should necessarily have a long-term effect on the child's school career.
It could have long-term effect but the social landscape through which a child is going to travel (develop) is too complex and full of other obstacle that it would be naive to think there should be a direct single-causal connection between intervention and outcome in the child many years later. Such expectations could only be based on simplistic Cartesian conceptions of mental change that would directly manifest in behaviour, but we also live in a complex social world where the behaviour and life-career of a child is not only a reflection of the ideal intentions or even caring behaviour of a mother.

Therefore it is unrealistic and naive to expect that upgrading the quality of interaction between caregiver and child should necessarily be reflected in the child's improved adaptation at school or other simple social measures. I would say this applies to all early intervention programs.... It springs from the engineering assumption that human beings can be predicted like simple physical events...

Secondly, it is not likely according to the same line of reasoning that intervention-treatment maybe from 5 to 20 meetings should necessarily have long-term effects. It may have a long-term effect if it is like a cycle of interactions that has slipped out of its normal course and is brought back to normality through some facilitative interactive moves. Under such conditions we can expect a long-term effect. But this may not be the case for most of our interactive behaviour. Intervention may not only require restoration of interactive patterns out of track, it may require the acquisition of new patterns of interaction and **these may need continuous contingent support for its sustainability.** Under such circumstances these patterns will probably need long-term contingent support and a relevant supportive milieu with recurrent situations that gradually transform these patterns into adaptive everyday routines. When we think in more a multi-causal ways about intervention, we should also consider intervening and preparing the social landscape of human encounters, situations or what Weiner calls "activity episodes" in order to provide a contingently support-system for the newly emerging interactive patterns.

But this concept of intervention is different from the classical Cartesian or medical intervention, where the basic idea is to repair a part that is deficient. In this case the reparation is in both acquiring new patterns of interaction with a social support system that is a natural part of the socio-cultural landscape. In order for that to materialize we need to assess whether this pattern does fit in and has natural supportive contexts or activity episodes within that cultural framework.

If we think of our competencies and skills as multi-causal - that it depends upon a series of supports and contingencies:

2. What is then the point?

The point is to raise the quality of care for the immediate benefit of the mother and the child. To make it more understandable and predictable, to see the child as a human being, to bring this domain into a frame of understanding and feeling that would make it more humane, more interpretable and more in line with our best cultural and moral intuitions of how human beings are and should be. By taking our children as sensitive, intentional and emotional human persons that are understandable and interpretable within our cultural traditions we may contribute to making them that - namely what we assume.

In other words, this is an interpretive enterprise, that could have long-term developmental consequences, probably better chances than program without anchorage in human common sense, but still this is too pretensions for any early intervention program that operates only in the caregiver - child dyad.
(See model of multiple regulations of child rearing and development).

3. What should be the criteria then for whether the program is achieving its goals or not?

We need then to specify goals of the program and maybe also hopes...

The goals would be (as a logical implication of the nature of the program):

a. That there is an improved understanding/awareness on the part of the caregiver for the positive qualities of care that should and could exist between herself and her child.

b. That she in addition to increased self-insight also has a stronger sense of self-confidence as caregiver.

c. That she is more differentiated in her perception of her child and his/her reactions.

d. That she has developed a more differentiated personal theory of how and why the child acts in different situations that is more interpretive and more based on the child's point of view and the child's intentions.

e. That she behaves more sensitively and considerate in relation to the child.

f. That the emotional relation child to the child is more positive and differentiated.

g. That the child's feeling towards the caregiver is most probably more positive and differentiated than before.

This entire thesis should be argued for in relation to the nature of the intervention.

This would be a more realistic micro-evaluation of the program in line with the nature of the program and its immediate intentions. It would of course be good if our interventions had long-term effects of a dramatic nature, that would help funding, but it is beyond any realistic understanding of how child development takes place in a socio-cultural reality. Such a microanalysis however could be more differentiated so that one could assess the single components of the program and even its "dosage". This could be done in small-scale experimental studies with in depth interviewing of the participants.

<u>On the following pages there is a compilation of formats we used so far in ICDP; this is not a blueprint and suggestions for improvements/changes are welcome.</u>

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II PRE-INTERVENTION ASSESSMENT TOOLS – BERGEN MODEL

FINDING OUT WHAT THE CONCEPTIONS OF THE CHILD ARE

Inside a culture, what mothers think about their infants, their naive theories of child rearing, their image of what a child should grow up to be shape their behaviour towards the infants, affecting both the manner in which they relate, attend and act towards their children.

In connection with the program it is important to know about parents' conceptions of the child, their conceptions of the child's potential for development and how they see own role in promoting the development of their child.

This type of information is essential in order to see whether there is sufficient emotional and conceptual space for positive communication to take place. If there is not, the space needs to be created by negotiating new more growth promoting conceptions that invite a more sensitive and mediational relationship between the caregiver and the child.

Misconceptions that block a child's development:

There are many kinds of misconceptions that can block a child's development. Sometimes these misconceptions may be linked to traditional superstitions connected with particular handicaps, e.g.:
Child with a physical or mental handicap may be considered, as a punishment from God and thus one should not attempt to modify his condition and intervene in the work of God.

In the third world, a quite widely spread conception that may inhibit a child's development, is the conception of bad fate or karma. There is nothing you can do with a child who has a bad fate because his development is already pre-ordained - who am I to intervene in a child's karma?

In traditional societies such conceptions are sometimes combined with a strong emphasis on obedience in children. This may prevent the development of children's initiatives, which is a precondition for reciprocity. Under such conditions there is only one-way instruction without expansion and explanation from the parents. The child learns external rules of obedience and respect in rote, repetitive fashion without real understanding. At the subsistence level it is quite usual that only the pure physical needs of the child are taken care of. The implicit conception is that a child grows like a plant, you only have to feed it and the rest will take care of itself. This custodial misconception of a child was quite prevalent in traditional institutions providing medical care for children, and it has created developmental tragedies on a large scale.

Another type of misconception of the child's potential for growth is sometimes associated with a diagnosis implying organic damage. When a child is diagnosed as brain injured, minimal brain dysfunction, low I.Q. or mental handicap, these diagnostic labels may invite static conceptions of the child's development. The child is brain injured so there is not much one can do about it, has been the traditional attitude under such circumstances.
Fortunately growth oriented diagnostic systems are now starting to appear with more focus on the child's potential for development than on the limitations incurred by the handicap.

Finally, another major cause of misconceptions that may hamper development is related to psychopathology in the parents. The child may symbolise something that releases hatred and rejection or ambivalence in the parents - the child is accepted and loved one moment and rejected the next. Under such unpredictable conditions the child may protect him/herself by withdrawing from all human contact and this implies at the same time a withdrawal from all growth promoting mediational influences in human interaction.

Interview on parents' conception of their child

Good and bad child-rearing:

1 Can you tell me, in your opinion what is the most important thing parents should be aware of when they bring up their children?

2 What, in your view, does a child need most of all in order to grow up in the best possible way?

3 In your view, how would you say good parents bring up their children?

4 How, would you say, bad parents bring up their children?

5 What would you say is the father's role in child rearing?

6 What is the mother's role?

Conception of the child:

7 Which are the qualities you would like to see develop in your child?

8 Which are the qualities you would dislike to see develop in your child?

Problems: methods of discipline of children:

9 You know that most parents have some problems in relation to their children, what are your problems, if any, with your child?

10 If a child behaves badly, what would you do to stop him?

Development and stimulation:

11 Is there anything you can do as parent to promote the child's development so that the child develops faster and better? What would you do?

12 At what age, in your opinion, do infants begin to understand the words spoken to them?

13 When, in your opinion, is it worth starting to talk to infants?

1	2	3	4	5
directly after birth	in the first month	at three month	at six month	when infant begins to talk

14 When do you think it is worth beginning to tell children stories?

1	2	3	4	5
at 3 months	at 6 months	at one year	at two years	at three years

Values and number of children / traditionalism / modernism:

15 What would you say are the advantages or benefits of having children?

16 What are the disadvantages of having children?

17 How many children would you say is the right/best number for parents to have? Why?

18 Does it matter whether you get many sons or many daughters?

Time mapping of a typical day in the child's life

In order to get a more concrete impression of a child's everyday range of activities and of its caring environment, it may be useful to make a map of a typical day in the child's life.
Fill in, either through observation and/or through interview with mother and preferably also another family member.

Name_____ Age_____

Time	Where is the child?	What is s/he doing?	With whom - or alone?
1.....	.....	.....	.....
2.....	.....	.....	.....
3.....	.....	.....	.....
4.....	.....	.....	.....
5.....	.....	.....	.....
6.....	.....	.....	.....
7.....	.....	.....	.....
8.....	.....	.....	.....
9.....	.....	.....	.....
10.....	.....	.....	.....…...

Comments on who are the caregivers and how each relates to the child:
.....

ACTIVATING INDIGENOUS CHILD REARING PRACTICES AND CHILD CULTURE

One of the objectives of this program is to promote and reactivate sound indigenous practices, like toy making, stories and fairy tales, games, songs, dances, artistic expressions of any kind, moral practices etc. although not all indigenous practices are necessarily worth cultivating.

Such reactivation should preferably be done by using a participatory approach, encouraging participants to come up with their own ideas and suggestions that are discussed and evaluated within the framework of the guidelines/criteria of mediation.

Questions that can be used to reactivate traditional child oriented practices in group discussions with caregivers

Duties/tasks:

- As a child, do you remember if you had some tasks or activities that you were responsible for carrying out? Which?
- How old were you when you started with this?
- Are there any other activities/tasks or duties that young children were expected to carry out in the traditional family? How? How old were the children?
- Are they different from the activities children are involved with now?
- Do children have any similar duties/tasks they are expected to perform? At what age?
- Play and activities with children:
- Do you remember some of the activities you used to do with your parents when you were a little child?
- Which activities did you like most of all?
- When you think of babies, were there any activities that you used to do with babies?
- Did your parents play with you when you were a little child?
- Do you remember how they played with you?

Toys:

- As a child do you remember if you had any toys?
- How did you get these toys?
- Were there any toys that your parents made?
- Do you know how to make toys for children?

Games:

Do you remember any games that adults used to play with children in the old way?

Are there any new games that you know adults use to play with children nowadays?

Do you remember any of the games that children used to play together?

What about nowadays, are there any new games? Which?

Do you remember some dramatic plays or role plays that you liked when you were a little child?

Stories:

- I suppose some parents used to tell stories for children? Was that usual? What kind of stories? About what or about whom? What was the typical content?

- Can you tell me some of these stories? What do you think about them, can they be used for children now?

Songs and dances:

- Were there any songs that you remember were usual to sing to children when you were a child? Which songs?

- Were there any songs especially for babies? (If possible record)

- I suppose there are new songs which are popular for children nowadays? Do you know any of the new songs that children like to hear?

- What about dances, did you learn any dances when you were a little child? Which?

- Now I have learned a lot about the ways you traditionally deal with children in your country. We must remember to include some of these activities, stories and songs in the program that we are in process of adapting. I hope you will try out some of these activities, stories and songs on your own children.

Let us now decide which activities we should try out on your own children till next time:

Duties/tasks.....….

Play and Activities .....

Toys.....

Games.....

Dramatic plays.....

Stories.....

Songs.....

Dances.....

Educational activities.....

Data collection sheet for research in parent/child interaction

Basic information Date of first contact_____

Name of child_____

Father_____ Mother_____

Date of birth_____ Birth weight in grams _____

Complications during birth: Yes:_____ No: _____

Born: 1) On term _____
2) 1 month early _____
3) 2 months early _____
4) 3 months early _____

Number of mother's pregnancies:_____

Complications during pregnancies:
_____

Was the child suffering from malnutrition? Yes____No_____

Breast-feeding for how long?
_____

Any serious accidents or illnesses till now? Yes _____ No_____

If yes, which _____

Was the child hospitalised for any reason? Yes _____ No _____

If yes, state reason_____

Is the child immunised? _____

If yes, against which illnesses?_____

The child's diet yesterday:_____

Is this diet usual? _____

If not, what is usualdiet_____

Mother's age _____ Father's age _____ Religion _____

Number of years of schooling: Mother _____ Father _____

Occupation: Father _____ Mother _____

Are parents living together? Yes _____ No _____

Who cares mostly for the child?

Mother	_____
Father	_____
Grandparent	_____
Other in home	_____
Sibling	_____
Day-care	_____
Others:	_____

If there is more than one caregiver, indicate:
_____

Number of other children in family _____ Their age and sex: _____

How many people on average live together in the home _____

How many rooms _____

Socio-economic level of the family:

Below _____ Average _____ Above _____

Who is supporting the family economically? _____

Please specify income if possible _____

How much did you spend: yesterday _____ last week _____

Is this typical: _____

How much do you spend on food per week: _____

On other things: _____

According to your opinion how heavy is the mother's work load throughout the day?

Heavy _____ Moderate: _____ Light: _____

How much time does the mother spend for individual care and play with the child? _____ hrs

Who is helping the mother with her workload? _____

To whom can she turn in case of distress or need?

_____

What is father's task in relation to care of the child?

_____

What is father's task in the home?

_____

Other comments about the child or the family situation:

_____

Finding out the quality of interaction between caregiver and child in direct observation or on video tapes

To be used by facilitators and trainers. Video tapes and photos are made of caregiver-child interactions in the prototypical everyday situations (see manual). Information gained from this pre-investigation constitutes the background for the training seminars and for the adaptation of the programme to the local context.

1. Assessment of qualities in individual caregivers based on ICDP guidelines

1. S/he expresses love and positive feelings in her interaction with the child	0	1	2	3
2.a. S/he is attentive to the child's initiatives and expressions	0	1	2	3
2.b. S/he is responsive to the child's initiatives and expressions	0	1	2	3
3. S/he is able to communicate in a non-verbal way with gestures	0	1	2	3
4. S/he encourages and praises the child for what the child does well both verbally and non verbally with confirming gestures	0	1	2	3
5. S/he is good at catching the child's attention so that they have shared attention when they are together	0	1	2	3
6. S/he gives names and descriptions to what the child experiences	0	1	2	3
7.a. S/he gives explanations and expands the meaning	0	1	2	3
7.b. S/he tells stories and encourages the child to dramatise or symbolise his/her experience	0	1	2	3
7. S/he provides positive regulations and sets limits in a positive way – keeps order without terror	0	1	2	3

2. Make an interactive profile based on the information in the previous scale (see above point 1.):

3

2

1

0

--Love—Initiative—Dialogue—Praise—Focus—Meaning—Expand—Regulate

NOTE: After a period of time make new observations and interactive profiles for the same caregiver interacting in the same situations with the child and compare profiles to establish if there are improvements.

III EVALUATION PROCEDURES – BERGEN MODEL

Within half a year from the start of an ICDP project it should be possible to evaluate the impact of the program by making various assessments. Outlined below is a collection of methods for the evaluation; some of which may be more practical to use than others depending on the project circumstances and its budget size.

A Assessment of quality of interaction of individual dyads (caregiver and child), through video observation and making of interactive profiles.

Pre-post evaluation of the effects of the ICDP program

This is relevant for a research project: video recordings of each caregiver and child are made pre and post intervention. Coding forms below should be used to make an interactive profile for each mother before and after intervention, to see if there is difference between the two assessments, in the direction of higher scores for each guideline on the post intervention profiles. This type of evaluation is laborious and expensive. Help from professionals should be sought – preferably from a nearby university.

VIDEO RECORDING OF CAREGIVER-CHILD INTERACTIONS FOR RESEARCH

Video recording interaction is used to capture subtle features of interaction between caregiver and child. By replaying a few times the same sequences on the film the subtler aspects of the recorded interaction can be revealed.

There are great individual and cultural differences in the styles of interaction. Using the recorded video and going slowly through the interactions these differences can be analysed according to the basic guidelines of the program.

By observing video recordings of normal mother child interaction in addition to interviewing the mothers, it is possible to identify the typical cultural patterns of interaction and also the typical forms of mediation within that culture. This knowledge represents a basic prerequisite for any facilitation or sensitisation to take place.

This ICDP program makes use of the video camera to record some mother-child interactions in the community before the start of the program and also after the program has finished.

For this purpose standard situations in mother-child typical everyday interaction are usually recorded with a video camera, such as feeding, bathing, playing

Before starting any filming the facilitator needs to establish a confident relationship with the mother/caregiver and the child and explain the intention of the visit in positive terms so that she does not get the feeling of being tested. Sometimes it is possible to present the project as a comparative study of different child rearing practices.
The facilitator needs to ask the mother to speak and act naturally with the child as in her typical everyday life.

It is important to find a position that is not too intrusive, so that the mother can forget about the camera, zooming in from some distance may be good; it is necessary though, to record the face to face interaction, the qualities of expression. (If the camera can stand by itself, it is perceived as less intrusive). Each situation needs to be filmed for 15-20 minutes, starting after the mother has adapted to the situation and is not too self -conscious.

Coding form 1

for assessing quality of interaction between caregiver and child (Either from video recordings or through direct observation)

Emotional expressive interaction

1 To what extent does the mother show the child positive feelings and that she loves the child?

1	2	3	4	5
to a very small extent	to a small extent	average	to a great extent	to a very great extent

2 To what extent is the mother aware of the child's signals, desires and intentions and to what extent does she try to adjust herself and follow what the child is concerned with?

1	2	3	4	5
to a very small extent	to a small extent	average	to a great extent	to a very great extent

3 To what extent does the mother talk to her child and try to get a positive contact and conversation going through emotional expressions: eye contact, smiles, gestures and sounds which go back and forth between the two?

1	2	3	4	5
to a very small extent	to a small extent	average	to a great extent	to a very great extent

4 To what is extent does the mother praise and confirm in a positive way what the child is trying to do?

1	2	3	4	5
to a very small extent	to a small extent	average	to a great extent	to a very great extent

Coding form 2

Mediational enriching interaction

1 To what extent does the mother help her child to catch her child's attention and direct and focus it to things in the surroundings so that they experience things together?

1	2	3	4	5
to a very small extent	to a small extent	average	to a great extent	to a very great extent

2 To what extent does the mother name and describe what she and her child experience together, showing at the same time enthusiasm and happiness at what they are experiencing together?

1	2	3	4	5
to a very small extent	to a small extent	average	to a great extent	to a very great extent

3 To what extent does the mother expand and enrich the child's experience of its surroundings by making comparisons with other experiences, giving explanations or by telling stories?

1	2	3	4	5
to a very small extent	to a small extent	average	to a great extent	to a very great extent

4 To what extent does the mother guide and direct the child in a positive way by helping it to make plans, showing positive alternatives of action, showing the next step in a task, and so on?

1	2	3	4	5
to a very small extent	to a small extent	average	to a great extent	to a very great extent

Making a profile

Make a profile of caregiver/child interaction based on the ratings that were given in the coding-forms in the previous pages.

Fill in, in the empty spaces, the mark (assessment) given for each of the eight guidelines of good interaction. Draw the profile afterwards.

	Emotional		**Mediational**
Mark:			
5	- - - - - - - - - - - - - - - -	I	- - - - - - - - - - - - - - - -
4	- - - - - - - - - - - - - - - -	I	- - - - - - - - - - - - - - - -
3	- - - - - - - - - - - - - - - -	I	- - - - - - - - - - - - - - - -
2	- - - - - - - - - - - - - - - -	I	- - - - - - - - - - - - - - - -
1	- - - - - - - - - - - - - - - -	I	- - - - - - - - - - - - - - - -
Guideline:			
	1 - - - - 2- - - - 3- - - - 4- - - -		5- - - - 6- - - - 7- - - - 8- - - -

Emotional guidelines:

1 = Showing feelings and love

2 = Seeing and following the child's signals /initiatives

3 = Talking and non-verbal emotional communication

4 = Praising and confirming

Mediational guidelines:

5 = Focusing the child's attention

6 = Conveying meaning; naming, describing

7 = Expanding, enriching; comparing, explaining

8 = Regulating, leading

B Assessment of changes in the caregiver using caregiver's own judgements

This assessment is based on mother's own free descriptions of the changes they have observed in themselves.

1 Use, both before and after the implementation of the programme, the form on the following pages for mother's spontaneous description of herself as caregiver

2 Use, both before and after the implementation of the programme, the form on the following pages for mother's perception of herself along the Likert scale

To assess if the program had a positive impact on the caregiver compare these assessment forms to see whether the mother had become more of the 8 qualities emphasised in the program:

- More loving and positive
- More attentive to the child's initiatives
- More responsive to the child's initiatives
- More able to communicate in a non-verbal with the child
- Giving more names and descriptions to what the child experiences
- Giving more explanations and expansions
- More positive regulations and more positive limit setting

The mother's judgement of herself as caregiver

1 The mother's spontaneous description of herself as mother

Ask the mother: Could you try to describe how you are as mother? What kind of mother would you say you are?

Translate her description into adjectives and write them down in the list below:

List of the mother's spontaneous self-characterisation as mother:

1.
2.
3.
4.
5.

Description by mother of her own strengths and weaknesses as caregiver:

1.
2.
3.
4.
5.

2 The mother's perception of herself as caregiver along a Likert scale:

Likert scale:

1	2	3	4	5
I----------I		I----------I		I----------I
to a very small extent	to a small extent	average	to a great extent	to a very great extent

Give the mother the following list of descriptions and ask her to indicate on the scale how she assesses her own behaviour with respect to these descriptions:

DESCRIPTIONS:	LIKERT SCALE:
-loving & positive	I----I----I----I----I
-attentive to child's initiative	I----I----I----I----I
-responsive to the child's initiative	I----I----I----I----I
-able to communicate non-verbally	I----I----I----I----I
-names and describes what the child experiences	I----I----I----I----I
-gives explanations and expansions	I----I----I----I----I
-makes positive regulations and limit setting	I----I----I----I----I

C Assessment of changes in the child

It is important to register if there are any observable changes in the child. This is usually done through testing, which can be quite laborious and technical - and sometimes irrelevant to the objectives of the intervention. Less laborious are the observational rating scales either through interview or given directly to mothers/caregivers. There are several forms below that could be used:

1. Form for mother's spontaneous description of the child

2. Form for mother's own perceptions of the child along a Likert scale

3. Form for mother's assessment of the child: checklist of risk symptoms

4. Form for facilitator's assessment of the child, the checklist of risk symptoms on Likert scale

*NOTE: The above form (under C 4.) the facilitators can fill in after paying home visits to the family:

a) Facilitators will visit the families to introduce the program and collect basic data at the start of the intervention and will have during that time an opportunity to observe the children and the way they behave in their home environment

b) Facilitators will visit the families at the end of the intervention to collect data from mothers about their assessments of the program and during that time will have again the opportunity to observe the children's behaviour in their own homes and families.

The qualities expected to develop as a consequence of the intervention that has been carried out through the ICDP program are shown bellow - these are ideal descriptions of the qualities we should look for:

1 An emotionally more positive and open child that would respond to emotional cues from people. (Guideline: 1,2,4)

2 A child that would be more self confident and active, following its own ideas and initiatives (Guideline: 2,4)

3 A child that would have a well developed vocabulary and knows a lot about the surroundings and would ask questions (Guideline: 3,6,2)

4 A child that would have fantasy, go beyond, explore and be interested in explanation, comparisons - more intellectual and with more fantasy. (Guideline: 2,7)

5 A child that would be more orderly and able to plan and reflect ahead and to be able to control its immediate impulses. A child, able to adjust to others and follow rules of cooperation. (Guideline: 5,7,8)

The mother's conception of the child

1 The mother's spontaneous description of her child:

Ask the mother the following questions: As a mother, can you tell me how your child is? Which qualities do you see in your child?

After the mother has given her spontaneous description translate her description into adjectives and note them down in the list below. Let her finish without influencing her in any way.

List of spontaneous descriptions of the child:

1.

2.

3.

4.

5.

Mother's conceptions of her child's strengths and weaknesses:

1.

2.

3.

4.

5.

2 The mother's perception of her child along a Likert scale:

Likert scale:

1	2	3	4	5
I	I	I	I	I
to a very small extent	to a small extent	average	to a great extent	to a very great extent

Give the mother the following list of qualities and ask her to indicate on the scale how she assesses her child on these qualities.

positive	I----I----I----I----I
open	I----I----I----I----I
responsive to emotional cues	I----I----I----I----I
self confident	I----I----I----I----I
active	I----I----I----I----I
follows own ideas and initiatives	I----I----I----I----I
has good vocabulary	I----I----I----I----I
asks questions	I----I----I----I----I
observant	I----I----I----I----I
has fantasy	I----I----I----I----I
likes to explore his surroundings	I----I----I----I----I
able to plan ahead	I----I----I----I----I
co-operative	I----I----I----I----I

Mother's assessment of the child:

Checklist of risk symptoms

1	Clinging in need of contact	yes..... no.....
2	Without contact with other children	yes..... no.....
3	Aggressive towards other children	yes..... no.....
4	Provocative in his contacts	yes..... no.....
5	Is sad and crying, have nightmares	yes..... no.....
6	Apathetic/withdrawn, dull without contact	yes..... no.....
7	Lacking self confidence	yes..... no.....
8	Does not speak	yes..... no.....
9	Disruptive, chaotic behaviour problems	yes..... no.....
10	Bizarre behaviour, repetitive mannerisms, lives in her/his own world	yes..... no.....
11	Shows clear symptoms of anxiety, fearfulness	yes..... no.....
12	Has special anxieties/fears for particular objects, persons, places etc.	yes..... no.....
13	There are no pathological reactions and attitudes of the kind mentioned above	yes..... no.....
14	The child is happy and active	yes..... no.....

Facilitator's assessment of the child:

Checklist of risk symptoms

Use Likert scale:

1	2	3	4	5
I	I	I	I	I
to a very small extent	to a small extent	average	to a great extent	to a very great extent

1	Clinging in need of contact	I.....I.....I.....I.....I
2	Without contact with other children	I.....I.....I.....I.....I
3	Aggressive towards other children	I.....I.....I.....I.....I
4	Provocative in his contacts	I.....I.....I.....I.....I
5	Is sad and crying, have nightmares	I.....I.....I.....I.....I
6	Apathetic/withdrawn, dull without contact	I.....I.....I.....I.....I
7	Lacking self confidence	I.....I.....I.....I.....I
8	Does not speak	I.....I.....I.....I.....I
9	Disruptive, chaotic behaviour problems	I.....I.....I.....I.....I
10	Bizarre behaviour, repetitive mannerisms, lives in her/his own world	I.....I.....I.....I.....I
11	Shows clear symptoms of anxiety, fearfulness	I.....I.....I.....I.....I
12	Has special anxieties/fears for particular objects, persons, places etc.	I.....I.....I.....I.....I
13	There are no pathological reactions and attitudes of the kind mentioned above	I.....I.....I.....I.....I
14	The child is happy and active	I.....I.....I.....I.....I

D Facilitator's assessment of mother's participation

In order to make this assessment it is helpful to consult the diary that the facilitators keep as a record of each of the meeting held with mothers.

Also the provided forms for assessment can be used:

The facilitator's assessment of the mother's commitment in participating in the sensitisation training

a) The facilitator's assessment of the mother's interest in the training:

1	2	3	4	5
I	I	I	I	I
very little	little	moderate	great	very much

b) How active was the mother during training?

1	2	3	4	5
I	I	I	I	I
very little	little	moderate	great	very much

The facilitator's description of the mother as a caregiver for the child

1 Spontaneous description of the mother/caregiver

Try to describe how you evaluate this person as a caregiver for the child.

What kind of caregiver would you say this person is?

In the same way as before, translate the description into adjectives and write them down in the list below:

List of facilitator's description of the person as caregiver:

1.
2.
3.
4.
5.

E Mother's assessment of the program

The very simplest way of doing this is to ask each caregiver what are their impressions of the training.

Use the form for the caregiver's assessment of the ICDP training:

The mother's assessment of the training:

a) Do you feel that you have benefited from participating in the training?

1	2	3	4	5
I	I	I	I	I
very little	little	moderate	great	very much

b) Can you explain in more detail why you feel you have benefited from participating in the training?

c) What was positive and what was negative in the training?

F Trainer's assessment of the facilitator's skill in delivering the programme to families

For more detailed descriptions see the following section called:

IV Evaluations used in institutions

- A Evaluation of the quality of facilitators/trainers' work in the field

IV EVALUATIONS USED IN INSTITUTIONS – the Angola project

The following set of forms was prepared for use in Angola, where the ICDP programme is being implemented on national scale in hundreds of institutions.

A Evaluation of the quality of facilitators/trainers' work in the field

The scales described below can also be used for self-monitoring and as another way of sensitising the facilitators for their work.

1. General scale to evaluate field workers - facilitators and trainers, both as teams and individually.

The following main questions can be used to assess both groups and individuals. The answer to the first question in each category should be either yes or no. The others are open for further explanation.(The questions could also be assessed on a Likert scale from 0-3)

1. Do they (she) work the time agreed upon per week?
How much time do they spend in the institution per week?

3. Do they (she/he) carry out their work according to a systematic plan?

4. Have they in advance made an assessment of the type of problems that are dominant among the children and their caregivers?

Which instrument do they use?
What is the average number of interventions they have for each group?

5. Do they follow a systematic agenda for sensitisation?
Do they have a manual as a reference?

6. Do they in advance discuss and plan the type of sensitisation that is needed for each group of caregivers?

7. Do the promoters and trainers discuss together in-group the progress of their work?
How often?

8. Do they analyse films together before intervention?
How often?

9. Do they use video-feedback with the caregivers?
How often?

10. Do they point out the positive things that the caregivers
do in relation to their children?

11. Do they use local cultural examples when they explain the 8 guidelines?

12. Do they give the caregivers tasks to do like exemplification and observational tasks?

Do they provide examples for the tasks that they give to the caregivers?

13. Do they investigate what is the caregivers' conception of each child? What is the caregivers' conception of their tasks of caring for the child?

14. Do they try to influence the caregiver's negative conceptions?'

How?
a: Through pointing out positive features in the child?
b: Positive redefinition?
c: Sharing positive memories with the child?
d. Other ways?

15. Do they make field notes of each session of sensitisation?

16. Do they (she) video-film the caregiver's interaction with some of the children from start and throughout the training so that they can observe changes or improvements in their interaction with some children?

17. Do they video-film from the beginning the changes that are taking place in some children throughout the training?

Points: 17 maximum

From 17 to 13: Very good

From 12 to 8: good

Less than 8: not acceptable

2. Scale of strengths and weaknesses of individual facilitators and trainers in their capacity as instructors (0= fits very little, 1= does not fit 2= fits well, 3= fits very much)

She is very good at giving explanations

0 1 2 3

She is good at giving examples from everyday life

0 1 2 3

She is very good in establishing contact with the caregivers

0 1 2 3

She loves children and is very sensitive in her descriptions

0 1 2 3

She is very good at giving demonstrations

0 1 2 3

She is very committed and working hard

0 1 2 3

She has long experience and background

0 1 2 3

Points:
Very good: more than 16
Good: more than 10
Acceptable: 7 to 10
Not acceptable: less than 7

3. Monitoring-scale for the content (agenda) of the facilitators' sensitisation of caregivers/parents

Mark off Yes/No on the points that are included in the sensitisation training:

a. Do you tell them about the ICDP Program and the purpose of the training?

b. Do you tell about the importance of their participation and of the significance of the program for their child's development?

c. Do you tell them about the importance of intimate contact for the child's development?

d. Do you come to an understanding with them that they need to participate actively and perform certain tasks in order to benefit from the program?

e. Do you talk about how their conceptions and attitudes can promote or block their contact and interaction with the child?

f. Do you give them tasks to observe the positive qualities and competencies of their child?

g. Do you praise them for the positive qualities that their child has or shows?

h. Do you praise them for the positive ways that the caregiver sometimes shows in caring for her child?

i. Do you explain the guidelines of good interaction with examples from everyday-life?

j. Do you give them tasks to observe and report back about how they use their guidelines in their everyday life?

k. Do you ask them how their child reacts when they start to use different guidelines?

l. Do you arrange groups where they can exchange experiences with other caregivers in the same situation?

m. Do you sometimes use role-playing to illustrate typical everyday situations of good or bad interaction?

n. Do you use video-feedback from their everyday life to illustrate good or bad interaction?

o. Do you use examples from adult life to explain how important the emotional expressive guidelines are?

p. Do you explain the difference between poor and rich mediation?

q. Do you use examples to show them how everyday situations can be made more enriching for the child by giving more meaning and explanations?

r. Do you give them tasks in-group or alone to illustrate how everyday situations can be made more enriching through mediation?

s. Do you explain to them the difference between negative and positive setting of limits?

t. Do you demonstrate or give them tasks to demonstrate the difference between positive and negative limit setting?

u. Do you encourage them to use more praise and positive confirmation in their interaction with their child?

v. Do you encourage them to give some time every day for intimate contact and sharing with their child?

Marks:
17-22: very good
12-16: good
9-14: should be improved
less than 9: not acceptable

(A similar scheme could also be developed for trainers using the standard agenda as the basis.)

Summary-scheme of the facilitator's competence as instructor:

Name: Target-group Institution

1. Guideline scale:
Points:
From 17 to 13: Very good
From 12 to 8: good
Less than 8: not acceptable

2.Scale of quality as instructor.
Very good: more than 16
Good: more than 10
Acceptable: 7 to 10
Not acceptable: less than 7

3. Scale for the content (agenda).
22-16: very good
12-15: good
9-14: should be improved
less than 9: not acceptable

Summary score:
1.....
2.....
3.....

B Assessment of individual children

Name: Sex:

Age: Date:

1. Caregiver's spontaneous description of the child

Ask the caregiver the following questions:" As a person who is close to the child, can you tell me how your child is? How would you describe your child? Which qualities do you see in your child?

When the caregiver has given her spontaneous description, translate this description into adjectives that covers her description and note them down in the list below. Let her finish without influencing her in any way.

List of spontaneous description of the child:

1.

2.

3.

4.

5.

2. Check-list of risk-symptoms in individual children:
Indicate: Yes or no (or Likert scale)

Name: Date:

1.Clinging in need of contact

1	2	3	4	5
Very little	Little	Medium	Much	Very much

2.Without contact with other children

1	2	3	4	5
Very little	Little	Medium	Much	Very much

3.Aggressive towards other children

1	2	3	4	5
Very little	Little	Medium	Much	Very much

4.Provocative in his contacts

1	2	3	4	5
Very little	Little	Medium	Much	Very much

5.Is sad and crying

1	2	3	4	5
Very little	Little	Medium	Much	Very much

6.Has sleeping problems and nightmares

1	2	3	4	5
Very little	Little	Medium	Much	Very much

7.Has eating problems

1	2	3	4	5
Very little	Little	Medium	Much	Very much

8.Apathy\withdrawn, dull without contact

1	2	3	4	5
Very little	Little	Medium	Much	Very much

9.Lack self-confidence

1	2	3	4	5
Very little	Little	Medium	Much	Very much

10.Refuses to speak

1	2	3	4	5
Very little	Little	Medium	Much	Very much

11.Disturbed speech

1	2	3	4	5
Very little	Little	Medium	Much	Very much

12.Disruptive, chaotic behaviour problems

1	2	3	4	5
Very little	Little	Medium	Much	Very much

13.Bizarre behaviour, repetitive mannerisms,
lives in her/his own world...

1	2	3	4	5
Very little	Little	Medium	Much	Very much

14.Shows clear symptoms of anxiety, fearfulness, panic

1	2	3	4	5
Very little	Little	Medium	Much	Very much

15.Has special anxieties/fears for particular
objects, persons, places etc.

1	2	3	4	5
Very little	Little	Medium	Much	Very much

16.There are no pathological reactions and
attitudes of the kind mentioned above

1	2	3	4	5
Very little	Little	Medium	Much	Very much

17.The child is happy and active

1	2	3	4	5
Very little	Little	Medium	Much	Very much

What are the positive features that you can observe in this child?

3. Conceptions of deviation and aetiology

What is the caregiver's explanation of her problem if any?

Are there any special stigma directed towards the child?

What are the positive features that the caregivers' can observe in the child?

History of the child before coming to the institution

Where are the family and what is their attitude to the child?

Family reunion is that possible or advisable?

4.Action to be taken with this child

1. Sensitise the caregivers for the ICDP principles:
Which principles are especially important for this child? _

2. Increase the number of caregivers: _

3. Try to form smaller family oriented-groups with
a stable "mother" or "father": _

4. Organize the children so that older children
form bonds and take care of the younger: _

5. Involve people from the outside to support
and form bonds with individual children: _

6. Improve the content of the child's day in
the institution with more educative activities: _

7. Try to find foster-homes outside the
institution for vulnerable children: _

8. Try to retrace the child's family: _

---

5. Ten questions to assess children with disability
(M.Durkin) Answer: Yes/No

1. Compared with the other children, did the child have any serious delay in sitting, standing or walking?

2. Compared with other children, does the child have difficulty seeing, either in the daytime or at night?

3. Does the child appear to have difficulty in hearing?

4. When you tell the child to do something, does he/she seem to understand what you are saying?

5. Does the child have difficulty in walking or moving his/her arms or does he/she have weakness and or stiffness in the arms and legs?

6. Does the child sometimes have fits; become rigid, or loose consciousness?

7. Does the child learn to do things like other children his/her age?

8. Does the child speak at all (can he/she make him/herself understood in words, can he/she say any recognizable words)?

9. For 3 to 9 years of age:
Is the child's speech in any way different from normal (not clear enough to be understood by people other than his/her immediate family)?

For 2 year old:
Can he/she name at least one object (for example, an animal, a toy, a cup, a spoon)?

10. Compared with other children of his/her age, does the child appear in any way mentally backward, dull or slow?

C Assessment of the need for intervention in institutions and homes

1.Form for surveying the psychosocial needs of children in institutions.
(To be used during visit and to be kept in the file on provinces).

Name of observer/visitor:

Date?

Where?
---

1. The intention of the visit:

2. Do you have any official statistics about the children in need in this region?

What are the most important numbers about children in need in the province?

3. Who are your contacts in the province?

4. Which institutions have you visited?
Also which organizational body/ies is/are in charge?

a.

b.

c.

d.

5. What is the situation of children in the places you have observed?
(also age, sex, places of origin) Short descriptions of impressions.

Institution:

A. (name)

B.

C.

D.

2. Check list of typical pathological behavioural symptoms observed in different institutions a, b, c and d.
(Mark off typical categories of incidence: many, some, few, none)

Institution name and date: a b c

……

Clinging in need of contact. Many none few none

Apathy, dull without contact.

Do not speak.

Disruptive, chaotic behaviour problems.

Aggressive

Bizarre behaviour, repetitive mannerisms, live in their own world of fantasy...

Fearful and withdrawn.

Few pathological symptoms of the kind mentioned above.

Most children appear happy and satisfied.

----

3. The personnel's (caregivers') description of the children's "needs":

("According to your experience, what do children here need most of all? What do they miss?")

The personnel's description of their most important tasks in relation to children:

1. Visitor's observation of the caregivers' general attitude and relationship to the children in their care?

2. Attitude of personnel (caregivers) to children "with problem"? (Visitor's impression)

4. What is the caregivers' diagnosis (description) of deviant children and how do they explain that the children are deviant?

Special stigma directed towards deviant child?

5. Typical history of children before coming to the institution.

6. Where are the families of the children?

7. Who are the children that need ICDP intervention mostly?
(Also which institutions?)

Why?

8. Do the children there also need help from the emergency package?

Medicines,
Food
Clothes

Are there other needs not covered?
Which?

9. Can contact be made with other organizations operating in the area for that purpose?

10. Are there special cultural practices, attitudes or conceptions that obliterate the training?
Or that should be taken into account?

a. "Negative practices" (beating the child etc.)

b. Local magical beliefs that may influence the attitude to children (like witchcraft etc)?

c. Caregivers' conception of a good and bad child.

d. Caregivers' conception of good care.
11. Are there any future plans or preparations for rehabilitating the children back to society in this institution?

12. Who are the caregivers who shall or will participate in the sensitisation training?

13. How reachable is the institution?

Transport?

Places to stay over-night?

14. Does the head of the institution know about ICDP?

15. Have they received an introduction to our work?

Brochure? (Please bring)

16. How is the attitude towards accepting the ICDP training in the institution?

Can we get a written contract with the institution?

Special problems?

17. How many facilitators are needed to cover the needs of the institution?

18. How many facilitators/trainers are needed to cover the institutions that need most urgently help in this region?

Each assessor should keep a logbook with anecdotes and impression.

NB: After each visit a short report should be written and filed with the relevant forms. Based on the information in this form it should be possible to make a mapping of the needs and a strategy of intervention in the region.

4. Questionnaire for evaluating psychosocial quality of care in an institution.

Name of institution.....Date.....

1. Do children have the opportunity to interact intimately with one or more caregivers every day?

0 1 2 3

2. Do children receive positive mediation/guidance from one or more caregivers during the day?

0 1 2 3

3. Is there space enough so that the children can play and move around?

0 1 2 3

4. Are there one or two stable caregivers for each child so that the child can attach him/herself to the caregiver(s)?

0 1 2 3

5. Do the caregivers guide and regulate the children in a positive way so that each child learns the basic social values of the community?

0 1 2 3

6. Do the caregivers in the institution have a positive attitude/image of the children and do they talk positively about them?

0 1 2 3

7. Do the caregivers in the institution in general attend to the psychological and educational needs of the children?

0 1 2 3

Personal comments on the situation of children in the institution:

5. Assessments of negative care giving - risk indicators:

(To be used in institutions or homes for individual caregivers as an indicator for the need for intervention - also as an indicator of improvement when there is a decrease in number of negative marks. 0= very little 3= very much)

There is no time to individual interaction and intimate contact with the child

0 1 2 3

She has a negative and rejection attitude and conception of the child

0 1 2 3

She pays only attention to the physical needs of the child

0 1 2 3

She relates to the child like a robot - without sensitivity, love and adjustment to his states

0 1 2 3

She beats and scolds the child in a brutal way when the child does not perform according to her expectations

0 1 2 3

She ridicules the child when it cries and request love and care

0 1 2 3

She talks disparagingly about the child when the child is present and hears what she says

0 1 2 3

She seldom or never shows love to the child

0 1 2 3

She talks very little to the child

0 1 2 3

She talks very little to the child beyond commanding and scolding

0 1 2 3

The child has no other person who relates positively to it

0 1 2 3

The presence of 2 and 3 in some of these indicators may be a reason for intervention/sensitisation.

6. a. Make a general profile using the guidelines to check the quality of the typical care that most children receive in the institution:

3

2

1

0

--Love--Init.--Dialog.--Praise--Focus--Meaning--Expand--Regul.

This type of profile can also be applied to each caregiver.

This scaling can also be done as a questionnaire:

6. b. Assessment of qualities in individual caregivers

She is loving and positive

0 1 2 3

She is attentive to the child's initiatives

0 1 2 3

She is responsive to the child's initiatives

0 1 2 3

She is able to communicate with non-verbal gestures with the child

0 1 2 3

She gives names and descriptions to what the child experiences

0 1 2 3

She gives explanations and expands on the meaning

0 1 2 3

She provides positive regulations and more positive limit setting

0 1 2 3

7. What will you do to improve the care of children in the institution that you are working in?

1. Sensitise the caregivers for the ICDP principles: ____

2. Increase the number of caregivers: ____

3. Try to form smaller family oriented-groups with a stable "mother" or "father": ____

4. Organize the children so that older children form bonds and take care of the younger: ____

5. Involve people from the outside to support and form bonds with individual children: ____

6. Improve the content of the child's day in the institution with more educative activities: ____

7. Try to find foster-homes outside the institution for vulnerable children: ____

8. Try to retrace the child's family: ____

D Evaluation of effects of the intervention

A simple evaluation procedure

It is important to evaluate the impact of the program both individually and on groups and institutions. The very simplest way to do this is to ask the caregivers what are their impressions of the training. Below is a simple scale to be used for this purpose:

1. The caregiver's assessment of the ICDP training.

(This can also be used for institutional personal)

Caregiver's name:.....
Dates of intervention start/finish:.....

How many interventions.....

Promoter/trainer's name who
did the sensitisation:.....

Do you feel that you have benefited from participated in the training?

1 2 3 4 5
|----------|----------|----------|----------|
Very Little Medium Much Very
little much

Can you explain in more detail why you feel you have benefited from participating in the training?
In which way?

What was positive and what was negative in the training if any?

2. Assessment of changes in the caregiver

There are different ways of categorising the interactive style of the caregiver (see Stern 1996 for a useful three dimensional categorization).

First of all it may be useful to get the caregivers' own free description of the changes they have observed in themselves as caregivers for their children.

Then, according to the program, we should expect that the caregiver would become "more" of the eight qualities that are emphasized in the program.

Below is a scale that can be used by an observer (or it could also be used by the caregiver herself).

All these qualities can be assessed on an observational Likert scale from very little (0) to very much (3), as indicated below:

Assessment of improved qualities in the caregiver

More loving and positive

0 1 2 3

More attentive to the child's initiatives

0 1 2 3

More responsive to the child's initiatives

0 1 2 3

More able to communicate in a non-verbal gesture way with the child

0 1 2 3

Giving more names and descriptions to what the child experiences

0 1 2 3

Giving more explanations and expanding on meaning

0 1 2 3

More positive regulations and more positive limit setting

0 1 2 3

After intervention we should expect changes in the direction indicated above.

3a. Assessment of changes in the child

It may be important to register if there are any observable changes in the child. This is usually done through testing, which can be quite laborious and technical - and some times irrelevant to the objective of the intervention.
Less laborious are observational rating scales either through interview or given directly to parents or caregivers, or q-sort scales.

There are many such scales.
Which qualities should we expect develop as a consequence of the intervention that has been carried out through the ICDP Program? Below follows and ideal description of the qualities we should look for - according to the program:

1. An emotionally more positive and open child that would respond to emotional cues in persons relating to him (Guideline: 1,2,4)

2. A child that would be more self confident and active, following his own ideas and initiatives (Guideline: 2,4)

3. A child that would have a well developed vocabulary and know a lot about his surroundings and would ask questions (Guideline 3 and 6, also 2)

4. A child that would have fantasy, go beyond, explore and be interested in explanation, comparisons - more intellectual and with more fantasy.(2,7)

5. A child that would be more orderly and able to plan and reflect ahead and to be able to control his immediate impulses. A child able to adjust to others and to follow the rules of cooperation. (5,7,8)

How can we develop a simple observational scale to assess whether there is a change in this direction?

1. We could first **ask the caregiver to describe freely the changes that they have observed in the child during the period of intervention**, and then assess afterwards whether they would go in the direction indicated above.

2. Make an observation scale based on the ideal description above by stating the adjectives indicated in the categories above and give a mark from 1 (very little) to 5 (very much) on each adjective, like this:

He is open and positive: 1 2 3 4 5

" self-confident 1 2 3 4 5

" etc.

" etc.

Such assessments should be done before the intervention starts and after it is finished...

3b. The caregiver's assessment of whether the child /ren has benefited from her participation in the training.

Has the child benefited from your participation in the training?

1	2	3	4	5
Very little	Little	Medium	Much	Very much

Why .....?

What are the effects of the program on the child/ren and what are the differences from earlier - if any?

V EVALUATION OF EFFECTS OF THE PROGRAMME BASED ON FOCUSED GROUPS AND QUESTIONNAIRES

1. Focused group meeting

A focused group of key informants is used to provide the background information through some key questions and from that information the variables are selected to be used in the questionnaire. The focused group is not the main research; it is to generate statements for the questionnaire.

- Select 4-6 informants from the environment/setting where the research is being planned.

These informants are representative of the larger population, and their replies are taken as a basis for selecting variables for the questionnaire.
It is important to have meetings with more than one group because persons in different positions, like teachers, parents and facilitators/trainers may have different experiences of the effects. It would be important to include the children, if that is possible. The idea is to use this information as a basis for the selection of items in the questionnaire that is going to be constructed.

- Before starting it is necessary to prepare some 6 to 10 open key-questions about the subject matter to investigate – i.e. what are the effects of the programme .

The questions will serve as a directive for the discussion and should be broad and open to begin with and then they can be narrowed down as the discussion proceeds. It is important that this becomes an exchange of ideas in a free atmosphere, not a group interview. It is also important that all participants can express their opinions and not allow one person to dominate the exchange. If it happens, the group leader should then interfere and ask the next person what is his opinion etc. New questions may be inserted if needed, the key-questions serves more as topical directives for the progression of the exchange.

- The questions prepared for investigating the effects of the program could be for example:

- You have now experienced this program in practice over some time; does this program, in your opinion, have any effect at all?
- What are the most striking effects you have observed?
- What are the effects that you have observed on the caregivers?
- What are the effects that you have observed on the children?
- Are there any other effects you have observed in the institution or on parents?
- What in the program do you think it is that produces these effects?
- Is there anything in the program that should be changed or emphasised?
- Is there anything in the program that is missing?
- What should we do to strengthen the effects of the program and our intervention?

- In order to collect all the information involved it is important to have a person making notes of the ideas expressed and this should preferably not be the group leader who raises the questions.

2. Listing the replies and making a questionnaire

- The next step would be to write down the replies on a list-form.

Do not double up questions, but select the questions that represent different replies to the various questions/topics.

- When this is done, then the next step is to make the questionnaire based on this list.

The replies can be organised in topics reflecting the questions. One way is to present the replies as statements like:

- Physical violence towards children has decreased
- The caregiver is more aware of the difficult children's problems
- The caregiver is less authoritarian and attends more the children's initiatives

Under each statement there can be three alternatives, like this:

- The caregiver is less authoritarian and attends more to the children's initiatives

AGREE NOT SURE DISAGREE

or

it can be made into a five point Likert-scale:

- Do you agree that the teacher is less authoritarian and attends more to the children's initiatives

1	2	3	4	5
Very little	little	not sure	agree	agree very much

All the key-items from the list are then organised in this fashion preferably with the most general to begin with, and organised according to the key-questions that were raised.

- In order to control for suggestibility and "pleasing the interviewer-effect", it may be useful to include some fake-statements that counteract the general trend of the expected/hoped for replies. It can be statements like:

- In my opinion the situation is exactly as before

AGREE NOT SURE DISAGREE

By inserting some items like that, it is possible to see the consistency of the person's replies. If the picture is consistent this gives more credibility to that persons replies.

- At the bottom of the questionnaire sheet there should be open space for "comments", or it could also be added: Is there something else you have observed that is not included in the statements above?

The size of the questionnaire should not exceed 20 statements about effect (?). If the person has more to add, he can do that in the comments at the end of the questionnaire. The statements should be numbered so that it becomes easy to identify them in the analysis.

3. Using the questionnaire

As a questionnaire is easy to administer and code, particularly if the replies are written, it can without problems be applied on a large population. If the persons are semi-literate, it may be necessary to use the questionnaire as an interview in the sense that the statements are asked as in an interview, but the filling in of answers such as 'agree', 'disagree', is done by the researcher.

- When the questionnaires are ready, they will be processed for analysis on computer. This should be fairly simple with preset categories.

VI PRE-POST EVALUATION OF THE EFFECTS OF THE ICDP PROGRAM

This is a more laborious and scientific procedure. In order to do this, one has to assess the qualities of the child or the institution before and after intervention and preferably compare it with other institutions or children where there has been no intervention that is using a control group. For our present purpose this may be too laborious. However it should be possible to assess the impact of our intervention at three points in time: **Before it starts, in the middle of the intervention period and at the end.** All within 1/2 year.
(If not possible, then before it starts and after it finishes).

The pre-post design has very clear limitations in the sense that we do not know what is the cause of the observed change.
It may be due to general maturation as part of normal growth
or other factors (see weakness of the pre-post design).

One way to avoid this weakness could be to split the group into two and to let the intervention start at different times; one between the pre- and the middle-test and the other between the middle and the post-test:

Pre-test Middle test Post-test
…. I …… Int.1 …… I ……..…… I …… 1. group

…. I ……I …….. Int.2 …… I …… 2. group

This design opens up for logical analysis of the possible factors that are operative in the assumed change:

1. In the 1. group we assume there is a change in the middle test after intervention 1. In that case the 2. group may serve as a control; if there is no comparable change in the 2. group at the middle test, we may assume that the observed change is due to the intervention 1.

2. Similarly in the 2. group; there is no external reason why there should be any positive change in the 1. group at the post-test after the middle test. Assuming that there is no change or a change in the sense of a slight decline, negative change, as to be expected because the intervention is not sustainable. In that case, if there is a marked positive change in the 2. group at the post-test, it is reasonable to assume that this is due to the intervention, and not due to maturational factors.

3. This design also may give an indication as to whether the intervention is sustainable within the time frame indicated.
If the positive change observed in the first group observed at middle test persists or increases in the post-test, it is reasonable to assume that this is due to the intervention and that it either is sustainable or has initiated a positive developmental process.

VII OBSERVATION OF CAREGIVER'S INTERACTIVE CARE OF CHILDREN

Descriptive checklist on positive qualities

The checklist can be filled in by the caregiver or by an observer

Phenomena	**Never (0)**	**Seldom (1)**	**Sometimes (2)**	**Often (3)**
Joy and fun:				
Sharing of joy				
Reciprocal smiling				
Positive teasing and laughing				
Clowning and surprising that releases laughter				
Telling jokes				
Dramatising and imitating for fun				
Dancing				
Singing and rhyming				
Games that release laughter				
Consoling:				
Putting the hand around the child				
Confirming the child's suffering by soft talking				
Touching in a consoling way (wiping out the tears)				
Calming down the child				

Embracing the child
in a consoling way
Talking and explaining
in a consoling way
(Redefining)

Intimate talking and sharing:

Motherese
interpretive
talk

Talking in an
intimate way about
something they
have experienced
together

Talking intimately
while they do
something together

Personal disclosure
of "secrets"

Personal disclosure
of personal feelings

Direct expressions of love:

Kissing the child

Embracing the child

Touching the child
in a loving way

Verbal expressions
of love

Confirming:

Positive confirming
eye-contact
with smiles

Sharing of joy and
reciprocal
confirmation

Nodding and signalling approval

Giving verbal approval and praise

Confirmative talking

Being sensitive to the child's state and initiatives

Responding and tuning in to the child's state and initiatives (with the categories above)

A. Sum emotional-expressive care: : Obtained/possible (%)

MEDIATION AND ENRICHING THE CHILD'S EXPERIENCE

Joint attention:

Calling the child's attention to a particular object or aspect

Looking together at one particular thing (object)

Joint attention with meaning:

Looking at a thing and describing what you see together

Looking at a thing and describing with enthusiasm what you see

Following the child's attention and initiative by commenting on what he sees/does

Showing how things

work (functional meaning)

Asking the child questions about what he sees

Expanding beyond what they see:

Giving explanations about what they see experience together

Analysing what they see together

Comparing what they are looking at with other experiences the child knows

Telling about past (origin) and future

Asking the child questions about why things are as he is looking at them

Symbolising

Telling stories about what they see/experience together

Symbolising through requesting the child to retell what they experienced

Symbolising through requesting the child to draw what they experienced

Symbolising through dramatisation of what they experienced

Symbolising through writing about what they experienced

B. Sum mediational care: Obtained/possible (%)

Regulation and control in relation to play-projects, chores or tasks

Instructive guidance

Demonstrating how to do it (modelling)

Demonstrating and explaining how to do the "project"

Demonstrating explaining step-by-step

Helping the child planning

Asking questions about how to proceed

Guiding the child's initiative

Supporting the child's initiative by preparing the setting

Supporting the child’s initiative by sustaining the goal of the project

Supporting and withdrawing, leaving the control to the child

Giving the child challenges

Guiding the child
by asking critical
questions on
procedure

C. Sum on cognitive regulation: Obtained/possible (%)

Setting limits and altruism

Stopping the child
without explanations

Distracting the
child giving positive
alternatives

Verbally stopping the
child by explaining
why it is not allowed

Stopping and
giving positive
alternatives

Stopping the
child by pointing
out the
consequences

Stopping the child
by explaining consequences
for others - how the
other child feels

Stopping the child
and make him take the
agreed upon punishment
(consequence)

Promoting moral understanding and altruism

Explaining to the
child why rules
are necessary

Involving the child
in making rules and
punishments/rewards

Involving the
child in compassionate
project (of assistance)
directed to another
child

Preparing the
setting for
co-operation

Discussing how
children who are bullied
or suffering feel

Role-playing and
dramatising typical
moral issue from
their everyday life
- playing perpetrator
and victim

Giving tasks for which
the child is responsible/
accountable

D. Sum on regulation/ morality:
Obtained/possible (%)

E: Total sum of all scores:
Obtained/possible (%)

By summarising the score on each of the categories above a sum-score for quality of caregiving will be obtained. This can be split into **A emotional care** ( ), **B. mediational care ( ), C. regulative cognitive care ( ), and D. regulative morality care ( ) and E. total care score ( )**

In a large project these score will probably constitute important diagnostic categories that may have predictive qualities.

APPENDIX:
Useful methods for evaluating ICDP

The first step to take in any evaluation is of course to decide which goals the interventions aim to achieve.

Conceptions:
Increased understanding about positive care giving and a more differentiated view of the child

Self-image:
Increased self-confidence as caregiver

Parent's psychological competence:
Better ability to see the interaction from the child's point of view (mentalization)
More empathy and affect consciousness

Parent's behavior:
More sensitive, positive and differentiated relationship with the child

Child's behavior:
The child's feelings are more positive and differentiated
The child's behavior is more positive and adequate for the age

These aims can be measured in different ways. Although it is important to be restrictive about the number of methods, it is also good to have data from different perspectives.
It is also important to know that ratings on different instruments are sensitive to change. It is meaningless to use an instrument if we not that it is vary hard to bring about change.

In order to evaluate the effects of ICDP, different distinctions among the methods can be made:

1. There is first the distinction between types of data collection methods. Data can be received from the person himself or herself by self-rating instruments. The person then fills out some kind of form, rating his or her attitudes, thoughts, feelings, experiences or behavior. Or the data may come from an interview, where someone asks the subject about attitudes, thoughts, feelings, experiences or behavior. Or, finally, the data may come from ratings of observed behavior, either in real time or filmed behavior.

2. Secondly, there is the question of source. Does the rating come from the child, from the parent or other family caregiver, or from a more distant caregiver such as a teacher?

3. Thirdly, about whom is the rating made? Does the parent or a teacher rate the child, or does a teacher rate a parent's behavior?

4. Fourthly, is the method used specifically made for ICDP, measuring or rating behavior that is defined as important by the ICDP principles, such as the 8 guidelines? Or is the method a more general one, used in different studies?

In the following description of methods, they have been categorized according to rating method.

Here we will mention general instruments that are well established and published scientifically and internationally. See also the list of ICDP-specific evaluation methods in the second part of this document. The best way is to combine ICDP-specific and general instruments.

Self-assessment methods

There are thousands of self-rating scales. In this context, several different types of rating scales seem to be of specific interest.

One concerns how the parent or teacher describes what he or she thinks about having been a participant in an ICDP course. Was the course adequate for the needs of the participant? This is the question of reception.

Another concern is how the conceptions about child rearing and parenthood have may changed before and after an intervention. Did the parent change opinion with regard to harsh punishment, or about how to show feeling, *in his or her own view?*

Then there are all the instruments that try to capture the individual's self-rated socio-emotional ability. We mention here a few that we have used, but there are of course many alternatives.

Interpersonal Reactivity Index (IRI; Davis, 1996) is used to measure the individual's self-perceived degree of empathy. It contains 28 items, and the results are analyzed using four subscales: Empathic care, Perspective taking, Fantasy, and Personal worry.

Toronto Alexithymia Scale (TAS-20; Taylor et al., 1999) measures the individual's self-perceived degree of alexithymia with a questionnaire containing 20 items. The scale contains three subscales: Difficulties in identifying feelings, Difficulties in describing feelings, and Externally oriented thinking. The scale has been widely used and validated in US, Canada, Netherlands, France, Germany, Italy, Korea, India and Lithuania.

Attachment Style Questionnaire (ASQ; Feeney et al., 1994) measures the individual's self-percived attachment. The answers are analyzed using three subscales: Secure, Avoidant, and Anxious attachment styles.

Experiences in Close Relationships (ECR; Brennan et al., 1998) is an alternative to ASQ. ECR uses 36 items to self-rate two subscales: Anxiety (over not being loved and getting abandoned) and Avoidance (of close relationships)

Security scale (Kerns et al., 1996) is a method for children. They are asked how they look upon their relationship to mother and father by answering 15 questions for each parent. The scales measure type of attachment style. The child must of course be able to read.

Although self-rating instruments are easy to administer in countries where people can be supposed to read and write, they have two apparent drawbacks. One is that they probably have a large degree of social desirability in them. People tend to rate themselves as they want to see themselves, or as they think that the researcher wants them to rate, or as a protest against the rating procedure etc. Self-rating is always a communication to the person who will look at the rating form. The other problem is that the wording and translation of items is culturally influenced, and that factor must be checked in each study. Most instruments have not been validate in other than Western countries.

Interviews

Adult Attachment Interview (AAI; George, Kaplan & Main, 1985) is primarily used to get data for rating an adult person's attachment style. This interview has been widely used in different social and cultural contexts. The rating of attachment patterns is very time consuming and requires special training.

The interview can also be used to rate a person's reflective functioning (RF; Fonagy et al., 1998), which is an operationalization of Peter Fonagy's mentalization concept. The rating of RF is much easier than the rating of attachment, and it can be made on a reduced version of the interview. We are currently testing AAI and RF in more focused ways, such as a depressed person's mentalization about depressive thoughts, or a criminal person's mentalization about his or her criminal activities. It could easily be used in order to rate a parent's ability to mentalize about his or her child.

Affect consciousness interview (ACI; Monsen et al., 1996; Lech, Andersson & Holmqvist, 2008) is used to assess a person's consciousness about several categorical affects, usually interest, joy, sadness, anger, fear, guilt, and shame. This interview has been used in several studies in Sweden and Norway.

Working Model of the Child Interview (WMCI; Zeanah et al., 1986) is a structured interview, where the parent is asked to describe his or her history of experiences with one child. Like the AAI, the answers are not rated for what is said but for how it is said, and it is supposed to catch the parent's attachment to the child. The interview is rather difficult to rate, but it gives very valuable information about the parent's conception of the child. The interview specifically catches these areas: the parent's richness of perception, openness to change, intensity of involvement, coherence, care giving sensitivity, acceptance, and view of infant difficulty.
The ratings are summed up as a description of the parent's working model of the child, where three main categories are distinguished: balanced/secure, disengaged/avoidant, and distorted/resistant. A newer version of the interview also categorizes a Disturbed pattern.

Parent Development Interview (PDI; Aber et al., 1985) is used to assess a parent's representational model of her relationship with a specific child. The interview focuses on three central domains: the parent's view of her experience in the parent-child relationship, the parent's view of the child's experience in the relationship, and the parent's overall awareness of the relationship.

Observation rating methods

Observing the child

Strange situation procedure (SSP; Ainsworth et al., 1978). This is the golden standard for measuring attachment quality in small children. The prerequisite is that the child comes with a parent to a test room. It is usually used for children between one and two years of age.

Attachment Q-sort (AQS; Waters & Dean, 1985) uses 100 cards that are sorted by the Q-sort method. It is an alternative to Strange situation. In contrast to the Strange situation, this rating can be made in the child's home. The observer is in the child's home several hours before rating the child's behavior. AQS does validly rate attachment. In a meta-analysis, 139 AQS studies including 13.835 children found positive validity, for instance that it gives similar results as the Strange situation.

An advantage in comparison with SSP is that AQS can be used for a broader age span than SSP (12-48 months).

Observing the parent

Atypical Maternal Behavior Instrument for Assessment and Classification (Ambiance; Lyons-Ruth et al., 1999) is used to rate parents' problematic behavior towards a child. It is based on video-recorded Strange situation interactions and is thus dependent on the test room.

Child-Adult Relationship Experimental Index (Care-Index; Crittenden, 1988) uses rather short video-recorded everyday interactions. It is also used with rather small children, up to two and a half year. This method ha primarily been used in clinical contexts. The rating method has to be learnt from Patricia Crittenden and is rather laborious to catch.

Maternal Behaviour Q-Sort (MBQS; Pederson et al, 1994/1999) is used to rate the mother's interaction with the child by sorting 90 cards with statements about the interaction according to the Q-sort method. The intention is to rate attachment styles from mother to child.

The method is rather easy to learn.
http://psychology.uwo.ca/faculty/pdfs/pedmor/MaternalBehaviourQSortPage.pdf

Observing the interaction

Emotional Availability Scales (EAS; Biringen et al., 1998) is used to rate videotaped interactions between children and caregivers. The interactions are rated on six dimensions, four of them measuring the adult's behavior and attitude (parental sensitivity, parental structuring, parental non-intrusiveness, parental non-hostility) and two measuring the child's behavior (child responsiveness and child involvement). EAS has been used in many studies in different countries. Our experience is that it is rather easy to get good interrater reliability. The ratings have good concurrent validity with similar rating instruments.

Methods should be evaluated as to:

What time do they take to administer or rate?

Are they sensitive for change?

In what respects are they culturally sensitive?

Some points about cultural sensitivity:

Looking at attachment, a large number of studies seem to have converged on the view that attachment patterns have about the same frequency in different cultures. What differs is the parent's ability to accomplish attachment security, where different cultural and social contexts seem to prescribe different parents behavior leading to secure attachment.

On many other issues, the knowledge is sparse.