



The Touchpoints Model of Development

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All parents benefit from affirmation of their child's development and the nurturing environment they have provided for their child. Our goal as caring professionals should be to join parents as allies in the systems of care for their children. Our present systems are too often crisis-driven, deficit-oriented, and unwelcoming to parents. Many families, particularly those who have a child with special needs, are often left feeling isolated and unsupported (Bowman et al., 1994; Turnbull, Turnbull, & Blue-Banning, 1994). Our focus instead should be on developing a system where providers are reaching out for stressed parents and where parents' ethnic, religious, and lifestyle attributes are valued. For example, rather than treating a pregnant teenager overtly or covertly as a failure, which will turn her away and mitigate our opportunity for successful interaction with her, we could accept her pregnancy, point to the potential future opportunity for her baby, and offer her our acceptance, understanding, and positively framed services. When providers can offer the necessary support and modeling for parents to understand their young child's development and to enhance it, they can play a crucial role toward the success of the family system.

For the past several years, we have been working on the Touchpoints' model (Brazelton, *Touchpoints* 1992, Brazelton and Sparrow, *Touchpoints 3 – 6*, 2001). Touchpoints are periods, during the first years of life during which children's spurts in development result in disruption in the family system. (Throughout life, there are, no doubt, similar developmental crises of disorganization and reorganization that involve not solely the individual but those he or she is intimately connected with as well.) The succession of touchpoints in a child's development is like a map that can be identified and anticipated by both parents and providers. Thirteen touchpoints have been noted in the first three years, beginning in pregnancy.

They are centered on caregiving themes that matter to parents (e.g. feeding, discipline), rather than traditional milestones. The child's negotiation of these touchpoints can be seen as a source of satisfaction and encouragement for the family system. Foreknowledge of these touchpoints and strategies for dealing with them can help reduce negative interactions that might otherwise throw the child's development off course and result in problems in the areas of sleep, feeding, toilet training, among others.

Touchpoints may occur somewhat later in premature infants, but they will be even more important as opportunities for supporting their anxious parents. Atypically developing children's touchpoints may in some instances occur at different times or have different features from those of typically developing children. It is preferable to carefully observe, understand, and respect each child's behavior for evidence of developmental disorganization and reorganization rather than to make unhelpful comparative judgments.

The guiding principles of the Touchpoints model can be found in Table 1. Professionals can use these Touchpoints as a framework for each encounter with families during the first three years of a child's life. Several guiding assumptions about parents form the core of Touchpoints' practice with families (see Table 2). *Parents are the experts on their child's behavior.* Together,

professionals and parents can discover themes that recur and strategies to negotiate upcoming challenges. For example, for four-month-olds, providers can predict that there will soon be a burst in cognitive awareness of the environment. The baby will be difficult to feed. He will stop eating to look around and to listen to every stimulus in the environment. To parents' dismay, he will begin to awaken again at night. His awareness of his surroundings will be enhanced by a burst in visual development. Yet, when parents understand the disorganization of this period as a natural precursor to the rapid and exciting development that follows, they will not need to feel as if it represents failure. From the Touchpoints framework, the guidance or 'scaffolding' of this sort that professionals can give parents is supportive rather than prescriptive. Anticipatory guidance is not delivery of 'expert advice', but a dialogue, a shared discussion about how parents will feel and react in the face of predictable challenges to come. This is, in part, based on how they have dealt with related issues in the past.

Parents find it reassuring that bursts and regressions in development are to be expected. The concept of overflow from one line of development to another is often a shift in thinking for parents, who without this concept would often misunderstand their child's behavior as pathological and question their own caregiving efficacy. In the face of their children's behavioral regressions, they wonder what they are doing wrong. Sharing these touchpoints preventively helps parents feel more confident in themselves and in their child.

Table 1. The guiding principles of the Touchpoints model

- Value and understand the relationship between you and the parent
- Use the behavior of the child as your language
- Value passion wherever you find it
- Focus on the parent-child relationship
- Look for opportunities to support mastery
- Recognize the beliefs and biases that you bring to the interaction
- Be willing to discuss matters that go beyond your traditional role

Table 2. Touchpoints parent assumptions

- The parent is the expert on his/her child
- All parents have strengths
- All parents want to do well by their child
- All parents have something critical to share at each developmental stage
- All parents have ambivalent feelings
- Parenting is a process built on trial and error

Table 3. Touchpoints practitioner assumptions

- Each practitioner is the expert within the context of his/her practice setting
- Practitioners want to be competent
- Practitioners need support and respect of the kind we are asking them to give to parents
- Practitioners need to reflect on their contribution to parent-provider interactions

In order to fulfill this opportunity to use the shifts in the baby's development and the vulnerability they stir up in parents to establish and deepen their relationships with families, a provider must make a difficult paradigm shift. (Figure 1)

Figure 1. A paradigm shift

A PARADIGM SHIFT

FROM:

- Deficit Model
- Linear Development
- Prescriptive
- Objective Involvement
- Strict Discipline Boundaries

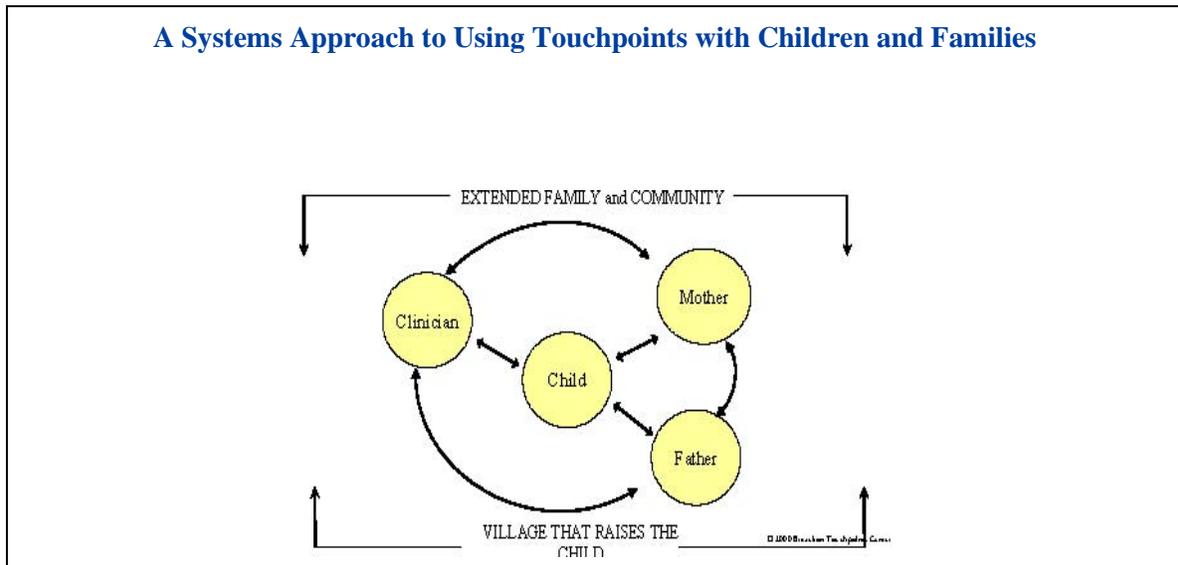
TO:

- Positive Model
- Multidimensional Development
- Collaborative
- Empathic Involvement
- Flexible Discipline Boundaries

As healthcare and childcare professionals, we are well trained to look for the failures and the defects in the child and parents, but these do not endear us to the families we work with. They sense our search for their failures. If we can change to a model of observing and valuing their successes, as opposed to a top-down, agenda-driven model, we can engage parents in a collaborative rather than a prescriptive relationship. Parents are aware and grateful for such a change. When we focus on their strengths, they are far more likely to share with us their vulnerabilities. Though this paradigm shift is easy for many professionals to endorse, it is more difficult for them to alter their interactions with families accordingly. We are too well trained in our medical search for impairments that we can “fix”, to stop, hold back, acknowledge parents’

expertise, and look for opportunities to support their mastery. As a result of our focus on their problems, we leave parents wary and defensive. When we can join them in a collaborative approach, they let down defenses and become available for a working relationship with us.

Figure 2. A systems approach to using Touchpoints with children and families



A systems model (Figure 2) is a valuable way to think of our role. Systems theory assumes that each member of the system is in balance with each other member. If there is a stress on the system, each member must adjust to the stress. As a result, stress becomes an opportunity for learning. If a provider wants the system to learn to succeed, she or he must become an equal member of the system. As a member, the professional must learn to understand and value the culture, the ethnicity, the religion, and the belief systems of the other members. Understanding a different culture is a lesson in humility, for the more we learn, the more we realize there is much that escapes us. Such a stance, which empowers the families we work with to transform us, is a far cry from the medical training of talking down to and of giving instructions to patients.

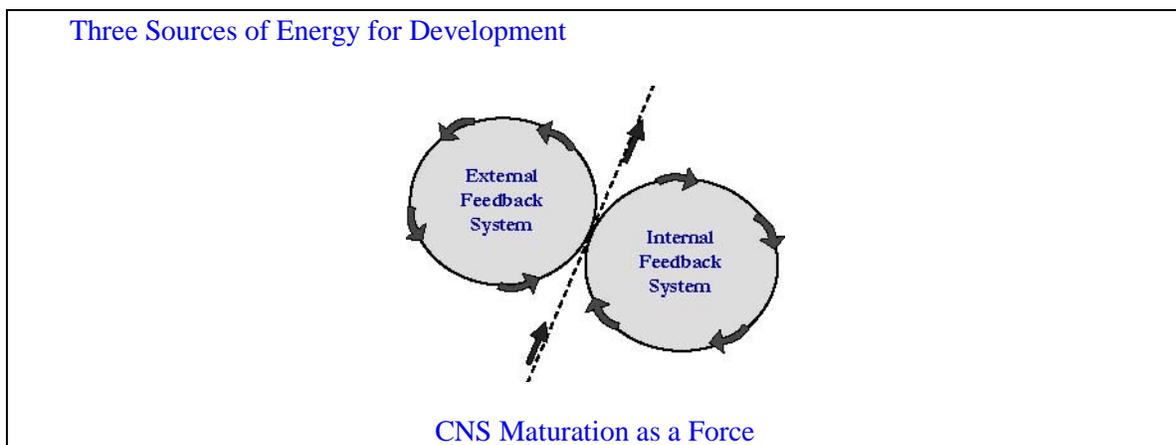
In order to effect this change in our medical and childcare outreach model, we have found that we can greet a family with an initial observation of the infant or child’s behavior. Initially, the provider can observe evidence of temperament (Thomas and Chess), stage of development (Ages and Stages Social Emotional Scales), and share these behaviors with parents.

Other meaningful behaviors to be shared with parents are those that offer evidence of a child’s own satisfaction in a new accomplishment. When a child strives to succeed at a developmental task, he registers his success with the behavior of, “I did it,” as the inner feedback cycle closes (Piaget). The inner feedback cycle (Figure 3), which is registered in the child’s behavior as he makes an effort to succeed, is a powerful observation to share with parents. This cycle, coupled with the parent’s efforts as represented by the external feedback cycle, fuel the expensive processes of development driven by the maturation of the Central Nervous System

(CNS). Parents can be encouraged to observe these two cycles by the provider and to revel in them, if they don't already.

Child behaviors that are meaningful for providers to share with parents emphasize the child's strengths and the parents' major contributions to the child's development. These shared observations can serve as an introduction to the relational model of provider-parent visits. Parents drop their defenses and are more likely to become available to history taking and sharing concerns with the provider. Each visit then becomes more valuable in fostering a working relationship between parents and provider, as parents come to trust that, along with their strengths, their vulnerabilities will be respected and valued.

Figure 3. Three sources of energy for development

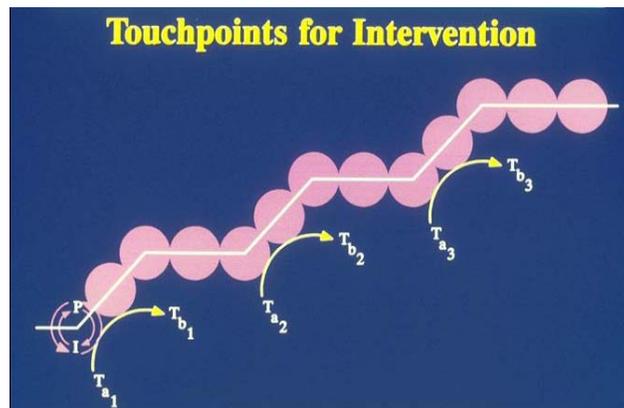


The trust of parents is also more readily won when providers demonstrate their understanding of and sensitivity to the predictable developmental needs of their child. For example, when I respect a nine-month-old's stranger anxiety, I have shown my capacity to care for a child more powerfully than by simply saying "I care". I never look a baby this age in the eye when the family enters my office. It is too intrusive, and is likely to produce a defensive, screaming baby. After parents sit down, I try to match the rhythm of the baby's movements. The infant recognizes and values this as an effort to communicate. When the baby demonstrates a behavior, I can imitate it, and he knows then that I respect him. One 8-month-old was warily clinging to her mother as they entered my office. The mother too was stiff and defensive. I waited until the baby made a raspberry-like sound from her mouth. I imitated it in my questions to her mother. "How is she (raspberry sound) eating? How is she (raspberry sound) sleeping?" After the second raspberry, this baby, at the peak of stranger awareness, reached out for me to take her. She reached up to feel my mouth. I blew out a raspberry. She grinned and blew one out to match mine. Her mother relaxed and said delightedly, "You really like babies -and they like you!" This expression of my interest in and ability to make a relationship with her infant had won over this understandably protective mother. Now we were off to a very different and relaxed visit, communicating warmly with each other and with the baby. The child's behavior is a powerful way for communicating with parents.

There are times in a child's development when the whole family is especially likely to be

available for this kind of communication. I call these predictable developmental events “touchpoints”. Each visit for preventive health care can be matched to a touchpoint. Childcare professionals can reach out for parents at drop-off and pick-up times to predict the onset of the next touchpoint. (Figure 4)

Figure 4. Touchpoints of development



Here are four touchpoints in the first year which provide opportunities for a clinician to join parents in understanding sleep issues:

1. 4 months – learning to stretch out to 8 hours by baby learning to find a way to get self to sleep at every 3-4 hour light cycle sleep.
2. 8 months – awakens again because of crawling mobility and stranger awareness (cognitive spurt).
3. 10 months – standing beside crib every 3-4 hours as if can’t get down.
4. 12 months – wakes up every 3-4 hours with newfound autonomy with walking plus increased dependence.

Here are four touchpoints for incipient eating issues:

1. Newborn – decision about breastfeeding
2. 4 months – imminent spurt in interest in environment causes split in feeding interest.
3. 9 months – needs to feed self with finger feeding with new pincer grasp.
4. 12 months - negativism of second year and setting up necessary diet so that independence can be settled on child.

A touchpoint is an opportunity for deepening the mutual relationship between provider (medical, child care, early interventionist) and parent. Each one is dependent on the predictable stresses of a child’s developmental surges and is matched by the parent’s passionate desire to do well by the child. As providers, we are wise to become aware of each of these stresses as opportunities. As we join the parents in their urge to foster the child’s optimal development, each

contact becomes rewarding to them as well as to us as providers.

Figure 5. Touchpoints



These are the predictable touchpoints (Figure 5) in the first few years. We have recently identified several of these in the years 3-6 (Brazelton and Sparrow, 2001).

The Touchpoints model was originally developed for the primary health-care setting. However, our model is now being utilized by professionals from other disciplines who work in a variety of settings. For example, child care, early intervention, and school all offer such opportunities. We value practitioners' expertise and encourage them to adapt the model to their community and practice settings. The assumptions about professionals using this model can be found in Table 3. The essence of Touchpoints training is in preventive anticipatory guidance, in its multidisciplinary approach, and its focus is on the common interest in the child that parents and providers share. Touchpoints focuses on building relationships as an integral *goal* of parent and practitioner interactions in diverse settings: childbirth education classes, during office and home visits, in provider-parent encounters at child-care centers and preschools, etc.

Consistent understanding and application of the Touchpoints approach across the range of health, childcare, and educational settings in a community can offer families a more coherent experience of multiple services provided. As practice settings move toward greater collaboration, a shared, explicitly articulated conceptual framework can improve coordination of care. When espoused by the organization and shared by colleagues, this framework can form the basis for professional development within the work setting and the community. Only then will we be able to move beyond the current state of fragmentation of services to more effectively join families as allies with a more caring, seamless system.

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