
Developmental and Behavioral Pediatrics

**A Handbook
for Primary Care**
Second Edition

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Touchpoints of Anticipatory Guidance in the First Three Years

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Description of Touchpoints™.

A. Touchpoints are the periods in the first years of life when children's developmental spurts predictably result in disruption of the family system. Developmental progress is often preceded in the infant and child by a transient (and inexplicable) period of behavioral disorganization and distress. The succession of Touchpoints in a child's development is like a map that can be identified and anticipated by both parents and pediatric providers.

1. Thirteen touchpoints have been noted in the first 3 years, beginning in pregnancy. They are centered on care giving 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, as well as a source of stress, 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.
2. Touchpoints may occur somewhat later in **premature** infants, but they will be even more important as opportunities for supporting anxious parents.
3. 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.

B. The guiding principles of the Touchpoints model. Professionals can use these principles as a framework for each encounter with families during a child's first 3 years (Table 4-1).

1. Several guiding assumptions about parents form the core of Touchpoints' practice with families (Table 4-2). Perhaps the most important one for the clinician to keep in mind is that *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 4-month-olds, providers can predict 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 as reflected in these behaviors 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 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.
2. Parents find it reassuring that bursts and regressions in development are to be expected. This represents a shift in thinking for parents who, without this information, 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.

C. A paradigm shift. In order to fulfill this opportunity to use the spurts 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 (Fig. 4-1).

1. Healthcare professionals are trained to look for the failures and defects in the child

Table 4-1 The guiding principles of the Touchpoints model

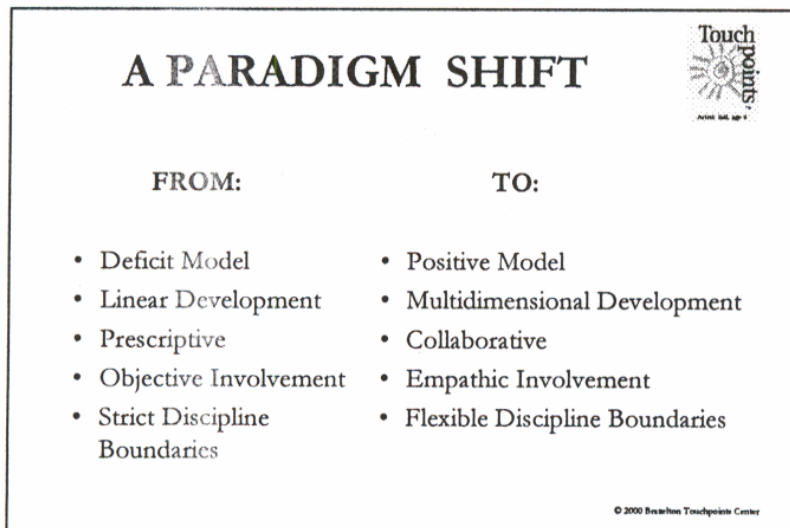
Value and understand the relationship between you and the parent
 Use the behavior of the child as your language
 Value passion wherever you find it
 Focus on the parent–child relationship
 Look for opportunities to support mastery
 Recognize the beliefs and biases that you bring to the interaction
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

Table 4-2 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

and parents. Unfortunately, these do not endear us to the parents of our patients. 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 (guidelines)-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.

- a. 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”, such that it can be difficult to 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 to develop an effective and satisfying working relationship with us.
2. A systems model is a valuable way to think of how clinicians can be most effective (Fig. 4-2). Systems theory assumes that **each member of the system is in balance**

**Figure 4-1.** A paradigm shift.

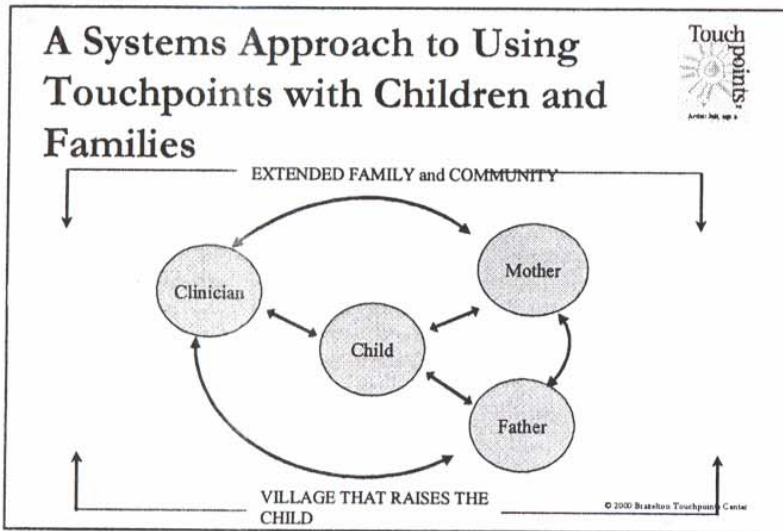


Figure 4-2. A systems approach to using Touchpoints with children and families.

with each other member. If there is a stress on the system, each member must adjust to the stress. As a result, stress can be an opportunity for learning.

If a provider wants the system to learn to succeed, he or she 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 the clinician should greet a family with an initial observation of the infant or child's behavior. Initially, the provider can observe evidence of temperament and stage of development, and share these behaviors with parents.
- Other meaningful behaviors to be shared with parents are those that offer evidence

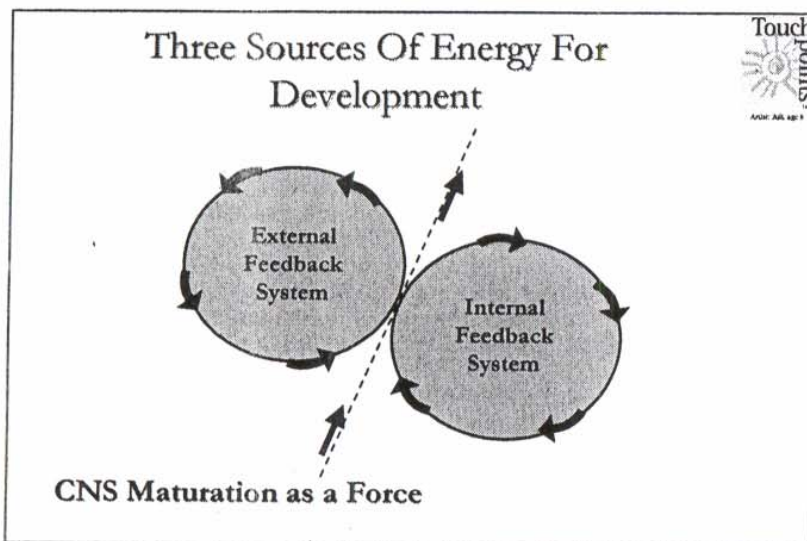


Figure 4-3. Three sources of energy for development.

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. The inner feedback cycle (Fig. 4-3), 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 processes of development driven by the maturation of the central nervous system. Parents can be encouraged by the provider to observe these two cycles 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 approach 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.
- 3. 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 the clinician respects a 9-month-old's stranger anxiety, he or she has shown their capacity to care for a child more powerfully than by simply saying "I care". The clinician should not be too intrusive by trying immediately to engage the infant. Rather, the clinician should engage the infant in response to the infant's signals of readiness and interest.
- 4. A Touchpoint provides an opportunity for deepening the mutual relationship between provider 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. Each of these stresses represents an opportunity. 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.

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Websites for Professionals

www.touchpoints.org