REFLECTIVE PRACTICE IN ORGANIZATIONAL LEARNING, CULTURAL SELF-UNDERSTANDING, AND COMMUNITY SELF-STRENGTHENING

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ABSTRACT: The infant mental health field can amplify its effects when it extends its purview beyond the dyad to the larger contexts in which infants and adult caregivers interact and develop over time. Within health, mental health, education, and other human service organizations, the quality of relationships is a critical variable in the individual-level outcomes that such organizations seek. The goals of this work and the means for accomplishing them are highly dependent on human qualities and interactions that are shaped by organizational processes. In communities, too, processes that shape relationships also strongly influence child-, family-, and community-level outcomes. The Touchpoints approach to reflective practice can guide relational processes among professionals, parents, and infants in organizations and communities that influence these outcomes.

Keywords: reflective practice, organizational development, culture, community, systems theory

RESUMEN: El campo de la salud mental infantil puede amplificar sus efectos cuando extiende su cobertura más allá de la díada a los contextos más amplios dentro de los cuales los infantes y los adultos que les prestan el cuidado interactúan y se desarrollan con el tiempo. Dentro de la salud, la salud mental, la educación y otras organizaciones que prestan servicios humanos, la calidad de las relaciones es una variable crítica al nivel de los resultados individuales que tales organizaciones persiguen. Las metas de este trabajo y los medios para lograrlas dependen altamente de las cualidades e interacciones humanas a las que les dan forma los procesos organizacionales. En comunidades, asimismo, los procesos que le dan forma a las relaciones también ejercen una fuerte influencia en el niño, la familia, así como los resultados a nivel de la comunidad. El acercamiento de Puntos de Contacto a la práctica de reflexión puede guiar los procesos de relaciones entre profesionales, padres e infantes en organizaciones y comunidades que ejercen influencia sobre estos resultados.

Palabras claves: práctica de reflexión, desarrollo organizacional, cultura, comunidad, teoría de sistemas

RÉSUMÉ: Le domaine de la santé mentale du nourrisson peut amplifier son impact lorsqu'il élargit son champ au delà de la dyade et vers des contextes plus grands dans lesquels les nourrissons et les adultes prenant soin d'eux se côtoient et se développent au fil du temps. Pour ce qui concerne les organisations ayant trait à la santé, à la santé mentale, à l'éducation et à d'autres services humains, la qualité des relations s'avère être une variable extrêmement importante dans les niveaux de résultats individuels que recherchent ces organisations. Les buts de ce travail et les moyens de les accomplir dépendent fortement des qualités humaines et des interactions qui tiennent leurs formes des processus de l'organisation. De même, dans les communautés les processus qui donnent forme aux relations influencent également l'enfant, la famille, ainsi que les niveaux des résultats de la communauté. L'approche *Touchpoints* à la pratique réfléchie peut guider les processus relationnels chez les professionnels, les parents et les nourrissons dans les organisations et les communautés qui influencent ces résultats.

Mots clés: pratique réfléchie, développement de l'organisation, culture, communauté, théorie des systèmes

ZUSAMMENFASSUNG: Der Fachbereich der psychischen Gesundheit von Säuglingen kann seine Wirkung erweitern, indem es seinen Geltungsbereich von Dyaden hin zu einem größeren Umfeld erstreckt, in welchem Kinder und erwachsene Bezugspersonen interagieren und sich mit der Zeit entwickeln. Innerhalb von Organisationen zur Gesundheit, geistigen Gesundheit, Bildung und anderen Serviceleistungen rund um den Menschen, ist die Qualität von Beziehungen eine kritische Variable auf der individuellen Ergebnisebene, die von den Organisationen angestrebt wird. Die Ziele dieser Arbeit und die Mittel, um diese zu erreichen, sind stark abhängig von menschlichen Eigenschaften und Interaktionen, die durch organisatorische Prozesse geformt werden. Dies gilt auch für Gemeinden: Abläufe, die Beziehungen formen, beeinflussen auch stark die Ergebnisse auf Ebene des Kindes, der Familie

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sowie der Gemeinde. Der “Touchpoint-Ansatz” zur reflexiven Praxis kann relationale Prozesse unter Fachleuten, Eltern und Kindern in Organisationen und Gemeinden steuern, die diese Ergebnisse beeinflussen können.

Stichwörter: reflexive Praxis, Organisationsentwicklung, Kultur, Gemeinde, Systemtheorie

抄録: 乳幼児精神保健の分野が、乳幼児と大人の養育者がゆっくり時間をかけて相互作用して発達するという、二者関係を越えたより大きなコンテクストにその視野を広げるとき、その効果を強めることができる。健康、精神保健、教育、そしてその他の福祉機関の内部で、関係性の質は、そのような機関が追及する個人レベルの結果における重要変数である。この仕事の目標は、そしてそれらを達成するための手段は、人の質と相互交流に高度に依存しており、それは組織プロセスによって形作られる。地域コミュニティでも、関係性を形作るプロセスは、子ども、家族、ならびにコミュニティレベルの結果にも、強く影響する。内省的臨床へのタッチポイント・アプローチThe Touchpoints approachは、これらの結果に影響する、組織とコミュニティにおける専門家、親、そして乳幼児の間の関係プロセスをガイドすることができる。

キーワード: 内省的臨床, 組織の発達, 文化, コミュニティ, システム理論

摘要: 如果幼兒心理健康領域能夠超越二人組合的範圍, 伸展到幼兒和成人看護者如何在較大環境中相互影響, 並如何隨著時間發展, 其影響就可以擴大。在健康、心理健康、教育, 和其他服務人類組織裏, 關係質量是這類組織所追求的一個個人關鍵變量成果。這項工作的目標和實現這些目標的方法, 在很大程度上取決於由組織過程塑造的人際關係之素質和互動。在社區裏, 這些塑造人際關係的過程, 也強烈地影響孩子、家庭以及社區水平的成果。反思性Touchpoints方法可以引導影響這些成果的組織和社區之專業人士、父母和嬰兒的人際關係。

關鍵詞: 反思方法, 組織發展, 文化, 社區, 系統理論

مفتاحية: يمكن لمجال الصحة النفسية للأطفال أن يعزز تأثيره عندما يمتد اختصاصه من الدائرة المحدودة للثنائيات التجريبية إلى السياق الأوسع حيث يتفاعل الأطفال ومقدمي الرعاية ويتطورون مع الوقت . وتعتبر جودة العلاقات من العوامل المحورية والمتغيرات الأساسية على المستوى الفردي التي تسعى إليها المنظمات الصحية والتعليمية والخدمات الإنسانية في عملها . أهداف هذا العمل وسبل تحقيقه تعتمد بشكل كبير على السمات الإنسانية والتفاعلات التي تكونها العمليات التنظيمية . وفي إطار المجتمعات أيضا نجد أن العمليات التي تشكل العلاقات تؤثر نتائجها بقوة على الطفل والعائلة وكذلك على مستوى المجتمع ككل . إن نموذج نقطة الاتصال (Touchpoints) في الممارسة التأملية يمكن أن يوجه العمليات العلائقية بين المتخصصين والآباء والأطفال في المنظمات والمجتمعات التي تؤثر على هذه المخرجات .

كلمات مفتاحية : الممارسة التأملية – النمو التنظيمي – الثقافة – المجتمع – نظرية النظم

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As a field, infant mental health amplifies its effects when it influences interventions and policies that extend beyond the dyad to the larger contexts in which infants, parents, and other caregivers interact and develop over time. Dyad-focused treatments can be embedded within systems-oriented approaches that help to strengthen and sustain their impact. Touchpoints (Brazelton, 1992) is examined here as an example of a systems theory-based approach to reflective practice that has evolved to situate infant–parent–clinician treatment models within relational parallel processes in organizations and communities (Douglass, 2011, p. 3).

The Touchpoints approach grew out of the research on newborn behavior and infant–parent interactions conducted by Berry Brazelton and others over the past half-century that laid the foundation for the infant mental health field (Brazelton, 1992; Lester & Sparrow, 2010; Sparrow, 2013; Stadtler, Novak, & Sparrow, 2010). This systems theory based model of human development proposes predictable periods of disorganization and reorganization as the process through which new skills and capacities emerge. Within the infant or child as a system, change in one system component or developmental domain leads to changes in others. The domains of sleep, feeding, self-regulation, and behavioral control are often those that are disrupted just prior to the reconfiguration of system components into new competencies (Heimann, 2010). Some researchers have speculated that these temporary normative regressions elicit greater parental resources at times when impending developmental advances require them (Plooij, 2010). At these times, parents, too, may require additional support to respond effectively to the increased demands of their offspring.

Within larger systems such as families and communities, changes in one system component such as the child, occur in interaction with other system components such as family members and professional providers. The child’s temporary developmental regressions are disorganizing not only for infants and children but also for the systems that contain and shape their development: family, other adult caregivers, and the organizations in which they work. During these periods, parents’ and other caregivers’ patience may be tested, and they may question their own and each other’s competence. Affirmation of parental and professional caregiver competence and reinforcement of a sense of confidence and self-efficacy are essential at these times, as are family and organizational cohesion.

Historically, professional training and socialization have not sensitized professionals to these effects of children's development on parents and other caregivers. Instead, knowledge and expertise about parenting have typically been assumed to reside primarily within professionals and their institutions, potentially undermining parents' sense of self-efficacy and mastery. Yet, both are critical to effective parental functioning. Because the infant mental health field was born from the same body of research as the Touchpoints approach (Osofsky, 2016, p. 44), individual infant mental health practitioners may be more attentive than other clinicians to the need to re-equilibrate the resulting power imbalance. However, the top-down paradigm—based on medical and educational traditions—remains deeply engrained in human services organizations and most family-facing sectors. The Touchpoints approach seeks to accelerate the paradigm shift from prescriptive to collaborative and top-down to co-constructed relationships at all levels in organizations and communities.

The Touchpoints approach was first offered as a one-shot training to improve parent-provider relationships at the level of individual practice in infant mental health, and perinatal and pediatric healthcare (Stadtler, O'Brien & Hornstein, 1995). Within the following 5 years, several lessons were learned.

First, it became apparent that similar challenges in these relationships occurred in all of the family-facing sectors: perinatal and pediatric health, mental health, early education, home visiting, child protective services and welfare, and beyond. Within and across these sectors, practices that had not incorporated strengths-based, relational approaches to infant, child, and family development could inadvertently undo advances in practice that had taken place elsewhere, particularly for individual families served by multiple sectors. As a result, the Touchpoints approach was adapted for early education and care and other family-facing professionals. This is why this article uses examples and draws lessons from a range of sectors that along with infant mental health are interdependent. Practice improvements are more effective when practitioners in one sector are able to see their connections to others in broader systems of care. This also is why the Touchpoints approach has been used to bring together agencies from different sectors within a community, for example, by some grantees of the Substance Abuse and Mental Health Service Administration's Project Linking Actions for Unmet Needs in Children's Health (Project LAUNCH) (Substance Abuse and Mental Health Services Administration, United States Department of Health and Human Services, 2008).

Second, practice change entailing a fundamental paradigm shift is unlikely to occur as the result of a single training event. Instead, reflective practice learning activities are required over time to allow for application and practice as well as opportunities to fail, learn, and try again. As this became apparent, Touchpoints' professional development delivery was redesigned to incorporate longitudinal reflective practice. Over the past decade or so, as a part of a larger, analogous trend, the use of a range of different continuous improvement tools for trial-and-error learning at the organizational level has spread across health, education, and other family-facing institutions. Examples include the Plan-Do-Study-Act Cycle (Langley, Moen, Nolan, Nolan, Norman & Provost, 2009.) and the Institute for Healthcare Improvement's (Institute for Healthcare Improvement, 2003) Breakthrough Series.

Third, individual learning and change cannot be effectively applied to and sustained in practice without corresponding learning and change at the level of organizations and communities. This article seeks to situate the core elements that guide the Touchpoints approach to individual-level practice (as in dyadic treatments) at the level of organizations and communities, where parallel learning and change reinforce the paradigm shift under way for individual practice.

THE ROLE OF RELATIONSHIPS IN HUMAN SERVICE ORGANIZATIONS AND COMMUNITIES

Within mental health, health, education, and other human service organizations, the quality of relationships is a critical variable in the individual- (child and parent) level outcomes that such organizations seek (Douglass, 2011; Dunst, 2002). In these organizations, goals of the work and the means for accomplishing them are dependent on human qualities and interactions shaped by organizational leadership, structures, and processes (Bryck, Sebring, Allensworth, Luppescu, & Easton, 2010). In communities, too, leadership, structures, and processes that shape relationships among community members and organizations influence the child, family, and community-level outcomes. For example, community collective efficacy, "defined as social cohesion among neighbors combined with their willingness to intervene on behalf of the common good" (Sampson, Raudenbush, & Earls, 1997, p. 918), emerges from relationships among community members and mediates child behavioral and academic outcomes (Sampson, Morenoff, & Earls, 1999).

Organization- and community-wide changes are necessary to support ways of being and working that improve relational quality and, in turn, child, and family health and well-being. In human service organizations, for example, leadership, organizational culture, tacit behavioral norms, formal and informal power distribution, and policies and procedures all influence staff relationships and relationships with the families served. Parallel processes can be designed, aligned, and managed across these organizational structures and processes, as well as individual practice, to serve the healthy functioning of other human systems such as families and communities (Douglass, 2011).

Reflective practice can be used to bring about and sustain these kinds of changes across organizational as well as community structures and processes. As a systems theory based approach to reflective practice, Touchpoints can be used to align dyadic-, organizational-, and community-level relationships in mutually reinforcing parallel processes. Reflective practice as employed by the Touchpoints approach focuses on core elements in three areas within organizations and communities: relationships, cultures, and systems.

RELATIONAL, CULTURAL, AND SYSTEMS CORE ELEMENTS OF THE TOUCHPOINTS APPROACH

The relational, cultural, and systems core elements of the Touchpoints approach build on theory and research spanning a range of related areas of inquiry:

- Infant behavior (e.g., Brazelton, 1962, 1973),
- Parent–infant interactions (e.g., Brazelton, Koslowski, Main, Lewis, & Rosenblum, 1974),
- Child and parent developmental processes (e.g., Brazelton, 1992; Sparrow, 2013),
- Parent–provider interactions in healthcare (e.g., Ahmann, 1994; Barnard & Morisset, 1995) and education (Dunst, 2002),
- Effective therapeutic relationships (e.g., Stewart et al., 1995),
- The role of cultures and contexts in childrearing (e.g., LeVine, 2010),
- Dynamic, developmental systems theory (e.g., Bronfenbrenner, 1979; Fogel, King, & Shanker, 2008; Sameroff, 1975),
- Organizational learning and development (e.g., Douglass, 2011; Glisson, 2007), and
- The role of community-level processes in human development (e.g., Sampson et al., 1999; Sampson et al., 1997).

Relational

Across these areas of inquiry, and at all of these levels, researchers and practitioners have identified and confirmed the critical importance of the quality of relationships. The Touchpoints approach to reflective practice can serve as a set of principles, processes, capacities, skills, and strategies for protecting and improving the quality of relationships in service of the advancement of a shared agenda for human development.

Relationships have moved center stage as systems theory has begun to displace stimulus–response, top-down, and other linear explanatory models of human, organizational, and community development. This is because systems theory specifies that system components interact with each other; in human systems, this occurs through multidirectional relationships. Human systems tend to be guided by the evolutionary biological imperative of species survival and reproduction. Human cultures tend to embody and transmit these and other human goals as well as often highly differentiated means for attaining them.

Cultural

Although there are innumerable definitions of culture, here it is conceptualized as a process in which emergent beliefs, values, behaviors, and practices continually shape and are shaped by biology, history, physical environment, local contexts, and other forces (Rogoff, 2003). Members of human systems (families, organizations, communities) manifest these sets of thoughts and actions in their interactions and relationships with each other. As they do so over the course of generations, these are tested, honed, retained, adapted, transformed, distorted, or discarded.

For individuals who participate in a shared culture, these beliefs, values, behaviors, and practices are often invisible, and assumed to be universal, at least until another culture is encountered. The latter may be judged as an aberration, leaving the universalistic assumptions of the former intact. In theory, cultures evolve in interaction with specific local conditions and contexts, and drive toward shared developmental goals (Rogoff, 2003, pp. 3–7, 85–88). However, this may not always be the case. Cultures interact with other cultures, and with larger forces that may overpower them. Human system members identifying with the same culture may not share all of the same beliefs, values, practices, and behaviors, in part because they also may identify with other, different cultures.

Systems

Relationships, cultures, and human development can be understood as processes involving the multidirectional and mutually influential interactions of systems components. The Touchpoints approach to reflective practice focuses on understanding one's own and others' experience of and contributions to these interactions, and the role of cultures in the ways in which these relationships unfold. The Touchpoints approach to reflective practice aims to expand the applications of these understandings by building the capacity to think in systems.

As a set of principles, strategies, and processes, the relational, cultural, and systems core elements can be used in:

- individual reflective practice,
- reflective supervision of clinical encounters,
- organizational change and learning, and
- community self-strengthening processes.

They can be introduced in preclinical training or in-service professional development activities, applied and reinforced by human service organizations and community leaders, and implemented in:

- staff meetings and community convenings,
- supervision,
- policies,
- procedures,
- protocols,
- performance evaluations,
- hiring and termination criteria and procedures,
- data use and other organizational learning activities, and
- other functions.

When used consistently and actively linked across these areas, the core elements can enhance systems functioning by aligning and coordinating the interactions of its members. In individual reflective practice, reflective clinical supervision, and group organizational and community processes, the principles and capacities serve as proactive as well as corrective guideposts. The processes and strategies can be used to plan and implement progress toward these guideposts and assist in calibrating for course corrections. In addition, Touchpoints-based principles can inform clinical and supervisory parameters as well as organizational and community policies, procedures, and protocols. These can all align with and mutually reinforce each other as well as parallel relational interactions occurring across all levels of organizations and communities.

Arising from the research cited earlier, the core elements of relationships, systems, and cultures required to advance the developmental goals of system members include:

Relational Core Elements

- **Multidirectional interactions**: Multidirectional rather than one-way transmission of information and affective energy;
- **Reparative processes**: These depend on safety and trust that allow for the identification of and effective response to relational errors such as miscommunications and misunderstandings;
- **Collaborative**: Collaborative than prescriptive processes and interactions, and power-sharing rather than hierarchical roles among interacting systems members; and
- **Observation, shared observation:** Distinguishing observation from inference and value judgment so that observations are shared and meaning is co-constructed.

Cultural Core Elements

- **Surfacing of biases and assumptions**: These may be operating outside of awareness;
- **Cultural self-understanding**: Attention to one's own cultural identities and histories, and how these shape one's perceptions of and interactions with others;
- **Cultural humility**: The search for and recognition of one's own contribution to miscommunications and misunderstandings, of one's assumptions about the universality of one's culture, and of one's ignorance about other cultures, and when and how these may influence the unfolding of relationships;
- **Reflective narratives**: Awareness of the human need to organize experience into culturally rooted narratives. Within and across cultures, individuals' narratives may contain conflicting causal attributions and explanatory models that influence the flow of information and affective energy in relational interactions; and
- **Strengths-based**: A strengths-based approach that can be used to understand cultural practices by situating them within the context of a culture's goals and purposes, as opposed to deficit-based approaches that propose judgements of other cultures from within it's own cultural context (Rogoff, 2003, pp. 16–19). Similar processes that assume positive intent, purposes, and goals also are applied to the understanding of the actions of individuals, families, organizations, and communities.

Systems Core Elements

- **Learning stance, readiness for change**: System members change themselves and each other as they learn from and with each other (Garvin, 2003; Rogoff, 2003);
- **Shared goals**: Identification and pursuit of shared goals;
- **Valuing diversity**: Shared understanding of divergent or conflicting positions as opportunities for strengthening relationships and mutually expanding understanding of each system member and the different realities that each experiences; and
- **"Seeing in systems"** (Senge, Hamilton, & Kania, 2015, pp. 28–29): This brings into view the contributions of all system members to the unfolding of their relationships and collaborative efforts.

The core elements are largely overlapping and interconnected. Although each is introduced in the sections on relational, cultural, or systems contexts described below many of them apply across some or all of these contexts. Many core elements illustrated in one of the following examples also are relevant to other examples used here to illustrate other core elements. The interlinking of these core elements is indicated in some but not all cases, and the reader is likely to notice other instances as well.

REFLECTIVE PRACTICE AND TOUCHPOINTS RELATIONAL CORE ELEMENTS

The Touchpoints approach begins with the role of relationships in human development. Relationships connect parents and children, providers and parents, and other members of human systems—families, organizations, and communities. Specific qualities of relationships are critical to effective functioning of human systems and positive developmental outcomes for their members.

Multidirectional interactions: *Multidirectional rather than one-way transmission of information and affective energy*.

System members' capacities to send, receive, and interpret each other's signals, to adapt to each other accordingly, and to co-create shared meanings and coherent narratives are necessary to survival, reproduction, and the pursuit of their interdependent developmental agendas (Hrdy, 2009; Wilson, 2012). In developmental systems, system members transmit and receive affective energy as well as information about themselves and each other, and adapt their states, behavior, and functions accordingly (see

also Systems Core Element–Learning stance, readiness for change: System members change and are changed by each other). These communications are multidirectional, involving complex interactions of multiple system members that occur in rapid sequence or simultaneously. Affective states as well as meanings are co-created, coregulated, and continuously evolved (Trevarthen, 1979; Trevarthen & Aitken, 2001; Tronick, Cohn, & Shea, 1986).

Reparative processes: *Dependent on safety and trust that allow for the identification of and effective response to relational "errors" (e.g., miscommunications and misunderstandings).*

When misunderstandings and maladaptive responses occur, system members can strengthen their relationships through their reparative efforts. For example, in the past, clinicians in health and mental health facilities were routinely discouraged by administrators and legal advisors from acknowledging errors to those in patient roles. More recently, though, the importance of apologies and making reparations has been gaining recognition in clinical practice.

In parallel to the emergence of professional apologies, human service organizations committed to identifying and correcting errors employ relational processes to guide:

- Self-reflection and mutual support;
- Individual, team, and organizational valuing of mistakes as opportunities for learning; and
- A systems-focused rather than an individual-blaming approach to continuous quality improvement. The systemic analysis of errors and corresponding systemic changes are deployed to prevent their recurrence (Alberstein & Davidovitch, 2011; Institute for Healthcare Improvement, 2003; Leape et al., 2009).

In some health and mental health service organizations, individuals in patient roles or their family members have been asked to participate in systemic error analysis and reparative and preventive efforts, including serving as trainers in professional development activities.

Collaborative rather than prescriptive processes and interactions, and power-sharing, rather than hierarchical roles, among interacting systems members

Similarly, clinicians can take a collaborative stance with individuals in patient roles as they formulate diagnoses and develop and prescribe treatment plans. When they do, their patients are more likely to provide critical information that can improve treatment recommendations and provide insight into potential treatment-adherence challenges that may lie ahead (Stadtler et al., 2010). When child-focused providers and parents share power in this way, they all are more likely to feel that they are truly on the same team. This kind of collaboration can produce a range of therapeutic benefits including, for parents, a reduction of social isolation and stress and an increase in self-efficacy. In turn, these can help improve children's developmental outcomes.

Human service providers transmitting information in a prescriptive manner, with a strongly held agenda or unexamined assumptions, are less likely to obtain accurate information on which to base their assessments and treatment recommendations. They are less likely to receive clear responses to their communications, and to interpret these responses accurately. Their communications may be understood and acted upon by the recipients of their care as much on the basis of the imbalanced nature of the interaction as the content of the communication. This may lead to unintended and undesirable consequences.

Reflective practice can be used to bring professional agendas, assumptions, and prescriptive stances into view and to surface and soften providers' understandable fears that often accompany the prospect of sharing power. It can be used to identify organization-wide processes and protocols that make it difficult to build collaborative relationships and to innovate new ones that make it easier. For example, clinical institutions may not provide easy or any access to clinical records, and these may be written in language that is not readily understandable to those who are the object of the documentation. Some healthcare facilities, recognizing the benefits of individuals' participation in their own treatment, have begun to experiment with Web-based, open notes that allow patients to view their own records. Another example, spreading across pediatric hospitals, is the replacement of traditional rounds with family-centered rounds. The child and family are invited to participate in these daily status-update, treatment-review, and planning discussions. Reflective practice can be used to help healthcare professionals examine and shift their stance, attitude, and language so that they can write records that are meaningful to their patients and engage in conversations with families that respect their roles in their children's care.

Prescriptive, hierarchical, and power-imbalanced relationships within organizations and across organizations in communities can impede the advance of collaborative relationships at the level of individual practice. In organizations, these relational qualities can obstruct the flow of communication and skew its content, interfere with shared learning, and distort processes of mutual adaptation and co-constructed meaning-making. Such characteristics of relationships are often organization-wide, emerging from and reinforced by organizational structures, processes, and leadership. According to Hemmelgarn, Glisson, and James (2006), "Human services are soft technologies that are often molded or adapted to existing organizational contexts" (p. 74). Giving up unilateral control of power to co-create shared power requires relational supports that encourage service providers to take constructive risks. These must be reinforced across organizational structures and processes, and require committed backing from leadership (Garvin, 2003).

Observation, shared observation: *Distinguishing observation from inference and value judgment so that observations are shared and meaning is co-constructed.*

Power imbalances in human services organizations and professional service relationships are sometimes played out in inaccurate provider inferences about child and parent pathology. These can prevent providers from observing child and parent strengths and discovering together with parents how they might pool their

strengths. When providers unilaterally impose, their own perspectives and those of their institutions, parental disempowerment, externalized locus of control, and dependency are likely unintended consequences (Sparrow et al., 2011) (also see System Core ElementStrengths-based approach).

When power imbalances impede shared observation and co-construction of meaning, interactions may emerge that are based on and reinforce the assumption that service providers possess the solutions while problems are located within service recipients. For example, professionals often infer parental deficits from their observations, and posit these as the cause of distress in infants and young children (Brazelton & Sparrow, 2001, pp. 333–334) (also see Cultural Core Element–Reflective narratives). This is entirely understandable and particularly likely when professionals empathize with the child's distress, and when the immediate family is the only domain in which they possess the tools and the authority to act.

Locating the problem in the parent also temporarily protects professionals from the self-blame that they often feel when unable to reduce the child's suffering. For many caregiving professionals, the integrity of their professional identity depends on being able to help in such situations, and this can be threatened by real or perceived ineffectiveness. The resulting feelings of failure can lead to unexamined efforts to shore up professional identity by shifting the blame to parents. This focus on perceived parental deficits may prevent the professional from appreciating challenges intrinsic to the child (e.g., self-regulatory behaviors, attachment behaviors, physiologic feeding anomalies, etc.) that contribute to parental behaviors mistakenly deemed to be causative (also see System Core Element–Strengths-based approach).

Similarly, the professional may not fully appreciate challenges intrinsic to professional–parent or institution–parent interactions (also see Cultural Core Element-Cultural self-understanding). Such challenges can arise when professionals and parents are unable to co-construct a shared understanding of the child, the parent's positive intent and that of the professional, the context in which the child is being raised, and the institution in which the professional must operate. These challenges can provoke parental behaviors that professionals may misinterpret as the cause of the child's condition. For example, parental anxiety, mistrust, antagonistic interactions with professionals, limited treatment adherence or refusal, among others, often originate not in the parent but in parent–provider or parent–institution interactions. Negative past experiences of such interactions also can manifest in these ways, but their relational origins often go unrecognized.

The Touchpoints approach specifies processes for setting aside assumptions that interfere with learning about families' experiences, and uplifting their knowledge and strengths (also see Cultural Core Element–Strengths-based approach). Shared observation and co-constructed meaning-making processes among providers and parents can be conducted so that together they strengthen their relationships, collective efficacy, and potential for learning and growth. Although it may seem counterintuitive, the focus on strengths may actually increase the likelihood that challenges and vulnerabilities are surfaced and effectively addressed.

At the level of organizations and communities, processes that identify and give voice to divergent and shared strengths, values, and goals also can engender collective efficacy (Sampson et al., 1999; Sampson et al., 1997). To accomplish this, whether with individual families or within a community, self-observation can help uncover inaccurate assumptions that obscure strengths, assumptions that may be buttressed by the stance of professional and organizational authority (also see System Core Element–Valuing diversity and Cultural Core Element-Cultural self-understanding).

Except in cases of frank abuse and neglect, the conviction with which providers causally attribute child distress to parental behaviors may be more strongly held than is warranted by available evidence. Such convictions are often arrived at when the complex contexts in which parent-child interactions are shaped are not fully appreciated. For example, welfare-to-work policies in the absence of affordable childcare or parental mental illness in the absence of affordable treatment may result in instances of presumed parental neglect that instead might be more accurately explained by inequitable access to social resources (also see Cultural Core Element–*Reflective narratives*).

With this perspective, infant mental health workers and the organizations in which they work might be mobilized to add policy tools to the dyadic ones that they may be more accustomed to wielding. Reflective practice can help professionals step back to see the big picture and a broader range of factors (Senge et al., 2015, pp. 28–29). It can be used to improve not only observational skills and the quality of relationships but also the functioning of family, organizational, and community systems (also see System Core Element–Seeing in systems).

Reflective Practice and Touchpoints Cultural Core Elements: Cross-cultural Understanding in Relationships and Systems

Surfacing biases and assumptions *that may be operating outside of awareness*

Many family-facing professionals tend to turn to parental behavior to explain infant and child problems. Children are assumed to be blank slates and parents as solely responsible for what is written on them. Mental health and healthcare cultures have evolved an array of beliefs, attitudes, practices, and modes of communication based on this assumption of decontextualized, one-way causality. This may lead to unintended negative consequences in the cross-cultural relationships of individuals divided by their clinical and patient or client roles.

Developmental systems theory, instead, based on observational research of newborn behavior, reveals how children act on their parents, shaping caregiver behavior from the moment they are born. Challenges identified in the child, the parent, or both are understood to arise from their interactions and the contexts in which these evolve: The functioning of each system member is understood in the context of his or her interactions with others as well as the forces interacting with the system. As a result, the focus of

treatment is the contextually situated relationship itself. Nonetheless, the old model of linear causality continues to be transmitted and reinforced in structures and processes of clinical organizations as well as in professional cultures.

Parent blaming and other biases of professional cultures can be surfaced through reflective practice. The Touchpoints approach proposes specific skills and strategies that build on self-reflection to co-create safety, trust, and mutual respect in relationships that bridge the cultures of service providers and participants. For example, the Touchpoints approach uses professional development activities grounded in research on the earliest interactions to sensitize participants to the variations in and power of nonverbal behavior, the resulting potential for negative assumptions, and reparative processes (also see Relational Core Element–Reparative processes).

Cultural Self-understanding: *Attention to one's own cultural identities and histories and how these shape one's perceptions of and interactions with others*,

Cultural self-understanding may be thought of as an iterative process and a developing capacity. Reflective practice can promote cultural self-understanding by raising questions about one's self and culture(s) that enable one to engage with those from "other" cultures authentically through the self rather than based on assumptions and stereotypes about the "other." Such questions include:

- Who am I?
- Where do I come from?
- Who are my people?
- What cultural activities do I participate in and how have these changed and remained the same over the course of my life?
- What privileges and resources have been conferred on or withheld from me on the basis of the cultural and other groups that I identify with or that others identify me with?
- How do all of these influence my ways of communicating and understanding?
- How do they help or prevent me from imagining and becoming aware of other ways, beings, and potentials?

Cultural humility: *The search for and recognition of one's own contribution to miscommunications and misunderstanding, of one's assumptions about the universality of one's culture, and of one's ignorance about other cultures, and when and how they may influence the unfolding of relationships*.

The term *cultural humility* refers to an awareness of the difficulty of knowing what one does not know, of seeing what one does not see. It suggests a particular stance that starts with reflection about one's own cultures—personal, family, local, tribal, ethnic, national, professional, and spiritual cultures—and of the influence of these on one's perceptions and expectations of others. Cultural humility requires a willingness to identify one's mistakes and misunderstandings, and to be ready to accept responsibility and apologize for them (also see Systems Core Element–Learning stance, readiness to change). It is a starting place from which to learn and seek guidance while recognizing that such guidance may not be deserved and may be uncomfortable for others to provide or too much to ask for.

Reflective narratives: *Awareness of the human need to organize experience into culturally rooted narratives that may include conflicting causal attributions and explanatory models that influence the flow of information and affective energy in relational interactions*.

When cultural humility is not operating, participants in one cultural group, including professional cultural groups, may generate narratives that serve to legitimize their own values and practices, but that are based on misunderstandings and judgments about other cultural groups, including clinical service recipients. This often occurs when professionals find themselves unable to organize overwhelming clinical data in ways that preserve their sense of task orientation and suggest hopeful paths forward. Although the resulting, typically deficit-focused narratives may be intended for communication within the group only, the attitudes and beliefs are inevitably expressed, at times in what may constitute microaggressions toward the "otherized" group.

Strengths-based approaches *that can be used to understand cultural practices by situating them within the context of a culture's goals and purposes, as opposed to deficit-based ones that propose judgements of other cultures from within it's own cultural context (Rogoff, 2003, pp. 16–19). Similar processes that assume positive intent, purpose, and goals also are applied to the understanding of the actions of individuals, families, organizations, and communities*.

Strengths-based approaches build on cultural humility. Rather than judging a belief or behavior that one does not understand or that appears to be detrimental, cultural humility allows one to consider the possibility that it represents a strength that one cannot yet see. Reflective practice is used to consider what purposes and goals these might serve, what unfamiliar contexts these may have emerged in, and to empathically feel one's way to the positive intent and constructive motivation behind the behaviors observed. This does not mean, of course, that all practices that are culturally rooted are for that reason alone inherently positive or constructive.

Reflection on the inevitable limitations of one's own knowledge, perspective, and experience can help one to seek out strengths in others by attempting to step inside their shoes. It also is critical to the capacity to contain the tension between being alone in one's differences and walking alongside another toward the common ground of mutual understanding.

Reflective Practice and Touchpoints Systems Theory Core Elements: Systems

Human development shapes and is shaped by contexts, cultures, the interactions of family and community systems, and the larger environments in which they are embedded (Bronfenbrenner, 1979).

Learning stance, readiness for change: *System members change themselves and each other as they learn from and with each other (Garvin, 2003; Rogoff, 2003).*

Children, families, organizations, and communities are continuously interacting with and changing each other as well as their environments. The Touchpoints approach emerged as a systems theory of development, in part, from the observation that newborns shape caregiver behavior at least as much as caregivers shape newborn behavior. Newborn behavior, in turn, is shaped by genes and epigenetics as well as in utero experience. Through these multidirectional interactions, infants adapt before birth to the contexts into which they will be born, not simply to respond to them but to act on them as well. Family, community, and other social systems contain and shape the developmental processes of disorganization and reorganization in which learning and change take place.

Reflective practice can aid providers in recognizing parallel instances of mutually influencing processes in clinical encounters. For example, as professionals influence infant and parent learning and growth, professionals also learn and grow as they enter into family and organizational systems. Reflective practice can help professionals attend to the predictable signs of their own disorganization that precedes their own learning and change, and the emergence of new professional capacities and skills that are shaped by interactions with infants, parents, and colleagues.

Parallels also can be identified within organizations and communities in which participants in learning change themselves and each other. A special instance of this occurs in cross-cultural work, whether across organizational cultures or across the different cultures of individual staff, community members, providers, and families. In cross-cultural work, the process of mutual understanding entails a reflection on one's own culture(s) and empathic efforts to understand the perspective of those of other cultures, of the purposes, goals, contexts, and drives that shape beliefs and behavior.

The use of reflective practice in this work also allows for the determination of when and how much self-disclosure and intimacy are needed to understand and positively engage each other's culturally rooted experience and personhood. This kind of cross-cultural work can be self-transforming (Rogoff, 2003, pp. 8–13). It changes those who involve themselves deeply in it, not in the sense of ever becoming "the other" or of rejecting one's own culture(s) but of letting go of one's own and each other's "otherness," of reconfiguring the relations of sameness and difference (Sparrow, 2010).

Shared goals: *Identification and pursuit of shared goals*,

Collaborative consultation is an application of the Touchpoints approach that has been used within and across organizations in numerous communities in the United States. Its purpose is to co-construct a common language and a framework of shared values and goals that can be used to align community resources, functions, and structures in support of optimizing child and family development (Sparrow, 2014; Sparrow, in press; Sparrow et al., 2011). One example is the process through which FIRST 5 Santa Clara County and other county agencies came together to deal with the methamphetamine epidemic of the early 2000s.

An alarming number of infants had been exposed in utero to the drug, and midway through that decade, the epidemic continued unabated. More than 60 different agencies were serving their families in this county with a population of approximately 1.5 million and a multitude of different cultures and languages. Each family might interact with 8 to 12 different agencies: NICUs, child protective services, courts and the correctional system, adult mental health and substance-abuse services, early intervention and home-visiting services, childcare, shelters, and food pantries, among others. These agencies varied widely in their own professional cultures and languages, with a range of beliefs, expectations, and requirements, at times in conflict with each other.

Jolene Smith, Chief Executive Officer of FIRST 5 Santa Clara County, realized that her organization would need to "partner with the dependency and child welfare systems because we wanted to impact the intergenerational cycle of children born to parents who experience trauma and struggle with substance abuse, many of whom are former foster youth themselves" (M. Daraio, personal communication, July 8, 2016). In discussing existing drug court practices, she stated that "In general most of the drug treatment courts have been adult focused. We have the opportunity and more importantly the responsibility to shift the focus to a child centered, family focused approach embedded within a social ecological model" (M. Daraio, personal communication, July 8, 2016).

Smith quickly concluded that the county needed a single common philosophy and a common language to bring into alignment the wide range of organizational cultures, to set up effective habits of communication and sharing across organizations, and to create a coherent experience for the infants and families they all served. It would take a common philosophy and language to identify, commit to, and effectively pursue shared goals.

Valuing diversity: *Shared understanding of divergent or conflicting positions as opportunities for strengthening relationships and mutually expanding understanding of each system member and the different realities that each experiences*,

The Touchpoints approach was chosen as the means of working toward a common philosophy and language in the Santa Clara County methamphetamine project. Inspired by the work of Dr. T. Berry Brazelton and the potential impact of the Touchpoints approach on children, families, and communities, FIRST 5 Santa Clara County implemented Touchpoints as a foundation of practice across its system of care in 2009. To date, Santa Clara County has 565 service providers (representing 65 agencies that include the County's court and child welfare systems) who practice Touchpoints (M. Daraio, personal communication, July 9, 2016).

Longitudinal professional development activities were provided across all roles within and across organizations. Everyone–guards, clerks, sheriffs, and judges–in the court that adjudicated mothers of babies born with positive methamphetamine toxic screens participated in Touchpoints training. The intent of the professional development experiences was not to impose an external philosophy or to allow one organizational culture to dominate.

Instead, reflective practice was used in the course of professional development to welcome divergent voices and to work toward understanding the value that each voice brought.

As a result of participating in Touchpoints workshops, service providers felt that they had more knowledge and skills to support families and their children. Over 90% of the Touchpoints participants reported an increase in confidence in their ability to engage and build positive relationships with the children and families they served, a broadened perspective through which to view parents/caregivers as the expert on their child, and an enhanced understanding of the importance of Touchpoints as a reflective practice approach to strengthen relationships with children and families (M. Daraio, personal communication, July 8, 2016).

Initially, many in the court system were highly skeptical of a strengths-based approach. They worried that professionals would be misled by parents whose drug addictions led them to be deceptive about their relapses. Participants learned to carefully and respectfully engage with each other's views, expanding their own perspectives. Gradually, opponents to the strengths-based approach began to see that instead of covering up the realities of these families' lives, this approach might actually help reveal them and point to more effective ways of working with them. Once they began trying out this new approach, they became convinced. In a training session for several hundred service providers in August, 2009, Judge Erica Yew explained:

> I have come to understand that in these families, in this system, there is trauma everywhere. The women who give birth to these babies have been traumatized before, during and after pregnancy. That is a big part of what interferes with their recovery. The last thing they need the Court or any of us to do is to traumatize them again. So now, when I'm adjudicating a mother of a baby exposed in utero, I step down from the bench to stand beside her. In my judge's robes, I open my arms and take her into mine. I want her to know that we are not here to hurt her again, but to help her find her way to her potential, and to help her experience our hope for her so that she can discover her own.

Seeing in systems *(Senge et al., 2015, pp. 28–29) so that the contributions of all system members to the unfolding of their relationships can be brought into view*

The "Drug Court" changed its name to "Family Wellness Court." This was not merely a name change but a fundamental shift in the understanding of substance abuse and in utero exposure as a multifactorial challenge. It would require a systemic lens to see the need for a wide range of interventions carefully linked across communities and systems. The Family Wellness Court took on the role of comprehensive case management, mandating the full complement of services that each family needed.

In addition to adult substance-abuse and mental health treatment, early intervention services, dyadic treatments, child protective services, and domestic violence prevention and response services, the court used a whole child, whole family, systemic approach to address each family's full range of needs and strengths. It worked closely with community-based agencies to assess and respond to each family's broader needs such as housing and food supports, job training, transportation, educational opportunities, social connectedness, and other critical needs. The coordination of these resources amplified their effects (Golan, Rouspil, Huang, & Williamson, 2012; Lucero, 2012). Coordination within organizations and communities, across system members, depends on a specific kind of reflection: "seeing in systems"—the capacity to hold individuals, dyads, and families in mind while also holding in mind the larger systems and contexts in which they interact and evolve (Senge et al., 2015).

Although the ecological model of human development (Bronfenbrenner, 1979) is widely accepted, its potential applications to infant mental health have not been fully realized. Reflective practice may play a role here, too, if it is used to see larger systems and to guide effective action not only within dyads but also within organizations and communities. For example, through reflective practice, community-level attributes such as social connectedness and collective efficacy (Sampson et al., 1999; Sampson et al., 1997) can be strengthened. If reflective practice can be used to strengthen relational processes in communities, the resulting co-construction of social capital in neighborhoods, schools, and parent-to-parent peer groups can reduce parental isolation and disenfranchisement—both risk factors for parental depression and child abuse and neglect.

CONCLUSION: REFLECTIVE PRACTICE AND ACTION

The positive effects of dyad-focused treatments can be protected and enhanced when reflective practice is used in organizations and communities to strengthen relational processes that encourage:

- trust and safety,
- the valuing of errors as opportunities for reparation and fresh insights,
- cultural self-understanding,
- stepping outside of one's self to see others' perspectives, and
- thinking in systems.

Common to all are efforts to improve the quality of the flow of information and affective energy among systems members, to expand and deepen mutual understanding, and to enhance the capacity for adaptation to each other and to the constraints and opportunities of shared contexts and environments. None of these suffice, though, to promote infant and parent mental health.

The course that human systems take depends not only on system member interactions but also on larger social, economic, and political forces (Bronfenbrenner, 1979). For example, accessible, affordable, and high-quality childcare and healthcare, paid parental leave, and living wage jobs for parents all have significant positive impacts on infants' well-being and optimal development. These depend on community-, state-, and national-level interventions and policies. Reflective practice that helps leaders and other system participants "see in systems" can mobilize them to act on

these larger forces so that they can advance toward their shared goals.

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