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PREFACE

Oral history has its roots in the sharing of stories which has occurred throughout the centuries. It is a primary source of historical data, gathering information from living individuals via recorded interviews. Outstanding pediatricians and other leaders in child health care are being interviewed as part of the Oral History Project at the Pediatric History Center of the American Academy of Pediatrics. Under the direction of the Historical Archives Advisory Committee, its purpose is to record and preserve the recollections of those who have made important contributions to the advancement of the health care of children through the collection of spoken memories and personal narrations.

This volume is the written record of one oral history interview. The reader is reminded that this is a verbatim transcript of spoken rather than written prose. It is intended to supplement other available sources of information about the individuals, organizations, institutions, and events which are discussed. The use of face-to-face interviews provides a unique opportunity to capture a firsthand, eyewitness account of events in an interactive session. Its importance lies less in the recitation of facts, names, and dates than in the interpretation of these by the speaker.

Historical Archives Advisory Committee, 1996/97

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ABOUT THE INTERVIEWER

Steven Maron, MD

Dr. Steven Maron is a pediatrician in private practice in Vineland, NJ. He is a Magna Cum Laude graduate of the Sackler School of Medicine of Tel Aviv University, in Israel (1982). After doing a rotating internship at Ichilov Hospital, Tel Aviv (1982-1983), he completed residencies in Pediatrics at St. Barnabas Medical Center in Livingston, NJ (1983-1985), and Albert Einstein Medical Center, Northern Division, in Philadelphia, PA (1985-1986). His interests include antique medical instruments, old medical books, medical history, and genealogy. He is an active member of the Medical History Society of New Jersey, for which he has recently completed a project on Dinshah P. Ghadiali, MD, a highly contentious and controversial New Jersey alternative medical practitioner.
Interview of T. Berry Brazelton, MD

DR. MARON: I’m Dr. Steve Maron. I’m interviewing Dr. T. Berry Brazelton, in his beautiful home in Cambridge, Massachusetts. It’s February 19, 1997. And first of all, may I thank you, Dr. Brazelton, for participating in the oral history program of the AAP. You’ve enjoyed a varied career as a pediatrician, researcher, lecturer, teacher, child advocate, writer, and TV personality, making things very easy for me as an interviewer. You are also now prominently featured on the Web. A quick search on the internet under Waco, Texas, shows the name Brazelton to figure prominently. I found several Brazelton Web pages, including a Brazelton Art Studio, and an address for a Brazelton family tree. In Doctor and Child you described being part of an extended close family. Could you mention something about your family’s history, any interesting anecdotes about relatives or ancestors?

DR. BRAZELTON: Well, my grandfather Brazelton was a self-made man. He came from Tennessee during the Civil War. His mother was killed in front of his eyes and they torched his house, and his father was already dead, so at the age of 14 he marched his four brothers and sisters to Texas. In one lifetime he had three wives, twelve children, made several million dollars in a day when a million dollars was a lot of money, and you know it was fascinating to grow up with this kind of pioneering around me. My other grandfather used to tell us stories. He had to stay awake at night to protect his father, who was the first circuit judge in Texas. He would stay awake to protect him from Indians. So we grew up with all of this lore about how you could make it, how if you didn’t make it, the other side of that is if you didn’t make it you were a real wimp. [laughs] So it really pushes you along.

DR. MARON: Also in the introduction to Doctor and Child you describe being the officially appointed baby-sitter for all the Brazelton cousins during festive family gatherings. Could you tell me a little bit about your parents, your school, growing up in Marlin, Texas, perhaps a little bit about Marlin, Texas.

DR. BRAZELTON: Well I really grew up in Waco, Texas. My mother came from Marlin and she left me some land and a little house that’s the oldest brick house in Texas. We have the deed to this land from Steven F. Austin, and all the governors of Texas, even the Spaniards before Austin, so it’s a very important part of my life. I go back down there and have 95 cousins in that area. So I take my Yankee children down there to meet them. I grew up in Waco, as the oldest grandchild of a French grandmother, Berry. I’m named for her and so I wanted to please her all the time. So I took care of all the other grandchildren while they had cocktails and dinner and so forth at her house. And she used to say to me, “Berry, you’re so good with children,” or “You’re
so good with babies.” I still hear it. Every time anybody says that, I hear my grandmother’s voice saying it. So she was a terribly important part of my life. My mother was a very strong lady. She formed the first abortion clinic in Texas in 1940. She was also the first female elder in the Presbyterian church, so you can imagine what growing up with her was like. She dominated my younger brother to such an extent that I could see when I was five or six years old that passion could go either way. It could either be negative or it could be positive, with the same kind of motivation. I really always knew what kind of pediatrician I wanted to be. I wanted to be the kind that could turn that passion into something positive, rather than negative. I think the combination of being the baby-sitter and watching my mother with my younger brother really dominated my thinking. I knew by nine what I wanted to do, and I’ve been lucky enough to be able to do it. I knew I wanted to be a pediatrician. I knew I wanted to give mothers a chance to turn that passion into something positive. This has really been sort of the goal of my career ever since I was nine years old, so I’ve been very lucky.

DR. MARON: I understand you finished high school at an early age, and couldn’t yet start college. Could you please speak a little bit about your high school experiences?

DR. BRAZELTON: Well I grew up in this little town. It was a little town then; it’s not so little anymore. I was always the youngest in my class. They pushed me through. I finished high school at 15. You know, I always felt inadequate, completely inadequate, because everybody else around me was developing. They were big, strong, athletic, and here I was this little wimp. When I finished high school at 15, I couldn’t go to Princeton, where I was destined to go because my father and my grandfather had gone there, so I had to go off to prep school in order to mature, ‘cause I couldn’t go in the shower with anybody else. [laughs]. I was too much of an immature character. So I went to Episcopal High School in Virginia, had a wonderful time there, and began to grow up a little bit anyway. I’ve never really grown up. But then I went to Princeton after that. It was so exciting to grow up in a little town and you know, feel safe and protected and have a lot of friends; but also to get away from that feeling of being the youngest or the most inadequate or any of the things that I felt, growing up there. Getting off to school was really a major turning point for me. I really had a wonderful time in college. I was the female lead in the Princeton Triangle for three years [laughs], and used to have a great time at all the parties because all these wonderful looking women would come up and say “How did you do that,” and I’d say, “By watching you.” So I had a great time all the way through college. I must say I didn’t learn very much but I certainly did have a good time. [laughs]

DR. MARON: Jumping ahead a little bit, please tell us about your internship at
Roosevelt Hospital. How was life for you different than that of interns today? At what point during your internship or before did you absolutely fix on pediatrics? Was that ever a question in your mind? Did you ever consider anything else?

**DR. BRAZELTON:** Well, I went first back to Texas for a year, to University of Texas in Galveston, because my father wanted me to come back. He died very young, and there was no reason to stay in Texas any longer. My mother didn’t mind if I came back to the east coast, and I was dying to get back up here. I transferred to Columbia Medical School in New York and graduated there finally. Finally. Because I hated medical school, it was such a brainwashing experience. To me, it’s just, I have an amnesia for it, I can’t remember anything but one doctor there, Dr. Loeb, who made us stand at the end of the bed and watch a patient for 15 minutes. We couldn’t ask him a question, and we had at the end of 15 minutes to tell him how old he was, what he did for a living, whether he was married or not, what he was in for, whether he was getting better or not, and after watching him, you could tell all that. I thought, “Oh my Lord, this is what I went into medicine for, to watch and to be that observant of people.” It really started me on what I’ve done ever since in my career, which is to really value behavior as a language. And I always knew I wanted to work with children, and of course they’re mostly nonverbal, or if they’re verbal they don’t tell you anything. I knew that I wanted to do that kind of work with children, and I went to Roosevelt Hospital in New York to intern. I hated working with adults. You’d get somebody well of one thing and they’d have ten other things going for them, so I thought this is not what I wanted to do. Then I went in the Navy, and was out at sea, was the only doctor for about 70 ships going back and forth to England. Again I had to work with adults. I thought, “This is not what I went into medicine for.” So when I got out of the Navy I knew exactly what I wanted to do. I always had, but I mean I knew how I wanted to go about it, and that led me up here to Boston to the Mass General [Massachusetts General Hospital], and then to Children’s [The Children’s Hospital, Boston].

But, you know, I still feel that our medical education is not preparing people for what they do. It’s preparing them for a deficit model. We’re very good at identifying everything that’s wrong with anybody, but we don’t have any idea about what’s going on in them or what’s right about them. Instead of just looking at people for their failures, which is what we are taught to do, we ought to be trained to make relationships, to value relationships, to know when we’ve got somebody on the same wavelength as we are, and to use that relationship as our major tool in medicine. I really resented my training in medical school and then even, I guess, in my internship and residency. I just thought we weren’t being trained like I wanted to be. So I went into child psychiatry. I did about five years of child psychiatry here at a little place called the Putnam
Children’s Center [James Jackson Putnam Children’s Center, Roxbury, MA], which was working with preschool age children. It still was a deficit model. Psychiatrists are always looking for failure, too. Again I just felt like this wasn’t really what I wanted out of pediatrics. So I kept searching. I got into practice because I was married and had children and had to survive; and I began to realize that practice in pediatrics was wonderful. It was just like the end of a dream. You made relationships. You kept them. I used to trade with people for whatever they did, for art or for, if they raised things, I’d trade rather than barter for money. It was just wonderful. You got close to them, you went and made house calls so you could see how they lived and what they liked in the way of art and then you knew better what to trade. And so, I had a wonderful time in practice here in Cambridge for 40 years actually. People, you know, were so grateful for a relationship that they would bring me little nuggets every time they came in about how their child had just learned to do something. You know, how they learned to use their pencil grasp, or how they learned to do something cognitively. And I put all those together to write my first two books. My first two books were written by my patients really. So I’m terribly grateful for the chance I had to be in practice. I feel like, you know, we ought to train people for practice, for how they can make relationships and how exciting it is to be close to somebody and have them really confide in you. People say, “Oh I don’t have time for all that.” I don’t think you have time for anything else. It was a wonderful time I had here in Cambridge. I’m very grateful for it. And it certainly is what I went into pediatrics for.

DR. MARON: Will you go back for a minute, to your psychiatric training? What specifically prompted you to seek that extra training in psychiatry and when did you decide to do that? Another thought that might help out is, Berry, the thing, to mention the years, if you remember.

DR. BRAZELTON: Oh, all right. Well I came to Boston in ’45, right after the war. Because I was out early, I got a wonderful post at the Mass General [Massachusetts General Hospital] with Allan Butler and at a very exciting time in medicine because we were recovering from the war and everybody was invested in making the kind of pediatrics we had work. Then I went to Children’s [Children’s Hospital, Boston] in ’47, and finished my residency there, and had a wonderful time with Charlie Janeway, he offered me a chance to stay on there. I said, “Charlie, I don’t really understand children or families, and that’s what I really went into pediatrics for. I want to do child psychiatry.” He said, “Oh Berry, and waste all this good pediatric training?” So I did it rebelliously, and then I got into this wonderful place in Boston that I was in from 1947 to ’52. First they let me be on the floor playing with kids for one year. Then they let me be a social worker for the second year. The third year they finally let me play like a psychiatrist, and then the fourth and fifth year we
did some research. Again, this deficit model was blaming the victim. Every
time you had an autistic child or an atypical child or a slowed down child, we
blamed the mother. We blamed the victim. It was a terrible, terrible model.
These women felt guilty so they’d submit to this blame. And we’d have them in
psychiatric treatment for year after year. Nobody got better. I thought, “Gee
this isn’t working. Something’s wrong with this model.” So I began to look at
babies, because I thought the baby is really contributing to this failure. As a
pediatrician, I knew that these kids were acting differently. I didn’t quite
understand why in those days. I don’t still, but I began to look at the baby, and
that led me to the newborn. As soon as you looked at newborns you could see
this baby is going to contribute to his own failure because they wouldn’t respond
the way a normal baby would, the way a mother and a father expect them to. So
the newborn scale really began in 1955. It has become my life’s work and
probably the biggest contribution I’ve made to pediatrics. It really came out of
that not feeling good about the blame the victim model. As soon as you began
to look at the baby, you could see, “Hey, maybe we can change this learned
failure system to a positive system.” As soon as you share the baby with the
parent, you can show them the good things first, and then go to the things that
they’ve got to work on. Then they were in your pocket. You just had them so
they were not only much more readily able to get to the baby, but to work with
you. Ever since 1955, I’ve been working on using the newborn as a way of
reaching out for parents to, not only for the newborn, but for the medical
system. It’s become a very exciting part of my life. I’m still working on it 40
years later.

DR. MARON: Could you tell us a little more about the background, and what led up
to the publishing of the Neonatal Behavioral Assessment Scale ultimately in 1973, and
the people who were involved?

DR. BRAZELTON: I came to Cambridge to be in practice with Ralph Ross
and Jock Robey, John Robey. Jock and I did a lot of work together in the early
days. We went to Mexico and studied babies there, and saw how universal
some of the behaviors we were identifying in the newborn were. I kept working
to look at what we were learning about newborns. We still didn’t think they
could see or hear in the 50’s, can you believe it? And yet when you handled
them or held them right, you know they not only saw and heard but they’d react
to you in predictable, exciting ways. They would reach out for you if you talked
to them the right way. You know, it became obvious to me that we didn’t think
they could see or hear or do anything because we’d never treated them as
people. Over the next 20 years, really 18 years, I was constantly trying to
hone this scale to fit what I was seeing in these babies. I never was a
researcher and still am not a good researcher. I had to learn about research
from colleagues who were very instrumental in helping me develop the scale.
I had a chance in the late ‘60’s to work with Jerome Bruner here at Harvard at the Center for Cognitive Studies, he exposed me to the model that I finally have found, a positive model. Child development people see the positives in things. And so it all came together. The pediatric training, the psychiatric training, and the child development came together in this model. As soon as I had the model, I dared to think about publishing the scale. It took 18 years and a lot of people working on it. A lot of child development people: Francis Horowitz, Arnie Sameroff, Ed Tronick. I could just list a whole bunch of them that got excited with me and helped me make it into a scale. I was saying “good, better, best” about everything. They said, “What do you mean by good, better, best?” I had to pin it down to a number. It’s the hardest thing I ever had to do. We aren’t trained that way in pediatrics, I don’t think. And so finally I got up enough courage to publish it in 1973. It’s become, you know, a sort of international base for looking at newborns ever since, which was nothing I expected at all. I feel like my life is full of all these serendipities that worked, so that was one of them, to get it published and get it out there. It’s been used in research and training, and of course the main thing that we’ve learned from it is how much the intrauterine experience of the baby has shaped the baby already at birth. That those first nine months are absolutely critical to the baby’s potential and to their behavior, which is fascinating and prepared us for the crack cocaine epidemic we’re into now. It prepared us for the effects of malnutrition on babies, and on these kids that are already atypical or difficult for parents to relate to. So we’ve learned a lot from using his instrument.

DR. MARON: The 1973 publication was in no way the endpoint. It was revised twice in 1984 and again in 1996. Could you speak a little bit about those revisions?

DR. BRAZELTON: Well as soon as you get a bunch of people involved with you in working on an assessment like that, they begin to see things that you probably wouldn’t have seen. Heidi Als for instance, took the scale and revised it and put it into an assessment of a premature baby. We all worked to do that. We all put together our thinking and it’s become a very powerful way of looking at premature babies. I’ve worked with other people; Barry Lester now has one for addicted babies, that is a revision. And Kevin Nugent, who’s really been working with me for 20 years anyway, has kept the scale alive as we learned about babies. And as we learned about them and saw more and more how competent they were and how really goal oriented they were, Piaget even asked me to come talk to him about newborns because he’d never really looked at a newborn. And you know how we learned how competent they were? We could see that babies kept themselves under control so they could follow your face or turn to your voice. As soon as you saw that you saw that, “My gosh, this baby is goal directed. He wants to be in control of his world.” It came as a
revelation. The scale was really quantitative for research purposes, and in the revisions over the years we’ve made it more qualitative. We can tell now how hard a baby works, how much it takes out of him to put the world together as a newborn, and how much it takes you to keep that baby together so he can interact with his world. These qualitative additions that we’ve made in the last two revisions are really the most powerful thing that we’ve done. We’ve made it into a real assessment of the baby as an individual. He has the potential for predicting temperament maybe later on, for what the parents need to do to reach that baby, to hang on to that baby, what they need to do when they get home with it. It’s been a real window into early intervention and the potential for starting early to give these babies a better chance. The revisions in ’84 and ’96 were really an attempt to keep up with the insights we were gaining about newborns and about what those meant to parents. That’s always been my goal, to try to understand how these related to what a parent was looking for.

DR. MARON: You mentioned your very active solo general practice; we touched on that a bit. This was something you maintained in parallel to your very active research and teaching activities. In Doctor and Child, you mentioned that your afternoons in the office were something you looked forward to, like a personal “lovey.” Could you tell us a bit about how you kept everything in balance? That couldn’t have been a bed of roses for you.

DR. BRAZELTON: Well, I had to be in practice, not that I resented it, because I had four children and an extravagant wife [laughs], and I was extravagant, and so I needed to be in practice. But I also wanted to document the things that we were learning, because we were learning so much, the parents and I together. We would develop for instance, a model around thumb sucking or around toilet training. Or they would tell me what they learned. Or one about crying at the end of the day, you know, in the first three months. Parents really told me what I should be thinking about these things. And so research became a window into how to think for me as a provider, but also into how they were thinking. It was just so exciting that I started publishing research very early. I was in practice about ten years when I got up the courage to start documenting some of these things. The parents would help me. They would say, “You’re off base there. You better get going.” And it was just wonderful, because you know, each time they came in they would contribute to what I was thinking. “What are you thinking about today, Dr. B?” And so we’d talk about it. I, now when I go around the country talking to parents, I always run into somebody who was in on some of that early research, and they come up and they say, “Do you remember me? I used to keep track of how much sucking my baby did or how much crying they did at the end of the day.” They’ve never forgotten it. So it was just one more link to my patients, I think, that started me on research. I think I realized how pediatrics at that point
didn’t have any backup for what we were doing. We weren’t really being trained for practice or for reaching out, and we didn’t have any documentation about what you did about thumb sucking or when you started toilet training, or any of the things that were our daily bread. It seemed to me that a big contribution to pediatricians in practice would be to give them research to back them up. It took extra time to do that, and it certainly cut down on income, things like that, but gosh, just think what it’s meant to me to have that kind of backup as a researcher, as a teacher. So I feel very lucky to have been able to do it all at once. It’s a lot of fun.

DR. MARON: Let’s talk a little bit more about your private pediatric practice. Your very busy, private pediatric practice. I understand you covered for two other pediatricians. How big an office was it? What was your setup like?

DR. BRAZELTON: Well I started in practice at the Harvard Pediatric Study in 1950 that Harvard set up for people who’d been in the war and were coming back to college. They provided pediatric care for them in this pediatric study, which was a group practice and was a predictor of what we’re into now. It was a wonderful, wonderful opportunity, because there were different disciplines working together. There were nurses who did a lot of the work. We as pediatricians shared call. We shared everything. I got a chance to consult with people at the end of the day for an hour each, and help them with their problems. So I really got the model that I lived by later from this group practice, which may be very much like what managed care could be.

Then I went into private practice here in Cambridge with two people, Ralph Ross and John Robey, and we shared call. We each practiced individually. I had a three room office with two examining rooms and one waiting room, and would see patients about every 20 minutes. Charged $5 a visit, and would make house calls for $10. I always would come home and have supper with the kids, and then go make house calls for two or three hours at a time. Unless you loved it, it could have been hell. But it was just wonderful, because the patients I had here in Cambridge were all wives of intellectuals, you know, MIT or Harvard, and they were all eager to share their experiences with me. They taught me so much. First of all I did a piece of research at Children’s Hospital while I was a resident about rheumatic fever. Because you know, academic, they wanted you to do research all the time you were there. Then I did one on hysteria, while I was in child psychiatry, and a pediatricians’ role in hysteria. Then when I got in practice I could see that these problems were really what needed documentation, like crying at the end of the day, or toilet training, or thumb sucking. And those were the things that really intrigued me, the sort of normal events that went on during a parent’s day. I thought if I could document what was normal and what was out of range, that pediatricians would have more
idea about what to do about them, and patients really led me into that kind of research. So I don’t think I took any extra time to do the research, it certainly took extra time to write it up. But it didn’t take extra time, it just took cooperation from my patients. They were so thrilled with it that in a way it cemented me to them even closer. I think I’ve had 25,000 patients in my 40 years of practice. I remember them all. They remember me. That’s what we’re liable to lose if we aren’t careful, that kind of relationship building, and that kind of feeling that we’re very close. I passed somebody, three people yesterday in Harvard Square here, all of whom had been patients of mine. We stopped and talked. I remembered their names, they remembered mine, we talked about what I knew about them. You know, they’re all grown and married and have children by now, but I don’t know how pediatrics is going to survive if people can’t get that kind of gratification out of what they do. So if we lose that, we’ve lost the ball game in pediatrics. Even when I decided to be an academician in the late 60’s, to go over to Children’s Hospital to teach, I kept my practice. I would teach during the day and then come back here at 4:00 in the afternoon and see patients until 6:00, and it worked. It kept me invulnerable to Harvard and its idiotic politics. They knew they couldn’t hurt me. And, so they left me alone. And it made academia a heck of a lot more exciting, because I wasn’t at the mercy of what was going on at the medical school. I was very lucky. I recommend it to anybody who is going into academia, to be sure to hang on to your own patients and balance it that way.

DR. MARON: Could you share any particular anecdotes from your practice with us? Perhaps a particularly interesting case or a particularly intellectual mother who was maybe a little bit harder to deal with than average?

DR. BRAZELTON: Gosh, it’s hard to go back that far. I had one mother who was frankly schizophrenic. And she’d been in McLean, which is our psychiatric hospital here, and got pregnant. I think she knew who the father was. Nobody else did. She came to me with this new baby, and she said, “You know, I’m gonna need a lot of help.” So we started out together. The baby seemed intact, using my scale. So she really was able to pull off enough energy and enough motivation from this illness of schizophrenia to mother that baby. She had to call me practically every day. But I had a phone hour every morning in which I would take in phone calls. It saved time and it was absolutely sacred, so it didn’t bother me to talk to somebody every day. That kid not only went through Yale and has finished but he’s gotten himself an MD. He was a football player, an athlete. He was successful in school, just a wonderful guy. And in essence we raised him together, this very sick mother. And as he got older, she got better, and she’s had a really, I think a fairly easy time recently. I still pass her on the street. She calls me every now and then to tell me how, what he’s doing, and I think he’s now married and has a couple of kids. So that
was the kind of thing you could do. I set up my practice with a phone hour in
the morning that was saved for people to call, and if they didn’t call me I called
them if I felt they were in trouble. The rest of the day was 20 minutes per
patient. I still dream about having an office full. But then I did something that I
really recommend to all pediatricians, and that is if they stood at the door and
said, “Oh, by the way, my eight year old is still wetting the bed. What do I do
about it?” I didn’t stop right then and talk to them. I said, “Gee, what a
wonderful question. Thank goodness you’re sharing it with me. Now I want to
see you at the end of the day, at one of these hours that I save. I want you and
your husband to come in, and you don’t need to bring the little boy, so we can
talk.” And I charged people in those days, I’ve forgotten, $50 or something
like that, but I charged them a psychiatric fee for that hour at the end of the
day. They would come in ready to share, ready to unload. And we could do
wonderful things in that hour at the end of the day. Pediatricians are really
missing the boat if they don’t take this kind of role. How we are going to do
that in managed care I don’t know; but I think that’s a real challenge. If we
want to play a more deep role with our patients, we’re gonna have to have time
to pull off and be available to them. So, these are the kind of things that I
learned in my own practice.

DR. MARON: The question in most pediatricians’ mind is how we go about doing
that, convincing the insurance companies to allow for that time.

DR. BRAZELTON: I think we have to just do it. I think we’re too much at the
mercy of insurance companies. We’ve got to have our own guts and stick to it.
I think with managed care particularly, if we don’t set it up our way, then we get
what we deserve, which is we get shoved around. I think again, it’s not just our
own well being that I’m thinking about, although relationships are very critical
to satisfaction. I think the parents really feel cared for and respected if you
have it set up so that they’re not just intruding all the time, which is the way we
set it up now.

DR. MARON: In 1972, you and your colleague, Dr. Edward Tronick, established a
child developmental unit at the Children’s Hospital in Boston, where you continue to be
active in teaching and research. It’s certainly grown since it began. Could you describe
the background to its founding and its evolution since then?

DR. BRAZELTON: Yeah, it was, again, serendipity. The head of Children’s at
that point, Dr. Leonard Cronkhite, who was one of my patients. He was in one
day and I said, “You know, Len, nobody wants to send their kids to the
Children’s Hospital unless they’re desperate. They’d rather go to the Mass
General or to the Floating Hospital where you could be with your kid all day
long, or you know, at least visit with them every day.” And he said, “Oh, my
gosh, really? Well why don’t you come over and change it?” And so I talked to Charlie Janeway. He said, “Why don’t you come and change it?” We were letting parents visit their kids for two hours on Saturday afternoon in those days. The kids started screaming on Thursday and screamed right through until Tuesday. Nurses and doctors said, “See, parents aren’t good for sick kids.” Well, the obvious thing was that they were just desperate, these children, and parents were desperate. So I went over in ’69 to try to change the atmosphere of the hospital, to become family friendly. I did it in a way that may be worth telling you about because I think people can maybe use the model. I decided that the only way to change it was to do two things. First, to do research to show that it mattered. The cardiologists and the cardiac surgeon let me do it, and so the research that I did was to show that if parents were there with their kids’ who’d been through major surgery, these kids recovered more quickly, went home more quickly, got better quicker. That helped. And the other was that I got the heads of every department together once a month at most, to decide how we change it. The nursing department, the PT [physical therapy] department, pediatrics, surgery, all of us came together in an effort to change the atmosphere of the hospital. It took about three years to do that, but we changed it and now it’s a very family friendly place. We have siblings on the ward. We did all of the things that you could dream about, but it took a lot of determination, a lot of effort. I was spending about half time doing it, the other half still in practice.

But then in ’72, Margaret Mahoney at the Commonwealth Fund asked me to come down and talk to her about nurse training. She told me what they were going to be doing to train nurses to be aware of child development and to be aware of family issues. and I said, “Oh Margaret, if we could only train pediatricians that way,” and she said, “Well aren’t you?” I said, “No, we never hear anything about that in our training.” And she said, “Well go back and train them.” And so she started me with enough money for fellowships. I took Tronick over from Bruner’s lab here at Harvard, he’s a psychologist, with me, and so we started the child development unit. She gave us a Cadillac model. We were able to do a lot of very important research with this model. We could train people, we brought pediatricians here and trained them in child development. There are about 60 of them around the country now. And we also could train nurse practitioners, which was a very important part of it. So for the next 20 years, we trained a lot of people in a two year fellowship in child development. After they finished their pediatric residency they came here and spent two years with us. It was a fascinating opportunity, and it really came from Margaret Mahoney, she was at Carnegie at that point, and then she went to Robert Wood Johnson, and then to Commonwealth Fund, and she just saw to it that we had enough funds to do this right, it made it possible to train 60 people. But gosh it was exciting. These young pediatricians would just come to
us hungry for understanding children and parents as soon as you could convince
them, for instance, if you get anxious with the mother, is it your problem, or is it
hers? Instead of taking it personally why don’t you say, “You know, she makes
me anxious. Well, maybe she’s anxious.” Their eyes would widen. We even
talked one day about what it was like to interview both mother and father at the
same time. There were two women and two men in training. We were
unloading how it felt to have two parents in the room at the same time. And
finally we got to the father. And the girls said, “You know, if I have a father in
the room I begin to feel like I’m seducing him, or that I’m into some sort of
heterosexual thing with him.” The men said, “I feel like we’re in some sort of
homosexual situation.” These guys unloaded why it was so hard to have a
father sitting there. As soon as they unloaded it, they could manage those
feelings, and it was just like a miracle. We really addressed feelings in those
days and really got them out there. You could see that the second you got them
out there you weren’t at the mercy of them any longer. It was a fascinating
opportunity.

DR. MARON: You mention in the introduction to Touchpoints that the concept of
spurts and setbacks, dubbed by you as “touchpoints”, is something that evolved very
gradually over time. How would you say your approach to developmental issues today
differs from your approach 40 years ago? What do you see as major differences
between the traditional pediatric approach to child development, and the touchpoints
approach?

DR. BRAZELTON: You really have done your homework, haven’t you? My
gosh, I’m amazed. I’ve always had the model of wanting to use the strengths
rather than the failures in parenting. That’s the most important thing that I’ve
ever uncovered in my own practice, and I hope in my own teaching. If we go
along with the deficit model, people who are under stress are going to run from
you. They don’t want to be identified as failures one more time. They already
know it themselves. So that was really my model in practice, to work on
people’s strengths, to back them up, to share them with them, and then get to
what was failing and we could reorganize it. Somewhere along the way, and I’m
not even sure where, I think maybe from the research, I began to realize that
there were predictable times in a parent’s and a child’s development, that
parents fell apart. And then I realized the child had fallen apart first, and then
the parents went with him. Why is he starting to suck his thumb again? Why is
he wetting the bed? Why is he lying, stealing, any of the things that kids do?
And I began to look for times when these were, and it turned out of course that
they were locked in to ages. And as soon as I began to realize that, I began to
realize that there were predictable times in a child’s development that they
would regress or disorganize. Development went in a burst of learning, in
leveling off and consolidating, and a burst. And just before each burst, there
was this period of regression, falling apart. The parents fell apart too. And if you could be there to predict that this was going to happen, parents began to feel empowered. They began to understand that regression was a very important part of progress. I had a mother the other night in Indianapolis who, in 1500 people, stood up in the front row and said, “Do you remember me, Dr. B?” And I said, “Yes.” And she said, “Well, 30 years ago you took care of my kids in Cambridge, and you made two predictions and they both came true.” I said, “What were they?” She said, “When he was only two days old you played with my first baby with me and you said, ‘Ooh, he sure is feisty. He’s going to fuss every night for the first three months.’ And he did.” Well all of us in pediatrics know that 85% of them fuss every day, so it wasn’t much of a prediction. But I said, “What was the other one?” And she said, “Well, he was only two months old, and he was playing around your office, and you said, ‘He hasn’t changed a bit. He’s going to be hell in the second year.’ And he was.” Well that’s 100%, you know, you can’t miss on that one. But this whole concept of predicting, and then joining parents in the job they have to do to make these touchpoints work was just so powerful that I thought, “You know, if pediatricians recognize that and set their well baby visits for those times, they could make them pay off in ways that I don’t think we’ve even dreamed of.” There’s six of these touchpoints in the first year, three in the second, two each year after, and they’re on a map for normal kids. They’re like a map for delayed kids too, but they’re on a different map. So I finally began to collect them and put them together again with the help of my patients, and then published it in that book.

Now we’re running training in using these vulnerable times for making relationships with people from all over the country to be trained in touchpoints. And we’re using them as a relational opportunity; each of these times there comes a chance to make a relationship with parents. We’re having a fabulous time. We trained people from ten different cities so far, and we’ve got four more coming in July. We are trying to change the paradigm in pediatric practice from a deficit model to one in which we value strengths. We use the child’s development as our language in reaching out to people. It works!

DR. MARON: You’ve traveled extensively, and studied child birth and child rearing practices from places in America to the Zinacanteco Indians, and Zambia. You’ve written extensively on your own experiences and on the experiences of others. Can you tell us how you developed your interest in cross-cultural research, and recall particularly memorable experiences?

DR. BRAZELTON: Well, obviously I wanted to travel, and that’s what really drove me to do cross-cultural work. I really wanted to get around the world, coming from Waco, Texas. [laughs] It was awful attractive out there. The
neonatal assessment really led me to do the cross-cultural work that I was doing. I was trying to see what was universal around the world in the way of infant behavior, and what was different from one culture to another. That really led me around the world. I was taking care of Margaret Mead’s grandchild, you know Margaret Mead, the anthropologist. I had just been offered this chance to go to New Guinea with Michael Rockefeller and Bob Gardner. So I was telling Margaret about it and she said, “Ooh, I don’t think you better go,” and I said “Why not?” And she said “Well first of all, no culture worth its salt will let a man come in and play with a baby. You’d have to dress up and go in drag.” And then she looked me over and she said, “You look too succulent, I don’t think I’d go.” [laughs] So she scared me off from New Guinea. But I did get a chance to go to Mexico, to the Zinacanteco, these Mayan Indians. Working with anthropologists down there I got a chance to see their new babies and to see how fantastic they were, how different from Caucasian babies in this country. They, at birth, in this cold climate, 8,000 feet high, would lie in front of a fire, and have beautiful ballet-like movements of their arms, their legs, and because they were so low-keyed motorically, they could watch a red ball or turn to your voice for 30 minutes without a break. We can get three minutes out of a Caucasian baby and then he throws off a startle or tonic neck reflex to break this cycle of attention. I thought, “Gee this is something.” I began to try to figure out whether it was intrauterine or genetic. You know, this is a crazy question now, that it’s both. Then we got a chance to go to Guatemala and see these same babies who had been malnourished in the uterus, and they were significantly different. So we got a picture of what malnutrition meant to babies in the uterus. Then I went to Greece, and then to Africa, and to Japan to study newborns. Obviously trying to get around the world.

The marvelous thing is that babies are qualitatively different from one culture to another, and because they’re so different they shape the culture around them. For instance, in Africa they’re very powerful and motoric. They want to get going even as a newborn. We even have a picture of a two day old newborn upright, Ed Tronick’s holding him, and I offer him a red ball, which I carry around with me, this two day old reaches out, grabs the ball with a one handed reach, and then looks at it like, “That’s what I meant to do.” Two days old. You know, absolutely incredible. Well, we say, “Yeah, but that was just luck.” Yeah, maybe it was, but you know maybe it had to do with motor excitement that goes with black babies in Africa. Because they’re so exciting, mothers there play with them all the time. And these kids just learn anything you want them to, if you play with them. And to me we have done something so terrible in this country in our attempt to meld everybody together. We’ve given up on these marvelous strengths that the baby brings and pushed them under. We’ve made diversity into a negative rather than a positive. I’d like to study diversity some day with touchpoints and wonder, how we’ve made people feel they were
second rate if they were diverse. This neonatal work is really the reason I got around the world, and boy, you don’t have to speak languages. You just play with their babies. I went to South Africa, before the revolution down there, and I said I would come if I could talk to black mothers as well as white, and they said, “Uh, all of your audiences will be mixed.” And I said, “You didn’t hear what I said. I know what mixed means down here. I want black audiences.” They said, “Oh we can’t get that many black people together.” And I said, “Then I’m not coming.” Well it took them a month, and then they called back and they said, “Well, we got you ten black audiences.” So I got into all the townships down there. I didn’t know what to say to these women. They were all desperate. Their husbands had been taken away from them. They were having to survive by leaving their kids in orphanages all day while they worked. I didn’t know how to talk to them, so I just took a baby and started playing with it. And of course as soon as I played with it, this baby followed me back and forth, and turned to my voice, and began to even reach for me, and these black women lined up in a line and would rub up against me. You know why? They wanted to rub the magic into their skins. They would line up in these long lines to rub up against me. We’ve got magic in our hands, and it was just so exciting to see. You didn’t need to speak their language, all you needed to do was use the language of the baby.

DR. MARON: In reference to your cross-cultural studies, did you derive any particular take-home messages for the stay at home pediatrician?

DR. BRAZELTON: Well, yeah. I think that the thing that I learned from them was how universal most behaviors are in the newborn, and yet there is a qualitative difference from one genetic group to another that should be respected and given enough opportunity, enough backup, that parents will respect the baby’s personality. For instance, black mothers will play with their babies more if I give them permission to do that. When I first came back from Africa, I’d say, “Why don’t you play with your baby more? He seems to love it.” And she, the mother would say, “Oh, he’ll get too feisty.” “Well, too feisty for what?” “He won’t fit in in first grade.” And I said, “First grade?” So they were already dominated by the kind of thinking that [William] Shockley and [Richard] Herrnstein, people like that were up to. If you get too excited motorically you’re not going to be cognitive sufficient. Nuts. Asian babies are quiet and very sensitive, and they deserve to be treated that way. Our school system isn’t made that way. It’s made for people who are aggressive, competitive, and so I learned if we really want to give kids the best self-image, we’d better respect what they bring to it. This has been a message of mine ever since, that if we wanted to as pediatricians, we could make diversity become a positive, but we’ve got to work on it. That’s the main thing I learned. The other thing was that it became so silly to me to say, “Is it nature or
nurture?” It’s both. You know, right straight from the uterus, it’s both. In Japan, for instance, we found these quiet, gentle babies that I’d seen in Mayan Mexico. They were on the islands off the coast of Japan. They paid attention to auditory and visual stimuli for significantly longer times at birth -- sometimes 30 minutes at a time. But if you went to Tokyo it was cut in half. If you came to San Francisco and looked at Japanese babies, it was cut way down to about 8 minutes, from 30 to 8 minutes. And you say, “What’s different?” Well, the intrauterine conditions. Mothers walk differently in San Francisco from the way they walk on the islands of Kyushu. And so you could already see that it was not only genes but it was also how those genes were shaped in the uterus. That led me to a kind of thinking about child development in general. That it’s not just the mother or just the baby, it’s the combination and how they handle what the given is. And it made me a lot more tolerant of what I ran into in the way of diversity.

DR. MARON: You’ve expressed concern in your writing about the effects of maternal sedation on mother-infant bonding. The concern you’ve expressed is supported by your own research and that of others. Could you speak about your involvement in this issue, and has the situation improved?

DR. BRAZELTON: Yeah, it’s changed enormously since I did that research on maternal premedication back in the 60’s. I was seeing babies whose mothers had been given huge doses of drugs to make labor easy. In those days, they gave 200-300 milligrams of barbiturates, 75 of Demerol, and these babies were OK at birth, They had good Apgars, but then they went to the nursery and collapsed. Nursery nurses had to keep stimulating them all the time, helping them suck out their mucus, all that. And they were significantly depressed for seven days after birth, and so I documented that in a piece of research. And Duncan Reid, who was the head of the Boston Lying In Hospital at that point, met me in the hall and screamed at me down the hall. He said, “Brazelton, come here.” And so I went cowering up to him. He said, “You’ve ruined my career. I’ve been working all this time to keep mothers happy through their labor and delivery, and you’ve wrecked it.” I said, “Dr. Reid, it’s the babies who are the ones that are paying the price for this.” And you know, childbirth education groups were springing up, Lamaze, all those, and they picked up on this research, and everything has changed. Now women have real control over their own labor and their own delivery.

We have another piece of research showing that epidurals affect babies too, even though people say they don’t. They do. We’ve been looking at some of the effects of different things that we do, of thinking about them, on babies, you know, like circumcision. What the hell have we been doing circumcisions as if pain didn’t matter to a newborn. We finally developed a way of doing a circ
[circumcision] without pain, but until you think about it you don’t really address it. And this is where I think research can help us as practicing pediatricians. Once you think about it, you say, “Yeah, why didn’t I do that anyway?” This is what I think research can do for you.

DR. MARON: In Infants and Mothers, which is certainly also about infants and fathers, and again in the introduction to the new edition of Toddlers and Parents, you mentioned the importance of extended leave for new mothers and fathers, to get acquainted with their new infants. You mention in the preface of the new edition of Toddlers and Parents that the minimum is really four months to get beyond the initial hurdles. Though parental leave has become customary in countries with socialized medicine, it seems fairly distant in our own. Can you speak about your activities and views in this area?

DR. BRAZELTON: Well again, it comes from research. We did research that led me to see that there were four stages of development in the mother-child, father-child bond, over the first four months. We could look at a film and tell you which stage the mother and the baby were in or the father and the baby were in, up to four months. If they were that easy to tell about, weren’t they also that important to both the mother and the father and the baby? If they were important, shouldn’t we be preserving it as a bond, rather than just throwing mothers back into the work force or fathers back into the work force without a chance to cement that bond between the baby and the parent? That research was really the base for the parental leave bill. Pat Schroeder and George Miller and Chris Dodd in the Senate and the House were really open to this. We began to fight for it ten years before we got it. But it really led to the bill that we have now, it just affects five percent of people. But it made every CEO in this country wonder, “What am I doing to families in my organization?” So it had a spread effect that was very powerful. It really came from the research we’ve done. However, I don’t know whether you know that research. It’s face to face. We put a baby in a baby chair and asked the mother and the father to go in and play with the baby. Over time, the baby and parent begin to develop this expectancy between them. We can tell you by a finger or a toe or mouth or eyes or heartrate, by six weeks of age, whether the baby is interacting with the mother or the father or a stranger. The baby’s behavior becomes so predictable. Now if it’s that predictable, isn’t it something that ought to be treasured and valued? We fought to get parental leave so they could learn about the baby’s behavior and how they fitted in to it.

DR. MARON: Day care is a topic you’ve discussed extensively in your books for parents. Could you discuss how you became involved in the day care issue, and what your efforts have been in this area?
DR. BRAZELTON: I have the same bias that I think everybody in this country has, that mothers ought to be at home, they ought not to be working. It’s a universal bias. It comes from attachment research, from all sorts of sources. So I was beating up parents who were working, in my practice, for a long time. Finally my three daughters, militant young women, said, “Dad, come out of the last century. You’ve got to get with it if you’re going to be in practice. You’ve got to help people, you can’t just beat them up.” And so I began to think about it and I realized I was beating them up for leaving their kids at a time when the children were so vulnerable. They were suffering from leaving them too. And so I began to look at it more closely. This was 1978, maybe, or something like that, way back there. I began to realize that women had to work, either financially or psychologically, and that it was a condition we better begin to face. So I began to look at what would make it easier for the child and for the parent, and of course child care was where it went to. Infant day care has got to be optimized, or we’re going to destroy an awful lot of children’s futures. As soon as you look at it, you can see it’s so easy to tell the difference between a good day care situation and one that isn’t. So I began to get quite involved in optimizing child care.

I wish I’d been able to change the minds of people in Washington before welfare reform, because we’ve done it all wrong. It’s not going to work. Pushing women into the work force without taking care of their babies is doomed to fail. Women who care about their babies aren’t going to stay in the work force for any longer than they absolutely have to, and if we’d done it the other way, if we’d looked at the kind of child care that we could provide them as a support system, then I think we could get women off welfare and into the work force and it would be successful. But you know once you turn something like that around, you see, “Oh my gosh I’ve been part of the problem all this time.” That was what I was, I was part of the problem, and so I’ve learned a lot.

DR. MARON: Again, as a child advocate, among your many activities you’ve been involved in looking closely at television, the good and the bad of it. You served on the AAP’s Committee on Public Information, and you participated in the forum on media at the 1970 White House Conference on Children. Please describe your involvement in this issue.

DR. BRAZELTON: In television. I think my own kids showed me how demanding television is for a child at a very early age. When they’re two or three, sitting in front of a TV is so demanding that they come away exhausted and disintegrated, and they’re cranky. Albert Bandura on the west coast showed that by five they are much more at the mercy of imitating what they’ve just seen. They’re modeling on the kind of aggression or sex role acting out with whatever they’ve just seen. So I really began to realize how powerful it
was as a competitor for our children, way back in the early 70's I guess. Peggy Charren, who runs Action for Children’s Television here, was a friend of mine so I got involved through her. I have been feeling that parents had better be in control of their children’s television or they’re going to have more than they can handle as the kids get older. I was put on a commission last year, two years ago I guess, by the Clintons to look at prime time for kids. We’ve never had a meeting, because the prime time planners didn’t want to be controlled. Children come last in our thinking in this country. We’d better think about it as pediatricians. We’d better get in there and fight for our kids’ minds, which is what is being affected.

DR. MARON: Could you speak a bit about your involvement in Mrs. Clinton’s health care reform program?

DR. BRAZELTON: Well, I got to know her first, and met her before they got to the White House. I liked her a lot. She spent a year in child development at Yale when she was in law school there, working with Sally Provence, one of my colleagues. I knew she knew a lot about children and about poor children, which is what she was working with at Yale. I really respected her for that. I got to know her a little bit when she was working on the health care bill. They needed me because, and it ought to be a challenge to every pediatrician, they could not get Congress’ attention when we talked about preventive health care. You could say it to them and, “Oh yeah,” they’d nod, “Yeah.” But we’ve got to have preventive health care. We can’t afford the kind of medicine we’ve got now, expensive bandaids. We need preventive health care. And we need to turn it back to people so they feel they’re in control of their own bodies.” And they’d nod away, but then they’d never do anything about it. And so I finally got to Hillary and began to talk to her about it, and talk to her about this touchpoints model of mine and how powerful it was to reach out for the 40% of kids that aren’t getting any prevention. She heard me every inch of the way. I was working with her for the preventive aspect of whatever bill we got.

When it failed, she said something to me, two things, maybe. One thing was about lawyers. I said to her, “You know, we’re dominated by our fear of malpractice and lawyers. Have you done anything about putting a cap on them?” She said, “Oh yeah, we’ve gotten them down to 50% of what they sue for.” I said, “Fifty percent, what are they getting now?” She said, “Seventy percent.” Did you know that? And then the other side was the preventive aspect, and she said “It’s going to be ten years before we get anything any of us want, and it’s time for you guys to get in there and fight for what you want. If you don’t, you’re going to end up with something that you don’t want and it’ll be your own fault.” And I thought, you know, that’s true. It’s up to us to get what we need and want. If we go on being managed by managed health care,
it’s our own fault. We’ve got to be fighters. We know what we need and want, we can get it. The interesting thing to me is that Hillary feels she failed on the health care bill. I don’t. I feel she shook medicine right at its roots. They’ve been running for cover ever since. And you know she did what the AMA [American Medical Association] should have done a long time ago, what the Academy of Pediatrics should have done a long time ago, she put health care out there for people to take pot shots at. We may never get universal health care, but that’s what we really need.

DR. MARON: Could you describe your activities in the AAP, some of which we’ve already touched on?

DR. BRAZELTON: Yeah, I was very active in the AAP a while ago. Then I don’t know, it just seemed like we didn’t get anywhere. It was, oh, in the 60’s and 70’s I guess. There was a very reactionary group in those days. I think they’re a lot more progressive now and I wish I were still involved, but the kind of efforts I was into didn’t seem to be popular, you know. I was sort of a, not a lone voice because there were other people like me that were fighting with me, Sprague Hazard, Morris Green, Julie Richmond, people like that, but nobody was taking us very seriously. So I got sort of discouraged about working with them and haven’t been very active. I was very active in the Society for Research in Child Development, and in Zero to Three, the National Center for Clinical Infant Programs. I was president of each of those. I had my hands full with other organizations that were more in line with what I was trying to do. So I dropped out of the Academy’s activities maybe at the wrong time because I’d love to be in on them now. They’re really much more proactive now than they were 20 years ago.

DR. MARON: Where do you see them being proactive?

DR. BRAZELTON: Well I think they’re behind universal health care, and behind preventive health care. Even Bright Futures, which was an effort that I was a little bit in on in the planning stage. To back up pediatricians, to address developmental issues, emotional issues, I think is a step in the right direction. It doesn’t go far enough, but it certainly is a step in the right direction. And all of that is new. You don’t realize it maybe because you haven’t been in practice that long, but they’re more of a proactive organization now. I’m proud of them.

DR. MARON: Your award-winning Lifetime series, What Every Baby Knows, and equally award-winning video series, Touchpoints, have enabled you to reach parents all over the country and possibly the world. You described a bit about your foray into television in the introduction to the book version of What Every Baby Knows, and you say that though you had offers, you were hesitant to accept those that seemed maybe a
little too Hollywood in their approach. I saw a program called *Our Kids and the Best of Everything*, from 1987, which the AAP has on file, and that came to mind when I read your description of the type of program you wouldn’t necessarily want to be involved in. Could you speak about your entry into television?

**DR. BRAZELTON:** Well it was just another serendipitous event. These people came to me from an organization in New York and said would I like to do television. I said, “Well I didn’t think I have time.” You know, I had all these defenses against doing it because I was really scared of what my colleagues would think of me getting so blitzy in front of the public. But fortunately, I did it, and it’s been the most wonderful thing I’ve ever done. Absolutely wonderful. That program, *What Every Baby Knows*, reaches people I never, never could have reached any other way. When I walk down the street, more minority people recognize me than white middle class. Fantastic. I was walking through the airport the other day, and this black woman on her hands and knees scrubbing the floor looked up and she said “Hey Doc, how are the babies?” I was walking down in the Bowery not too long ago. This homeless looking man was coming toward me with his, what do you call, his, braids. So he was looking at the ground, so I sure looked at the ground, and as we passed each other he said “I sure like your show, Doc.” And I said, “What? Do you watch it?” He said, “Yeah, whenever I can find a TV with cable on it.” I said, “Oh my Lord, do you have kids?” He said “Yeah, right over in the corner of the bank, do you want to meet her?” He took me over into this corner of the bank where this mound of dirty clothes and this homeless looking wife pulled out a beautiful four month old baby and started talking to her, and of course she talked back. And then he turned to me and said, “Now give Dr. B,” she went “ooh” to me. I thought how in the world would you ever reach people like that. I began to talk to him. He was one of these downsized people. He and his wife had been downsized and they had no place to live. But you know, how would you ever reach people without a medium like television. And so, here I am saying don’t let kids watch TV, and yet it is the most powerful medium we’ve got so far. I think we ought to be fighting for using it properly. It’s so powerful.

**DR. MARON:** There are certain similarities between your career and that of your very esteemed colleague, Dr. Spock. You both trained in both pediatrics and psychiatry, yet consider yourselves first and foremost pediatricians. You both worked hard to de-mystify parenthood for parents, and to encourage parents to trust their own instincts. In his memoirs, Dr. Spock mentions you as the source of some major revisions in *Baby and Child Care*. And around 1980 he consulted you among others when he was looking for an editorial collaborator for yet another edition of *Baby and Child Care*. Could you share some impressions of those times when your paths crossed? And did you have any disagreements with Dr. Spock?
DR. BRAZELTON: I took care of his grandchildren, I saw what his daughter-in-law went through to raise those kids, so if I came close to a disagreement it was that. So that’s as close to a disagreement as I ever came, because I admire him tremendously. I think he changed pediatrics. He changed parenting in a very powerful way in the 40’s. We both, I think, were influenced by [Donald W.] Winnicott in England who was also a pediatrician and a child psychiatrist but acted like a pediatrician and was interested in preventive psychiatry. A wonderful, wonderful man. Every pediatrician ought to read his stuff. Then along came Ben Spock and changed the model of parenting to a much more child-oriented approach, much more sensitive to what parents brought with them, their strengths. I think he changed life for everybody in the 40’s with his *Baby and Child Care*. He’s been a model for me all the way along I think. I was scared of some of the things he did, like getting himself put in jail for his political feelings. So when I began to be proactive politically, I began to think, “Oh gosh, here I am doing the same thing I criticized him for,” but you know, you’ve got to do it. We’ve got to. He’s 94 I guess now, and he’s still a wonderful, wonderful man. I’ve been with him a lot. We’re friends now, with his new wife, 40 years younger [laughs]. He comes to visit us every now and then.

He taught me something that was very interesting. This is what an observer he’s been all his life. He said, “You know, boy and girl newborns behave differently.” He was always good at picking out boys from girls when he was teaching at Western Reserve, did you know that? He had an 80% hit rate. Nobody else got over 50%. And so I said, “Ben, how did you tell the difference. Were you just guessing?” And he said, “Oh no, I was looking for certain things. Little boys have curly hair or are more likely to. Little girls are more likely to have straight hair. Little girls will have a lower forehead and boys a higher forehead. Little girls have a round face as newborns. Little boys a v-shaped face like their buttocks.” And then he said the most interesting thing of all. He said, “If you get a newborn looking at you, little girls and boys look at you differently. A little girl looks at you with a long, low look. A little boy looks at you with a rapid look and cutoff.” You know, as soon as he said that you realize that this is why parents do what they do. They go in slowly with the little girl and you know, soothe her down because she’s looking at you slowly. Go into the boy like this and jazz him up. This is the kind of observer he is. He’s a wonderful man.

DR. MARON: You’re now enjoying a very busy semi-retirement. Could you tell us a little bit about some of your non-medical activities?

DR. BRAZELTON: Yeah, I’m not retired at all. I don’t want to; my wife doesn’t even want me to. But she had to face it. She said, “Oh Lord, you’d
drive me crazy if you were at home.” And I would. I’m a Type A personality, as you can easily see. But I’ve also had a chance to keep on with the kind of work that I got started in the child development unit at Children’s. I’ve managed to survive there. Finally got a full professorship, and now they’ve got a Chair named for me at Harvard, which is incredible. I had to raise the money for it, but at least it’s a Chair in Child Development in Pediatrics. So I hoped it would lead other people to feel like they should include this in pediatric training. But more recently, I’ve done something that I felt very guilty about doing, but I recommend it heartily. I’ve tied myself to a big major company and been willing to do what they asked me to do, which was to get on the internet under their aegis. I have a page on the internet which has 1400-1800 hits a day. And by constructing it from my book *Touchpoints* people go on it, stay on it, get their answers, and get off. I don’t get more than one or two questions a week to have to answer. So it’s serving its purpose. I’ve also done some infomercials, in which I don’t have to hold up diapers but they get held up after I do something constructive for people in the infomercial.

All in all they respected when I demanded that I didn’t want to sully my professional name. And in exchange they’ve given me enough money to run my programs at Children’s, which are very important to me. One is the center for the newborn assessment scale, which is now in use all over the world. We have eight centers in Europe, three in the Orient, two in South America, eight in this country for training people to use the scale, reaching out to parents, so that was very important. I’m still very involved in that. The other is the touchpoints training. We’re training centers from around the country. They send multidisciplinary people to be trained over a week to use the touchpoints as opportunities for making relationships with hard to reach people. We’re finding it just changes the whole community. We’re having a wonderful time with that program.

The third program is what I call my road shows. I go around the country and I lecture at night to parents, usually 1500 or 2000 parents. The next day three of my colleagues join me and we use the day to bring together professionals. And usually 300 or 400 of them come. What we’ve found with these road shows, we do ten of them a year, is that the whole community comes together. The parent evening, they all come together, because they ask the same questions. The next day the professionals in the community come together. It brings whole communities together. These road shows are very powerful. We’ve had a wonderful time with them, I’ve been doing them for about 12 or 15 years, something like that. They’re certainly important to me, and I think to other people. We’re finding that about four major companies in this country are now available to us for creating a family friendly situation. Optimal child care. Preventive health care. Improving education in the community. You know, this
is where we’ve got to go in this country. We’re not going to get it out of government any longer. Maybe we will while the Clintons are there, but I doubt it. But if we can change this country to become family friendly, through big business, maybe we can save this country. I don’t see any other hope for us, but that’s one.

DR. MARON: You’re certainly a very prolific writer. Have you experimented with other types of writing? Are you working on your memoirs perhaps?

DR. BRAZELTON: No I don’t think I, my family says, “Don’t ever do that dad.” I don’t think I’d ever do that. I’ve got about twelve books out for the adult. This year I was on the west coast. This four year old came up to me and he said, “Dr. B why don’t you ever write a book for kids. You just write for mommies”. I said, “I wouldn’t know what to write for kids.” He said, “Well I can tell you something. Tell why I go to the doctor and what you’re looking for. Are you just looking for my badness?” And I thought, “My gosh, this is why kids are so vulnerable. They think we’re gonna find their badness.” A friend of mine from the west coast, Kathryn Barnard, a nurse in Seattle, was here, she and I got to work on my eight year old grandson, and he drew the pictures for the book. Then I wrote why, what we’re looking for, it’s been a hit. Kids are really hungry to understand why they go to the doctor. Most of the writing that I’ve done has either been professional or for parents. I’ve had a great time with 27 books.

DR. MARON: Certainly one of the great bugaboos of the general pediatrician today is the issue of attention deficit and hyperactivity. Pediatricians find themselves under tremendous pressure to medicate children referred to them by teachers, principals or school nurses, before a thorough evaluation has been done. Insurers regard drugs as more cost effective than counseling sessions or special education support. The result is over-medication of children. What do you see as the background and history for this present crisis, and what can pediatricians do?

DR. BRAZELTON: Well, I think we’ve always looked for easy ways out. I don’t think that’s anything new. Medication is an easy way out if it works. The trouble is that with many of them medication won’t work. So you’re medicating kids for something that’s really not doing them any good. So I think ADHD is a very important one for us to look at and say, “Hey, what are we missing?” In my own work in any psychosomatic disorder, like asthma or like almost any disorder, in which the psychological is playing a major role as it does in ADHD, the biggest thing we’re going to lose is the child’s self image, and the child’s image of himself as competent. Also this fear that nobody knows how to help me. Those two together are enough to destroy a child’s future self image. If we work as pediatricians to preserve those two, couldn’t we turn around most
disorders? With ADHD since probably 95% of them are not ADHD, but are just anxious kids. Couldn’t we turn them around?

I’ve been looking at it this way. If we start early enough, and identify them early enough, and I think we can - I even think we can identify them in the first year. We’ve got to be careful about that because of the labeling - but if we have them identified by three and four years of age, as we certainly can, I’ve been turning it back to parents. I’ve been saying, “You know, this kid needs to know that we understand him and that he can understand himself and he can manage this himself.” And they look at me like I’m crazy. So I say, “Now this is what I want you to do. I want you to keep a chart of what he’s like when he’s OK, what he’s like just before he blows, what he’s like when he blows, and then what he’s like afterwards.” They begin to realize, hey, he blows and then he’s fine, and he blows then he’s fine, and so when they finally get that under their belt at about four, I say, “Now let’s figure out how to cut off those peaks. And just before he blows, let’s help him change the subject. Let him fall back on sucking his thumb or twirling his hair or running around the room, whatever he needs to break the cycle, and then bring him back and let him settle down to learn. In the process he will learn that he can control himself.” By five, now, these kids are taking over. When they get to school, unless the teacher respects what they’re doing, she can screw it up. So we’ve got to get to teachers too. But parents begin to capture this model and it works. It’s just like smoothing out this kind of life for these kids.

I really got it from asthma. You can do the same thing with kids with asthma. If you get to them before they get too frantic you can do something. You can say, “See, we know what to do.” They begin to know that we know. I make kids with asthma, for instance, when I have had to give them a shot of adrenaline or whatever, I say, “I want you to stay in the office for an hour.” Then in an hour I bring them in and I say, “How are you?” “I’m OK.” And I say, “Well what made you OK?” “Uh, I don’t know, I’m just OK.” “No, remember that shot? That’s why you’re better. We know what to do. You and I know what to do.” And if it’s been an oral medication, they have to sit there until they’re better. Then I say, “Now remember, next time, before you get so bad, tell your mommy you need that medication.” I tell the mother she has to call me when this occurs the next time. So she calls. And I say, “Did he take his medication?” “Yeah.” “Well let him get on the phone. Are you better?” “Yeah.” “Well why?” And then finally you can see it dawn, oh, it was the medication. Their asthma begins to diminish, you know, they’ve got it under control. I think any time we have an asthmatic that has to go to the emergency ward for care, we have failed our mission. I’ve had one in my practice that I couldn’t control, but the others, by starting early, we just got it beat. So, you know, these are fascinating problems to me as a pediatrician. And we’ve got to
beat them.

DR. MARON: Your book, The Earliest Relationship, was the result of a collaborative effort between yourself and infant psychiatrist Dr. Bertrand Cramer. Could you tell us a little bit about the story behind the preparation of this book?

DR. BRAZELTON: Well I’d written a book before that was called On Becoming A Family, which really had my thoughts in it. And I was in France giving a Princess Napoleon lecture for the psychiatrists in France. When I went up on the stage to give it, and there were about 5,000 of them there, I think, the head of psychoanalysis in France said to me, “You’re the first American who’s ever given this lecture, and we’re very nervous about you. Please don’t use your hands when you speak and don’t say anything you’re not sure of.” And I said, “Dr. Libovici, you’re asking me not to do the things that every Frenchman does. He always uses his hands. He always says things he doesn’t know anything about.” And Libovici laughed. Well, I gave the lecture and everybody liked it, and so he said, “Now you ought to write a book with that in it. We need to know this in child psychiatry,” because this was all about infancy and the early attachment. And so he sicced me on Bertrand Cramer. It took us five years to write that book. He wrote about the psychiatric side of it. I wrote about the pediatric side. But you know, we didn’t speak the same language. He comes from Switzerland, he was a psychiatrist. I was a pediatrician, thought in English. It was hard to get our thinking to come together. I think it’s successful, but it was harder than I ever dreamed it would be.

Most of my books I’ve written alone because it’s so much easier. I love to write. I’m not a writer but I just like to describe, and I recommend writing to all pediatricians. Because we have so many things happen to us that can be meaningful. One gains an awful lot of insight by writing it down.

DR. MARON: Could you tell us a little bit about your hobbies?

DR. BRAZELTON: Well, antiques, I love to collect antiques. I like to play tennis, to sail, and fortunately I’m still able to do those things. I guess that those are about it. I like to travel. [laughs] And do research. I don’t like to just travel, I like to go and get to know a country and get involved with people. And you can do that through their babies. It’s a universal language.

DR. MARON: Thank you very much.
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CURRICULUM VITAE

Name: T. Berry Brazelton, MD
Date of Birth: May 10, 1918
Place of Birth: Waco, Texas

Education:
  1940 A.B., Princeton University
  1943 M.D., Columbia University

Honorary Degrees:
  1987 Doctor of Science, Russell Sage College, Troy, New York
  1990 Doctor of Humane Letters, Northeastern University, Boston
  1991 Doctor of Education, Wheelock College, Boston
  1991 Doctor of Science, Wheaton College, Norton, Massachusetts
  1992 Doctor of Public Service, Cedar Crest College, Allentown, Pennsylvania
  1992 Honoris Causa, Highest Honorary Degree, University of Lisbon, Portugal
  1994 Doctor of Science, Loyola University of Chicago, Chicago, Illinois
  1994 Doctor of Science, Tufts University, Medford, Massachusetts
  1995 Doctor of Science, University of Massachusetts, Dartmouth, Massachusetts

Postdoctoral Training: Internship and Residencies:
  1944-1945 Medical Intern, Roosevelt Hospital, New York
  1945-1957 Medical Assistant Resident, Massachusetts General Hospital, Boston
  1946-1947 Assistant in Pediatrics, Harvard Medical School, Boston
  1947-1948 Resident in Pediatrics, The Children’s Hospital, Boston
  1950-1953 Assistant in Pediatrics, Harvard Medical School, Boston

Research Fellowships:
  1947-1951 Training Fellow (Child Psychiatry), James Jackson Putnam Children’s Center, Roxbury
  1948-1950 Research Fellow (Child Psychiatry), Harvard Medical School, Boston

Licensure and Certification:
  1947 Massachusetts Medical License

Academic Appointments:
  1953-1966 Instructor in Pediatrics, Harvard Medical School
  1956-1957 Lecturer in Pediatrics, Yale University Medical School
  1956-1957 Lecturer in Pediatrics, Cornell Medical School
  1957-1961 Lecturer in Pediatrics, Boston University School of Social Work
1966-1969  Clinical Associate in Pediatrics, Harvard Medical School
1967-1971 Research Associate and Lecturer, Center for Cognitive Studies, Harvard University
1969-1972 Assistant Clinical Professor of Pediatrics, Harvard Medical School
1972-1989 Chief, Child Development Unit, The Children’s Hospital, Boston
1972-1986 Associate Professor of Pediatrics, The Children’s Hospital, Harvard Medical School
1986-1988 Clinical Professor of Pediatrics, the Children’s Hospital, Harvard Medical School
1988 Adjunct Professor of Psychiatry, Human Behavior and Pediatrics, Brown University
1988-Present Professor of Pediatrics, Emeritus, Harvard Medical School and Children’s Hospital, Boston
1990-Present Visiting Scholar, Child Study Center, Brown University

Hospital Appointments:

1967-1971 Senior Associate in Medicine and Coordinator of Patient Care, The Children’s Hospital, Boston
1967-1988 Active Pediatric Staff, Mount Auburn Hospital, Cambridge
1971-Present Senior Associate in Medicine, The Children’s Hospital, Boston
1972-1988 Chief, Division of Child Development, The Children’s Hospital, Boston
1977-Present Pediatrician, Active Staff, Boston Hospital for Women, Boston
1981-Present Associate Pediatrician, Beth Israel Hospital, Boston
1992-Present Board of Advisors, Center for Physician Development, Beth Israel Hospital, Boston, Massachusetts

Other Professional Positions and Major Visiting Appointments:

1967-1970 Board of Directors, American Association for Child Care in Hospitals
1968-1975 Consultant, International Childbirth Education Association
1969-1971 Chief, Good Samaritan Convalescent Unit, The Children’s Hospital, Boston
1970-1972 Chairman, Section on Child Development, American Academy of Pediatrics
1971-1975 Long-Range Planning Committee, Society for Research in Child Development
1973-1978 Staff of Mather House, Harvard University, Cambridge
1974-1978 Corporation of Mount Auburn Hospital, Cambridge
1975-1979 Board of Governors, Society for Research in Child Development
1975-1977 Director, National Center for Infant Mental Health, Washington, DC
1976-Present Director, Medical Institute, Johnson & Johnson Institute for Pediatric Service
1977-1988 Pediatric Consultant, Radcliffe Child Care Center, Cambridge
1977-1978 Clausen Visiting Professor, University of Rochester Medical School
1981-1987 Board of Directors of International Study Center for Children and Family, Greece
1983-1984 Consultant, Erikson Institute, Chicago
1983-Present  Consultant, Atrium School, Watertown, Massachusetts
1984-Present  Advisor to Mailman Family Foundation, White Plains, New York
1992        Advisory Board, Parent Infant Clinic, School of Mental Health,
            University of London, England
1993-1998   Advisory Council, Save the Children (USA)

Awards and Honors:

1971  Child Study Association of America Award, Infants and Mothers:
      Individual Differences in Development
1972  The Council on International Non-Theatrical Events Award, *Newborn*
1972  Certificate of Merit, *The Children Who Can’t Sit Still*, The
      Association for Children with Learning Disabilities
1973  Cine Golden Eagle Award for Education Development Center, *Gabriel*
1975  Honorary Founder Award, The Association for Child Care in Hospitals
1976  First recipient, Lula O. Luchenco Award in Family Medicine,
      University of Colorado
1976  Third Annual Lecture in Memory of Harry Bakwin, M.D., New York
      University
1977  Medal of Outstanding Service to Children, *Parents’ Magazine*
1977  Clausen Visiting Professor, University of Rochester Medical School
1978  Frederick A. Packard Lecturer, Pediatric Society of Philadelphia
1978  Alpha Omega Alpha
1978  Helen Ross Lecture, Chicago Psychoanalytic Society
1978  Outstanding Contribution to Children, Massachusetts Psychological
      Association
1978  Film Award: *Brazelton Neonatal Assessment Scale*, American
      Journal of Nursing
1978  John F. Kennedy Memorial Lecturer, Georgetown University
1978  Strothers Lecturer, University of Washington School of Nursing
1978  First Prize: *Newborn*, American Film Festival
1978  Selection for film *Newborn*, American Psychological Association
1979  Henry Kempe Lecturer, University of Colorado Medical School
1979  W.K. Kellogg 50th Anniversary Lecture, American Public Health
      Association Annual Meeting
1980  Citation from the Governor of Massachusetts, “In recognition of
      contribution to the urgent needs of refugees”
1980  Arthur Reieri Lecture, Mott Foundation
1980  First Francis C. MacDonald Memorial Lecturer, Concord,
      Massachusetts
1981  Harriet Elliott Lecturer, University of North Carolina at Greensboro
1981  Amberg-Helmholz Lecturer, Mayo Clinic, Rochester, Minnesota
1981  Margaret Mahler Lecturer, Department of Psychiatry, Medical College
      of Pennsylvania
1981  Lucille Lewis Memorial Lecture, Tennessee Association for the
      Education of Young Children
1981  Edith Buxbaum Memorial Lecture, Psychoanalytic Society, Seattle,
Washington
1981 Ramana Memorial Annual Lecture, Department of Psychiatry, University of Oklahoma
1982 Henry Goldberg Memorial Lecturer, Cornell Medical School
1982 Lowell Lecture, Cambridge Forum, Cambridge, Massachusetts
1982 Dreyfus Memorial Lecturer, Michael Reese Hospital, Chicago
1983 Earl Hayes Baxter Lecturer, Columbus Children’s Hospital, Columbus, Ohio
1983 Amos Kendall Lecturer, Gallaudet College, Washington, DC
1983 C. Anderson Aldrich Award, American Academy of Pediatrics.
1984 Arthur Parmalee Lecturer, University of California, Los Angeles
1984 Honorary Board, Boston Institute for the Development of Infants and Parents
1984 Honorary President, Equal Opportunity Fund, Jerusalem, Israel
1984 R. B. Miller Memorial Lecture in Neonatology, Beth Israel Hospital, Boston
1984 Loretta Bender Lecturer, Queens Children’s Psychiatric Center, New York
1984 McIver Furman Lecture, Del Mar College, Corpus Christi, Texas
1985 Honorary Member, Association for the Care of Children’s Health
1985 Phyllis Lewander Memorial Lecture, National Children’s Hospital, Washington, DC
1985 Winkelman Award, Philadelphia Psychiatric Center
1986 Mead Johnson Visiting Professor, University of New Mexico
1986 Lowell Glasgow Memorial Professor, University of Utah
1986 Perinatal Society of Texas Lecturer, Levelland, Texas
1986 Mac Birdsong Lecturer, University of Virginia Medical School, Charlottesville
1986 Margaret Williams Memorial Lecture, SUNY Upstate Medical School, Syracuse, New York
1986 Eli Friedman Memorial Lecture, Boston City Hospital, Boston
1987 Hershenson Lecturer, Boston Hospital for Women, Boston
1988 Westinghouse Award for Science Journalism-Michelle Trudeau’s National Public Radio, Newborn
1988 Massachusetts School Psychologists Association Award: Parent Advocate of the Year
1988 Cum Laude Lecturer, Episcopal High School, Alexander, Virginia
1988 President, National Center for Clinical Infant Programs
1988 Schonell Memorial Lecture, Royall Children’s Hospital, Queensland, Australia
1988 Merle J. Carson Lecturer, Ch. IV, California Academy of Pediatrics, Orange County, California
1988 Cine Golden Eagle Award, To Make a Difference: Film for Nurses, Ross Labs, Columbus, Ohio
1988 Nominated for Ace Award Best Informational Host, Lifetime, Cable TV

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<th>Year</th>
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<tr>
<td>1988</td>
<td>Brigid Butterfield Lecturer, Children’s Hospital, Denver, Colorado</td>
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<td>1989</td>
<td>Woodrow Wilson Award for Outstanding Public Service, Princeton University</td>
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<td>1989</td>
<td>Parent Advocate Award, Massachusetts School Psychologists Association</td>
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<td>1989</td>
<td>Cynthia Longfellow Lectures, Sarah Lawrence College, Bronxville, New York</td>
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<td>1989</td>
<td>Honorary Member, Catalanian Pediatric Society, Barcelona, Spain</td>
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<td>1990</td>
<td>Visiting Professor, Ft. Worth Children’s Hospital, Ft. Worth, Texas</td>
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<td>1990</td>
<td>Infant Mental Health Advocacy, First T. Berry Brazelton Mental Health Advocate Award, to be given biannually to advocate for children in Texas</td>
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<td>1990</td>
<td>John Welch Visiting Professor, University of California, San Diego</td>
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<td>1990</td>
<td>Ace Award for <em>What Every Baby Knows</em>, Best Educational Program on Cable for Parents, Nomination for Best Host</td>
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<td>1990</td>
<td>American Medical Writer’s Association Award: Finding a Comfortable Voice Aids in Patient Interaction for Physician Educator</td>
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<td>1990</td>
<td>Association for the Care of Children’s Health T. Berry Brazelton Lectureship, Washington, DC</td>
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<td>1991</td>
<td>Blanche F. Ittleson Award for Service to Children and Families, American Orthopsychiatric Association, Toronto</td>
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<td>1991</td>
<td>Small Miracle Award, Center for Autistic Children, Philadelphia, Pennsylvania</td>
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<td>1991</td>
<td>American Psychiatric Association Lecture</td>
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<td>1991</td>
<td>Honorary Member, New York Council for Psychoanalytic Therapists, New York</td>
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<td>1991</td>
<td>Honorary Member, Society for Psychoanalytic Training: Award for Distinguished Writers</td>
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<td>1991</td>
<td>Honorary Co-Chairman, Children’s Festival, Boston Area Educators for Social Responsibility, Boston</td>
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<tr>
<td>1991</td>
<td>Award for Public Service, Action for Boston Community Development, Boston</td>
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<td>1991</td>
<td>Father of the Year, Father’s, Inc., Boston</td>
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<td>1991</td>
<td>Jerome S. Bruner Award, Please Touch Me Institute, Philadelphia, Pennsylvania</td>
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<td>1991</td>
<td>Champion for Children Award, Variety Preschoolers Workshop, Syosset, Long Island, New York</td>
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<tr>
<td>1992</td>
<td>Silver Medal for Videotape Series for <em>Touchpoints</em>, New York Film Festival</td>
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<tr>
<td>1992</td>
<td>Distinguished Child and Family Advocate Award, Sidney Albert Institute, State University of New York, Albany, New York</td>
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<tr>
<td>1992</td>
<td>Honorary Member, Freudian Society and Psychoanalytic Training</td>
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1992 Institute of New York
Honorary Member, Chair #14, Portuguesa de Portadores Tressomia,
Lisbon, Portugal
1992 Board Member, Fathers, Inc., Boston
1992 Camille Cosby Award, Judge Baker Children’s Center, Boston,
Massachusetts
1992 Golden Apple Award for *Touchpoints* videotape series, National Film
Festival, New York
1992 Eric Denhoff Lecture, Rhode Island Hospital for Women and Children
and Meeting Street School
1992 Cine Golden Eagle Award for *Touchpoints* videotape series,
Washington, DC
1992 Gold Award for Videotapes, for *Touchpoints*, Cinema Worldfest,
Houston, Texas
1992 Max Rosenn Lecture in Law and Humanities, Wilkes-Barre University,
Wilkes-Barre, Pennsylvania
1993 Distinguished Scientist Award for Public Policy, Society for Research
in Child Development
1993 Edith G. Neisser Memorial Lecture, Institute for Psychoanalysis,
Chicago, Illinois
1993 Award for Distinguished Contribution to Public Policy for Children,
Society for Research in Child Development
1993 Nomination for Daytime Emmy Award for *What Every Baby Knows*
1993 Award for Commitment to Children and Families, Advisory Council of
the Office for Children, Commonwealth of Massachusetts
1993 Alan Marks Memorial Lecture, Department of Pediatrics and
Psychiatry, Boston Floating Hospital
1994 Nomination for Ace Award for *What Every Baby Knows*
1994 Honorary Member, National Association of Pediatric Nurse
Practitioners
1994 10th Anniversary Award for a Lifetime of Family Advocacy, The
Boston Parents’ Paper
1994 Isabella Graham Award for Public Service, Graham Wyndham
Services, New York
1994 Bessie Rothschild Lecture, 92nd Street Y, New York
1994 Emmy Award for Daytime Host, Educational Series
1994 Prudential Center Honor for Contributions to the Lives of Bostonians
1994 Nomination for Emmy Awards for Daytime Host, Education Series,
and for *What Every Baby Knows*
1995 C. Everett Koop Health Advocate Award, American Society for
Health Care Marketing and Public Relations
1995 Award for 10 years as Contributing Editor, Family Circle Magazine
1995 Lowell Lecture, Suffolk University
1995 Fowler Lecturer, Louisiana State University, New Orleans
1995 Parents as Teachers Child and Family Advocacy Award, St. Louis,
Missouri
Major Committee Assignments:

1960-1968  Advisory to Spurwick School, Portland, Maine
1968-1969  Member, Consultant Board, Joint Commission for Mental Health
1972-Present Board of Visiting Fellows, Wheelock College, Boston
1975-Present Trustee, Johnson & Johnson Institute for Pediatric Service
1977-Present Board of Directors, National Center for Clinical Infant Programs
1977  Board of the Joint Conference Committee, Boston Hospital for Women
1979-1982 Governor’s Advisory Council on the Family, Boston
1980-1982 Cambodia Crisis Committee, Washington, DC
1980-1984 Advisor to National Anthropological Film Center, Smithsonian Institute, Washington, DC
1981-1987 Board of Directors, International Study Center for Children and Families, Athens, Greece
1984 Corporation, U.S. Committee for UNICEF
1984-1988 March of Dimes, Social Research Committee
1985 Advisory Board, Women’s Action for Nuclear Disarmament
1985 Advisory Board, U.S. Friends of Inter American Children’s Institute
1985 Board of Directors, Neonatal Intensive Care Unit Parent Support, Inc.
1985 Scientific Advisory Board, World Association for Infant Psychiatry
1986 Governor Dukakis’ Special Commission for the Study of Providing Parental Leave
1988 Co-Chairperson, Parent Action for Parent Power
1988-Present Committee on Minority Participation, Society for Research in Child Development
1989 Advisory Committee, National Children’s Day
1989-Present Board of Directors, Parents As Teachers, Missouri Board of Education
1990-Present Early Childhood Intervention Advisory Committee, U.S. West Foundation, Englewood, Colorado
1991-1995 Advisory Board, National Council of Jewish Women
1991-Present Planning Committee to Link Child Care and Education, Child Care Action Campaign, New York
1991 Special Advisor, Mayor’s Council for Children, Youth and Families, Cambridge, Massachusetts
1991 Advisory Board, Connecticut Campaign for Children
1991-Present Advisory Committee for Nutrition-Cognition Institute, Tufts University, Medford, Massachusetts
1992 National Advisory Board, Institute for Family Centered Care, Bethesda, Maryland
1992 Honorary Chairman, Association for Care of Children’s Health
1992-1993 Governor’s Advisory Council, Special Commission on Foster Care, Massachusetts Department of Social Services, Boston Massachusetts
1992-1995 National Advisory Council, Hoff Foundation for Mental Health, Austin,
1993 Texas
Honorary Co-Chair, 1993 Membership Fund Campaign, Association for the Care of Children
1993 National Sponsor, National UNICEF Day, United States Committee for UNICEF
1993 Advisory Panel Member, Children’s Rights Council
1993 Advisory Committee, U.S. Program, Save the Children
1993 Honorary Membership, American Psychoanalytic Society

1993 Board of Advisors, The Endowment for Children in Crisis, Boston, Massachusetts
1993-Present Statewide Advisory Council, Office for Children, State of Massachusetts
1994-Present Advisory Board, Save the Children
1994-Present Advisory Board, United Way, Zero to Six Project
1994-Present Commission on Children 3-4, Massachusetts Office of Education
1994-Present Advisory Board, UNICEF U.S. Committee
1994-1996 Board of Visitors, Dimock Community Health Center, Roxbury, Massachusetts
1994-Present Board of Directors, Family and Work Institute
1994-Present Board of Directors, Public Voice for Food and Health Policy
1994-Present Advisory Board, Reach Out and Read Program, Boston City Hospital
1995-Present Advisory Board, Kohl/McCormick Early Childhood Teaching Awards
1995-Present Advisory Council, Children’s Education Television under Secretary of Commerce, Washington, D.C.

Editorial Boards:

1968-1972 Child Development
1968-1972 Science
1986-Present Zero to Three
1988-Present Journal of Infant Mental Health
1994-Present Children’s Health Care: Journal of the Association for the Care of Children’s Health

Memberships, Offices and Committee Assignments in Professional Societies:

1957-Present American Academy of Pediatrics
1969-Present Society for Research in Child Development
1969-Present National Association for Education of Young Children
1967-Present Association for Care of Children’s Health
1967-1970 Board of Directors, Association for Child Care in Hospitals
1970-1974 Public Information Committee, American Academy of Pediatrics
1970-1972 Chairman, Section on Child Development, American Academy of Pediatrics
1971-1975 Long-Range Planning Committee, Society for Research in Child Development
1975-1992  Board of Governors, Society for Research in Child Development
1980-1984  Committee on Psychosocial Development of Children and Families, American Academy of Pediatrics
1983-Present Society for Behavioral Pediatrics
1983-Present Advisor, Society for Developmental and Behavioral Pediatrics
1985-1987  President-Elect, Society for Research in Child Development
1987-1989  President, Society for Research in Child Development
1988-1991  President, National Center for Clinical Infant Programs
1993-Present Family-Centered Care, Washington, D.C.
Major Research Interests:

1. Developmental processes in normal and “at-risk” infants
2. Assessment of neonatal behavior
3. Intervention with “at-risk” infants--premature and small for gestational age infants
4. Development of early mother-infant interaction
5. Cross-cultural studies of infant behavior
6. Touchpoints
7. Neonatal Behavioral Assessment Scale

Principal Clinical and Hospital Service Responsibilities:

1967-1981 Senior Associate in Medicine and Coordinator of Patient Care, The Children’s Hospital, Boston
1971-Present Senior Associate in Medicine, The Children’s Hospital, Boston
1972-1988 Chief, Division of Child Development, The Children’s Hospital, Boston
1977-Present Pediatrician, Active Staff, Boston Hospital for Women, Boston
1981-Present Associate Pediatrician, Beth Israel Hospital, Boston
1994 Founder, Brazelton Center for Infants and Parents, Child Development Unit, Children’s Hospital, Boston
1995 Founder and Director, Touchpoints Project, Child Development Unit, Children’s Hospital, Boston

Publications

Articles:


23. Brazelton, T. B. “Assessment of the infant at risk,” *Clinical Obstetrics and*


65. Lester, B. M., H. Als, and T. B. Brazelton. “Regional obstetric anesthesia and


96. Brazelton, T. B. “Touchpoints: Opportunities for preventing problems in the parent-


**Chapters**


1978.


115. Brazelton, T. B. “Touchpoints for anticipatory guidance in the first three years.” In Behavioral and Developmental Pediatrics, edited by S. Parker and B.


**Books:**


