Diversity-Informed Infant Mental Health Tenets: Together in the Struggle for Social Justice

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To create a just and equitable society for the infants and toddlers with whom its members work, the infant mental health field must intentionally address some of the racial, ethnic, socioeconomic, and other inequities embedded in society. The Diversity-Informed Infant Mental Health Tenets, presented and discussed here, are guiding principles outlining standards of practice in the field and pointing the way to a just society via engaged professional practice. Copyright Irving Harris Foundation. For more information about the Diversity-Informed Infant Mental Health Tenets please visit www.imhdivtenets.org, email contact@imhdivtenets.org or call +1-312-621-3814.

Over the past 30 years, the field of infant mental health has evolved exponentially. Within this multidisciplinary field, practitioners of all kinds — clinicians, researchers, practitioners, and policy makers — all work to ensure the emotional, physical, social, and cognitive well-being of children from the prenatal period through 3 years. The field's work has been elevated partly because of what the science reveals about brain development and early experiences, and other critically important research that demonstrates how a young child's experience can shape long-term outcomes. In the past few years, the field has made great policy gains such as the increased federal funding to support early learning programs, federal funding for home visiting, and other policy efforts that support young children's healthy development.

Significant to this work has been the training, capacity building, and development of innovative programs led by members of the Harris Professional Development Network (PDN). Over the past 20 years, the PDN has played a critical leadership role in changing the landscape of services for infants and small children by promoting infant mental health and child development and by integrating core principles of infant mental health into systems and services that work with the most vulnerable children in the United States and Israel. These programs have also created models to work with children in war zones and children facing natural disasters. The PDN has been instrumental in professionalizing infant mental health providers by creating certificate

Diversity-Informed Infant Mental Health Tenets

1. Self-Awareness Leads to Better Services for Families: Professionals in the field of infant mental health must reflect on their own culture, personal values, and beliefs, and on the impact racism, classism, sexism, able-ism, homophobia, xenophobia, and other systems of oppression have had on their lives in order to provide diversity-informed, culturally attuned services on behalf of infants, toddlers, and their families.

Stance Toward Infants and Families

2. Champion Children's Rights Globally: Infants are citizens of the world. It is the responsibility of the global community to support parents, families, and local communities in welcoming, protecting, and nurturing them.
3. Work to Acknowledge Privilege and Combat Discrimination: Discriminatory policies and practices that harm adults harm the infants in their care. Privilege constitutes injustice. Diversity-informed infant mental health professionals work to acknowledge privilege and to combat racism, classism, sexism, able-ism, homophobia, xenophobia, and other systems of oppression within themselves, their practices, and their fields.
4. Recognize and Respect Nondominant Bodies of Knowledge: Diversity-informed infant mental health practice recognizes nondominant ways of knowing, bodies of knowledge, sources of strength, and routes to healing within diverse families and communities.
5. Honor Diverse Family Structures: Families define who they are comprised of and how they are structured; no particular family constellation or organization is inherently optimal compared to any other. Diversity-informed infant mental health practice recognizes and strives to counter the historical bias toward idealizing (and conversely blaming) biological mothers as primary caregivers while overlooking the critical child-rearing contributions of other parents and caregivers including fathers, second mothers, foster parents, kin and felt family, early care and educational providers, and others.

Practice/Research Field Principles

6. Understand That Language Can Be Used to Hurt or Heal: Diversity-informed infant mental health practice recognizes the power of language to divide or connect, denigrate or celebrate, hurt or heal. Practitioners strive to use language (including "body language," imagery, and other modes of nonverbal communication) in ways that most inclusively support infants and toddlers and their families, caregivers, and communities.
7. Support Families in Their Preferred Language: Families are best supported in facilitating infants' development and mental health when services are available in their native languages.
8. Allocate Resources to Systems Change: Diversity and inclusion must be proactively considered in undertaking any piece of infant mental health work. Such consideration requires the allocation of resources such as time and money for this purpose and is best ensured when opportunities for reflection with colleagues and mentors as well as on-going training and consultation are embedded in agencies, institutions, and systems of care.
9. Make Space and Open Pathways for Diverse Professionals: Infant mental health workforces will be most dynamic and effective when culturally diverse individuals have access to a wide range of roles, disciplines, and modes of practice and influence.

Broader Advocacy

10. Advance Policy That Supports All Families: Diversity-informed infant mental health practitioners, regardless of professional affiliation, seek to understand the impact of social policies and programs on diverse infants and toddlers and to advance a just policy agenda for and with families.

programs, disseminating evidence-based treatment models such as Child-Parent Psychotherapy, and replicating innovative programs such as Minding the Baby and Fussy Baby.

Despite major successes deepening the field, there continue to be vast unmet needs across the socioeconomic spectrum of young children and their families, with particularly unacceptable gaps in access and quality of mental health and early childhood learning services for poor children, many of whom are African American, Latino, or Native American or represent other non-dominant racial and ethnic communities. In many cases, professionals in the infant mental health field are disproportionately Caucasian, while many of the most vulnerable young children are children of color. In order to create a just and equitable society for the infants and toddlers with whom its members work, the field must intentionally address some of the racial, ethnic, socioeconomic, and other inequities embedded within society.

To begin to address these inequities, the PDN, as a group, has made one of its primary goals to deepen the field's commitment to diversity-informed, culturally attuned, inclusive, and equitable practice. To that end, members of the PDN studied some of the incisive and influential statements of core values of infant mental health and many ground-breaking innovations addressing diversity and inclusion that were underway across the disciplines and around the globe. This research revealed that diversity issues tended to be held as an area of specialized knowledge (e.g., infant care practices of a particular cultural group) or as a special skill set (e.g., the idea of "cultural competence"). What was missing was a shared vision of the role played by human diversity in those very principles and practices universally embraced within the field. Certain core principles of infant mental health, such as the importance of early relationships, are difficult to uphold evenly within a society where certain groups and relationships are recognized and revered, while others are discounted

or denigrated. It became clear that infant mental health is a matter of social justice. Wide recognition exists regarding the urgent necessity of protecting and promoting the health and well-being of infants and small children. Yet, there are no guidelines for equitably working toward this end given the cultural and institutional barriers based on class, race, and other inequities with which professionals all live and work. Thus, the PDN created the Diversity-Informed Infant Mental Health Tenets (see box) in an effort to offer such guidelines. The Tenets are a working document putting forth a vision of a society and a field in which all infants and toddlers – regardless of racial and ethnic identity, family structure, and ability – will be recognized, respected, and well-served. Most of the Tenets expand on familiar principles of infant mental health. The Tenets attempt to expand the core principles through a diversity, inclusion, and fairness lens. The Tenets are divided into three sections: (a) stance toward infants and families; (b) practice/research field principles; and (c) broader advocacy. Each Tenet is discussed in terms of not only what makes it important, but also what makes it difficult to uphold. It is hoped that this working document serves to bring together diverse practitioners committed to eradicating barriers to the healthy development of all infants, families, and communities. We submit that in this sense, professional development in the field of infant mental health means striving for social justice.

Moving Toward Diversity-Informed Practice

The field of infant mental health has come a long way in a short time. Reflecting on the origins of the field, Selma Fraiberg (Fraiberg, Shapiro, & Cherniss 1980) once recalled the public outrage with which the creation of the first infant mental health program in the nation was met. "When a two-line announcement appeared in our local newspaper that a professor in the department of psychiatry had received a grant from the National Institute of Mental Health for an infant program," Fraiberg wrote, "an irate taxpayer promptly wrote a letter to the editor demanding to know why the taxpayers should be asked to support a crazy woman professor who wanted to put babies on a couch and psychoanalyze them" (p. 49). Discomfort with the phrase "infant mental health" persists today. This discomfort can include the potential implications of the idea of mental illness, as well as concern that the term is too limited in some ways (e.g., it narrows the developmental age range, highlights only some domain(s) of developmental concern, or implies the need for the services of particular professional disciplines to the exclusion of others).

Those who promote the term infant mental health, however, embrace a holistic view of the infant in the context of family and community and intend the phrase to describe the conditions of infants' healthy development and general well-being. To that end, ZERO TO THREE (2001) put forward the following definition of infant mental health, suggesting that this phrase describes

> the young child's capacity to experience, express and regulate emotions, form close and secure relationships, and explore the environment and learn. All of these capacities will be best accomplished within the context of the caregiving environment that includes family, community, and cultural expectations for young children. Developing these capacities is synonymous with healthy social and emotional development.

Professionals in the field have developed key infant mental health concepts or principles to guide multiple avenues of effort including policy, research, training, and practice. Examples include the work of the Michigan Association for Infant Mental Health (Weatherston, 2002) to develop practice standards and an interdisciplinary workforce plan, the MI-AIMH Endorsement for Culturally Sensitive, Relation-Focused Practice Promoting Infant Mental Health; (California Center for Infant/Family and Early Childhood Mental Health; Heffron, 2011) to provide training guidelines and a professional endorsement system; and the California Interagency Coordinating Council on Early Intervention (2010) to develop practice standards for early intervention personnel. In reviewing knowledge bases from multiple disciplines, Zeanah and Zeanah (2009) identified points of consensus that also serve the function of guiding principles.

There are consistent themes among these documents. Early experiences, development, and relationships are of special importance throughout the life span. When constitutional or contextual vulnerabilities, or both, are present, children and families benefit from services and supports that are collaborative with them and informed by multidisciplinary perspectives. The field has considerable science knowledge and practice experience to support translating these principles into action.

In the early decades of the field—the "color blind" years—writing tended to focus on an imagined universal infant without regard to the sociocultural and historical-political context as a shaping force. In recent years, the importance of culture in influencing infant and family experience has been widely recognized and many authors note the importance of considering culture in planning and implementing interventions in support of infants, toddlers, and their families. The groundbreaking report of the National Research Council and Institute of Medicine (2000) on the science of early childhood development asserted that "culture influences every aspect of human development and is reflected in child-rearing beliefs and practices designed to promote healthy adaptation (p. 25)," but concluded that while this basic concept is compelling, "the database is thin and the imperative for extensive research is clear." With respect to research, the Council noted several challenges to studying the contributions of culture to parenting and child development, including lack of diversity in the children and families on whom research has been conducted as well as the need for far greater integration across the relevant disciplines (e.g., anthropology, ethnography, and sociology as well as the more typically represented early childhood fields) in research terminology, design, and practice. With respect to service systems and delivery, the Council articulated several characteristics regarding cultural competence. These included identifying underserved groups and eliminating culture-based barriers to service provision; monitoring the cultural appropriateness of assessment, research, and intervention procedures for the target families; and facilitating policy planning, staff training, and community participation in order to ensure the development, delivery and maintenance of culturally competent services.

The notion of cultural competence has been transformative within the field of infant mental health and across the disciplines that comprise it, bringing urgent attention to the necessity of building awareness of the influence of culture on practitioners, families, institutions, and systems (Maschinot, 2008). Yet some have noted that important components of human diversity that must also be considered and addressed in infant mental health work fall outside of the category of culture. For example, Ghosh Ippen (in press) has suggested that "culture,

while of critical importance, is [just] one factor among many to consider " and points to age, gender, immigration history, culture of origin, acculturation, social class, and trauma history as examples of salient aspects of experience that may not be touched by a cultural competence framework. Furthermore, a focus on culture often implies a focus on the culture of the recipients of infant mental health services, rather than on the influence of intersecting forces of oppression on provider–family relationships, on shaping research designs, or on systems of care more broadly. Ghosh Ippen (2009; Ghosh Ippen & Lewis, 2011) propose an alternate framework—diversity-informed practice—in order to account for these broader issues. She described it this way: "Diversity-informed practice is dynamic, focusing not just on values, beliefs or experiences of a group or individual but on interactions among people with different views. It also involves an understanding of how interactions are shaped by the larger sociopolitical and historical context" (in press). In the present document, the term diversity-informed practice is adopted in order to tap these many strata of human experience and strive for the highest possible standard of inclusivity in all spheres of practice: teaching and training, research and writing, policy and advocacy, as well as direct service.

Considering the Diversity-Informed Infant Mental Health Tenets

The Diversity-Informed Infant Mental Health Tenets have been devised to support all those in the field in working toward social justice and inclusivity. The discussion that follows describes each Tenet in the context of the serious impediments a professional faces in striving to uphold it.

1. Self-Awareness Leads to Better Services for Families: Professionals in the field of infant mental health must reflect on their own culture, personal values and beliefs, and the impact racism, classism, sexism, able-ism, homophobia, xenophobia and other systems of oppression have had on their lives in order to provide diversity-informed, culturally attuned services on behalf of infants, toddlers, and their families.

The first and arguably the most important step to providing diversity-informed services is an examination and understanding of one's own background, experiences, and identities. This awareness of one's personal assumptions, values, and biases ultimately allows the practitioner to differentiate between the families served and his assumptions. This awareness, including awareness about personal privilege and societal privilege generally awarded to heterosexual, middle-class majority groups, informs the practitioner's relationship with colleagues and clients, as well as the work the practitioner engages in on behalf of clients. Awareness and consciousness of one's cultural background, beliefs, and biases develop best in tandem with a dedicated effort at understanding others' cultural beliefs and heritage. In this process, the infant mental health practitioner acknowledges the ways in which the "isms" listed here lead not simply to instances of discrimination between individuals but also to institutionalized forms of injustice. Note that this Tenet is closely linked with Tenet #8, which recognizes the critical importance of dedicating agency resources to supporting this important aspect of individual professional development.

Stance Toward Infants and Families

2. Champion Children's Rights Globally: Infants are citizens of the world. It is the responsibility of the global community to support parents, families, and local communities in welcoming, protecting, and nurturing them.

If one embraces the core values and guiding principles of infant mental health discussed in the section above, one is hard pressed to apply them to only certain groups of human infants. One would not say, for example, "relationships matter - for American babies." Rather, it must be recognized that all infants offer and require much, and it is the responsibility of the world community to ensure that caregivers have access to adequate resources that are compatible with family and local cultural values. Diversity-informed infant mental health practice entails cultivating an awareness of the plight of infants locally and around the globe, and fostering their well-being in keeping with one's unique capacities and resources.

The United Nations Convention on the Rights of the Child (UNICEF, 2012) created a human rights treaty delineating the civil, political, economic, social, health, and cultural rights of children. It came into force in 1990 and has yet to be ratified by the United States despite its being embraced almost unilaterally by other members of the United Nations. Many of its articles reflect the notion of infants as citizens of the world, including the simply stated Article 6: "Children have the right to live. Governments should ensure that children survive and develop healthily." Given the large numbers of immigrant cultures in the United States, Article 10 has special significance here. It states that "Families whose members live in different countries should be allowed to move between those countries so that parents and children can stay in contact, or get back together as a family." Diversity-informed infant mental health practice and policy recognizes that love knows no borders and that infants' best interests are served when those who love them are able to care for and protect them.

3. Work to Acknowledge Privilege and Combat Discrimination: Discriminatory policies and practices that harm adults harm the infants in their care. Privilege constitutes injustice. Diversity-informed infant mental health professionals work to acknowledge privilege and to combat racism, classism, sexism, able-ism, homophobia, xenophobia, and other systems of oppression within themselves, their practices, and their fields.

Infant mental health is a social justice issue because discriminatory policies and practices that harm adults harm the infants in their care. Such practices may limit adults' capacities to protect and nurture the infants in their care in overt or covert ways. For example, prohibitions against interracial marriage in the past, or today against same-sex marriage or marriage among adults with disabilities impedes parents' ability to claim, care for, protect, and provide for their children in material ways and also inflicts psychological wounds for parents that can negatively impact parenting relationships. In addition to overtly discriminatory policies and practices, marginalized groups are routinely subjected to covert forms of oppression. With respect to race, insidious forms of racism include structural racism (as reflected, for example, in the gross overrepresentation of children of color in the child welfare system or the race-based achievement gap that is ubiquitous in education systems across the nation); white privilege; internalized racism; and racial microaggressions (Sue, 2010). Diversity-informed infant mental health practice entails identifying and working to eradicate both overt and covert forms of discrimination within one's personal and professional spheres.

As systems and institutions often reproduce aspects of the forces of oppression that operate in society at large, problematic patterns and divisions of labor can easily be reproduced even

within well-meaning infant mental health agencies. For example, higher-status positions may be held by dominant group representatives who may be less sensitive to or invested in combating various forms of oppression, leaving such battles to be fought by professionals representing non-dominant groups. Diversity-informed infant mental health agencies and systems of care must work to ensure that professionals representing minority status groups do not shoulder an undue burden (e.g., combating racism or other systems of oppression in the workplace, serving especially vulnerable families, striving for inclusivity). Such efforts are shared among all infant mental health professionals and supported by agency and community policies.

4. Recognize and Respect Nondominant Bodies of Knowledge: Diversity-informed infant mental health practice recognizes nondominant ways of knowing, bodies of knowledge, sources of strength, and routes to healing within diverse families and communities.

Professionalization processes involve knowledge-production, behavior-regulation, and standard-setting, and foster identification with and investment in each of these. Each professional is a steward of the funds of knowledge and approaches to practice that the professional inherits, but each also has a responsibility to critique, adapt, expand upon, and see beyond inherited ways of understanding and doing things. Rather than seeing themselves as the sole holders of knowledge and sources of healing, diversity-informed infant mental health practitioners listen carefully to the infants and families they serve in order to support them in drawing on endogenous resources. Diversity-informed infant mental health practice involves continually revising professional wisdom in light of the lessons learned from infants and families.

5. Honor Diverse Family Structures: Families define who they are comprised of and how they are structured; no particular family constellation or organization is inherently optimal compared to any other. Diversity-informed infant mental health practice recognizes and strives to counter the historical bias toward idealizing (and conversely blaming) biological mothers as primary caregivers while overlooking the critical child-rearing contributions of other parents and caregivers including fathers, second mothers, foster parents, kin and felt family, early care and educational providers, and others.

Although this Tenet may at first glance appear to be simple to embrace, fully implementing it would entail a radical reworking of infant mental health discourse and practice. As was discussed in the section above, most studies of typical early childhood development have been normed on middle class, able-bodied children of European-American descent. In addition, most of these children represent (or are assumed to represent) nuclear families with heterosexual parents. (It is quite rare to come across an infant mental health text acknowledging the prevalence of gay parenthood that is not specifically addressing an issue related to parental sexual orientation.) Whenever heterosexual, white, middle class, able-bodied nuclear families are represented as the norm and biological mothers are assumed to be the only salient caregivers, historical biases are reproduced and further entrenched. These ideas reinforce barriers to a more accurate and inclusive recognition of the reality of family diversity.

A notable exception is James P. McHale's and Elisabeth Fivaz-Depeursinge's (2010) discussion of co-parenting in infancy and early childhood. They state that since the mid-1990s, there has been an upsurge in both basic and applied research studies of co-parenting, though most published reports have involved two-parent Western nuclear families headed by children's mothers and fathers. This has been an unfortunate, unnecessarily limiting constraint, because co-parenting alliances exist in all families where more than just one person assumes responsibility for a child's care and upbringing (p. 354). McHale and Fivaz-Depeursinge go on to state clearly and inclusively that "in heterosexual two-parent family systems, the key co-parenting figures will be the child's mother and father. In gay and lesbian two-parent family systems, it is the two women or the two men raising the child together" (p. 361). In recognition of the unequivocal findings of decades of empirical research demonstrating that there are no adverse child outcomes associated with gay parenthood (American Psychological Association, 2005; Gatrell & Bos, 2010), diversity-informed infant mental health discourse follows the example of McHale and Fivaz-Depeursinge in using inclusive language to redress the historical tendency in the literatures that comprise the field to either omit any reference to gay people and their families (rendering them invisible) or represent them in terms of pathology. Diversity-informed infant mental health agencies review program materials, such as intake forms, to ensure that inclusive terms such as "parent or guardian" are used rather than the standard heteronormative structure of "mother and father." Logos, flyers, posters, and other imagery are also examined with an eye toward heteronormativity versus inclusivity.

Along similar lines, diversity-informed infant mental health practitioners recognize that single parent families, adolescent parents, divorced parents, parents with disabilities, extended kin networks, and other nondominant parental and family constellations have often been erroneously assumed to provide less optimal child-rearing environments than heterosexual, able-bodied nuclear families. Often adversity factors disproportionally affecting particular parenting groups (e.g., higher rates of poverty associated with adolescent parents) are conflated with those parents' competency, resulting in the idea that it is a parent's age rather than his or her socioeconomic status that poses a "risk" with respect to child well-being. Diversity-informed infant mental health practitioners combat such discrimination and stereotyping by affirming and including a wide range of family structures and learning directly from families which adults are important in the child's caregiving circle.

Embracing Tenet #5 entails a radical reworking of long-held discursive conventions and structures of thought. The idea of "the mother" as primary caregiver runs deep not only within the professional literatures comprising the field of infant mental health, but across artistic and popular cultural media, and throughout society at large. And indeed, in many instances biological mothers do provide disproportionate amounts of infant care and do hold positions of unique and inestimable importance for developing children. But it is readily recognized that while an infant requires such devoted caregiving in order to survive and thrive, this caregiving need not be provided by a biological mother. Adoptive mothers, fathers, grandmothers and grandfathers, aunts and uncles, other "felt family," or psychological parents with no blood relation to a child may successfully assume the role of sole or primary caregiver or may be critical members of a caregiving network.

When professional infant mental health literature continues to refer to primary caregivers as mothers by default, it reinforces this dominant norm as universal and optimal, lending professional authority and sanction to this construct. One will often encounter a footnote on the first page of a professional paper

addressing some aspect of parenting that reads something like this: "While the term 'mother' is used in this article to refer to the primary caregiver, the authors recognize that fathers and others sometimes serve in this capacity…" A caveat or disclaimer such as this stops short of truly including fathers and other potential important caregivers. In fact, in an insidious way it excludes them and justifies it by suggesting that their contributions are exceptional, special case instances—literally marginal. In this way infant mental health discourse tends to serve a "gatekeeping" function (Pruett, 1997), regulating and undermining the involvement of fathers and others in child rearing by reproducing, naturalizing, and romanticizing the dominant norm and disregarding the reality of the critical roles played in child rearing by other caregivers even when biological mothers are involved.

Practice/Research Field Principles

6. Understand That Language Can Be Used to Hurt or Heal: Diversity-informed infant mental health practice recognizes the power of language to divide or connect, denigrate or celebrate, hurt or heal. Practitioners strive to use language (including "body language," imagery, and other modes of nonverbal communication) in ways that most inclusively support infants and toddlers and their families, caregivers, and communities.

Part of the structuring of the human psyche and of the social order happens through language. Consider, for example, the long history of the use of the universal masculine in the English language, wherein a subject was by default referred to in the masculine unless specifically marked as different from/other than the masculine norm (e.g., "the infant at his mother's breast"). Despite the fact that (through hard work on the part of many people) this convention has changed such that it is no longer acceptable in scholarly discourse to use the universal masculine, many injurious linguistic practices persist, some in the form of conventions and some in the form of individual instances of expression.

For example, it is important to examine the conventions and language around disability. Linton (2006) asserted that professionals must re-look at the most basic assumption of the "nondisabled position and its privilege and power. It is not the neutral, universal position from which disabled people deviate, rather it is a category of people whose power and cultural capital keep them at the center" (p.171). The social construction of ability and disability interacts with the social construction of self and powerfully influences how people come to see themselves. Rousso (1985), a psychotherapist and an adult with a disability, wrote that an infant or young child experiences a physical disability as an inherent part of the body and self which needs appreciation, acceptance, and affirmation. The moment with the most potential for emotional trauma comes not when the child realizes there is a difference but when the child discovers that the differences are perceived by society as inferior (Rousso). The discovery of this meaning does not happen in a vacuum but is shaped by society's views and by our views as professionals. Language is a part of that perspective shaping process. Language that empowers the person rather than the condition (a child with autism rather than an autistic child) promotes well-being (Snow, 2009). Language which confuses disability with perpetual suffering, passivity, or superhuman status constricts rather than opens the possibility for full development (Linton). Perspectives on disability which imply a fix-it rather than a whole person view confuse normality with full humanness (Turnbull & Turnbull, 1986). Within this fix-it framework, the parent–infant relationship shifts from nurturance to treatment and the child's worth is reflected through progress.

As is true in any field, all of the professional and scholarly discourses that comprise infant mental health are prone to reiterating turns of phrase, structures of thought, and systems of meaning that denigrate or exclude individuals or groups in insidious ways. Diversity-informed infant mental health practice therefore attends carefully to words—written and spoken, on posters and flyers and intake forms, in articles and research protocols, in policy and public awareness campaigns in an attempt to be affirmative and inclusive with respect to the experience of all infants, toddlers, families, and communities.

7. Support Families in Their Preferred Language: Families are best supported in facilitating infants' development and mental health when services are available in their native languages.

The National Standards on Culturally and Linguistically Appropriate Services (Office of Minority Health, n.d.) mandated that health care organizations receiving federal funding make linguistically appropriate services available to clients (Aronson Fontes, 2005). It is recommended that all agencies and practitioners, regardless of funding sources, also strive to uphold these standards. Although translation and interpretation supports are an important vehicle for combating disparities in access to infant mental health services and resources, they should always be considered to be a triage effort and a temporary measure signaling the need for expanded linguistic competence (and associated cultural attunement) in the workforce. Many core developmental and parenting issues are subtle, complex, and highly emotionally charged. Much is lost in translation when an interpreter is used or when parents are forced to speak in a language other than their native one. When services are unavailable in families' native languages, the message sent is that the services are not for them, and more broadly that their infants have not been anticipated and are not welcomed by the dominant society or its systems of care.

Linguistically appropriate service delivery is especially important in the field of infant mental health because of the central role played by language acquisition in all realms of development and the salience of the language to the meaning-making potential of caregiving relationships. Parents and caregivers draw on their own preverbal and early language-saturated caregiving experiences in tending their own children. Language develops and acquires meaning in the context of the relationships with the significant others upon whom children depend. These people in turn depended upon others as children, and through the interface with the socio-cultural, political, geographical, and historical conditions that influenced the adults as children a great deal of cultural knowledge is transmitted along with language acquisition.. The language or languages that were acquired in early childhood are deeply entwined with children's and adults' internalized representations of themselves and of the other people they learn languages from. These languages become integral aspects of the self experience and of the relationship with those language-specific relationships. Language therefore, is closely linked with identity and is also part of coping and defense mechanisms (Javier, 1989 cited by Madrid n.d.; Pérez-Foster, (2001, 2008). In addition, according to Santiago-Rivera and Altarriba (2002), certain experiences seem to be intimately connected to the first language learned and cannot be "recoded" (p. 34) in another language, no matter how proficient and cognitively integrated in both languages is the bilingual individual. The notion of the "native tongue" and its centrality to the cognitive, affective, and sensorial dimensions of early experiences, underscores the importance

of using therapeutic interventions that are linguistically appropriate when serving immigrant infants, parents, and communities.

8. Allocate Resources to Systems Change: Diversity and inclusion must be proactively considered in undertaking any piece of infant mental health work. Such consideration requires the allocation of resources such as time and money for this purpose and is best ensured when opportunities for reflection with colleagues and mentors as well as on-going training and consultation opportunities are embedded in agencies, institutions, and systems of care.

Diversity-informed infant mental health practice connotes a stance as much as a focus. For example, although specific diversity issues may appear on the agenda of a staff meeting at a particular agency, diversity-informed agency culture is as much reflected in the question of who creates the agenda, what diversity qualities are embodied in staff members, or how this matches or contrasts with the diversity qualities of families served. Every infant mental health undertaking has cultural implications, although these may be either considered or ignored. Issues such as the allocation of program resources; the setting of agency priorities; and the accessibility, legibility (social as well as linguistic), and perceived salience of services are all matters that carry cultural meaning. In a society in which issues such as race, class, gender, sexual orientation, disability status, immigration status, and others are fraught with conflict and in many instances saturated with historical trauma, the chances are that if diversity issues are not addressed deliberately they will be played out covertly in ways that may replicate injurious patterns in society at large or reproduce historical injustices. For these reasons best practice entails the proactive dedication of time and financial resources for planning and reflection regarding diversity issues.

Because these matters tend to be emotionally fraught for individuals as well as for groups, it is critical that every infant mental health practitioner have predictable access to a colleague or mentor with whom to deeply consider personal meanings of diversity issues. One of the gifts of the field of infant mental health to the wider professional world is an understanding of the importance of the on-going cultivation of a reflective stance as a matter of continued professional development. A paradigm shift has occurred, for example, in many mental health and social service disciplines away from purely administrative or educative supervision and toward reflective supervision. Because of the deep roots in this practice, infant mental health practitioners have contributed substantially to this evolution. It is clear to infant mental health practitioners that a caregiver's capacity for reflection, and specifically for "holding the baby in mind", is a key factor in determining the quality of the caregiver–child relationship and shaping the child's own developing capacity for thinking, feeling, and relating. The field of infant mental health has also long recognized the power of parallel process—how mutually influencing the parent–child and the practitioner-family relationships often are. A commitment to making space for consistent personal reflection is grounded in respect for these powerful processes. Building on this insight and commitment to personal reflection, diversity-informed infant mental health programs, agencies, and systems dedicate resources to providing on-going opportunities on individual and group levels for genuine engagement with the social justice issues on which infant mental health depends.

9. Make Space and Open Pathways for Diverse Professionals: Infant mental health workforces will be most dynamic and effective when culturally diverse individuals have access to a wide range of roles, disciplines, and modes of practice and influence.

Dominant structures of power and forces of oppression have long conspired to systematically limit the access of people of color and other minority groups including persons with disabilities to white collar and high status professions and to positions of influence in trades, institutions, and systems. The National Research Council and Institute of Medicine (2000) noted that "significant cultural distance between providers and recipients of health and human services can make it difficult to build and sustain the kinds of relationships that often determine the short-term acceptability and ultimate success of an early childhood intervention or family support program" (p. 66). Such cultural distance furthermore serves to reproduce injurious divisions within the social order that construct certain groups of people as ill, ignorant, or lacking while other groups are elevated to the status of healers, educators, and purveyors of resources. In the words of Banerjee Brown (2007), "Privilege and discrimination are made possible because of one another" (p. 19).

In order to counter this historical and contemporary reality, infant mental health agencies, systems of care, and training programs must proactively recruit and promote people of color and representatives of other minority groups not only into the field, but into positions of leadership. This is not possible unless individuals are prepared to recognize and relinquish the unearned power or status that constitutes privilege (McIntosh, 2002). The recognition that one may have unwittingly long benefited from racism and other forms of oppression is painful and requires significant personal reflective work that must be supported at a systems level by consistently available diversity-informed reflective consultation, supervision, or mentorship. Such consultation, supervision, or mentorship is likewise essential for those "swimming upstream" to assume leadership positions contrary to historical and contemporary trends, as personal issues such as internalized racism, or homophobia, and survival (or "thrival") guilt may, without ongoing support, impede individual success and hence hold back progress in the field and harm infants, toddlers, and families.

Broader Advocacy

10. Advance Policy That Supports All Families: Diversity-informed infant mental health practitioners, regardless of professional affiliation, seek to understand the impact of social policies and programs on diverse infants and toddlers and to advance a just policy agenda for and with families.

Professionals in the field of infant mental health play an integral role in the lives of families. Regardless of professional status, infant mental health practitioners advocate for families within their settings and in formal and informal policy and advocacy efforts. When advocating on behalf of families, diversity-informed infant mental health practitioners are conscious not to impose their own values on clients, but to instead understand the experience and self-definition of the infant, family, or community, and consider how the proposed policy or advocacy will impact family and community life. This disciplined consideration of the experience of the other requires ongoing personal reflection about one's own individual experience, as well as an understanding of the role of racism, classism, sexism, able-ism, homophobia, xenophobia, and other systems of oppression, as discussed in relation to Tenet #1. Tenet #10 holds that such personal and professional reflection must also be translated into action at the

policy level on whatever small or large scale is possible in keeping with the resources of the practitioner, program, or system of care.

Author Biographies

Maria Seymour St. John, PhD, MFT, is assistant clinical professor in the Department of Psychiatry at the University of California, San Francisco and director of training of the Infant-Parent Program at San Francisco General Hospital. Endorsed by the California Center for Infant-Family and Early Childhood Mental Health as an Infant-Family and Early Childhood Mental Health Specialist, a Reflective Facilitator II and a Mentor, Dr. St. John has published on subjects related to race, class, gender, and sexuality in infant mental health work in numerous books and journals including Zero to Three, Feminist Studies, Studies in Gender and Sexuality, Attachment and Sexuality, and the World Association of Infant Mental Health Handbook of Infant Mental Health. Her writing examines infant mental health discourse and practice from the perspectives of psychoanalytic, feminist, queer, and postcolonial theories.

Kandace Thomas, MPP, is a program officer at the Irving Harris Foundation, where she plays a leadership role in the Foundation's efforts integrating early childhood development and child trauma knowledge and principles into systems serving young children, including domestic violence prevention and treatment programs, child welfare, and pediatric training programs. In this capacity, she manages grants and special projects in the field of early childhood mental health and child trauma, domestic violence, reproductive health, and social justice. In her work, Kandace partners with local and national grantees to build the capacity of organizations and systems to incorporate child development best practices into their work. Kandace has been instrumental in creating the Diversity-Informed Infant Mental Health Tenets, a list of ten guiding principles outlining standards of practice in the infant mental health field that point the way to an equitable society through engaged professional practice. Kandace is also a doctoral student at Erikson Institute.

Carmen Rosa Noroña, MSW, MS. Ed., CEIS is from Ecuador where she was trained and practiced as a clinical psychologist and also served as a consultant in two UNICEF-funded projects for abandoned young children. She is the clinical coordinator of the Child Witness to Violence Project /associate director of the Boston Site Early Trauma Treatment Network at Boston Medical Center-Division of Developmental and Behavioral Pediatrics. For 20 years, Carmen Rosa has provided clinical services to infants and toddlers and their families in a variety of settings including early intervention, home, and community-based programs. She co-developed the Birth to Three Clinic at Boston Medical Center and was a Fussy Baby specialist at Baby Steps a NICU follow-up clinic for fragile babies and their parents. She is a senior Child-Parent Psychotherapy Trainer and her practice and research interests are on the impact of trauma on attachment, the intersection of culture, immigration and trauma, tailoring mental health services to new immigrant families, and on cross-cultural supervision and consultation. She is a member of the Culture Consortium of the National Child Traumatic Stress Network and has translated and adapted materials for Spanish-speaking families affected by trauma.

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On page 10, the authors refer to the Michigan Association for IMH's (MI-AIMH) practice standards. However, since this writing, the authors have learned that the MI-AIMH's interdisciplinary endorsement includes culturally sensitive, relationship-focused practice promoting infant mental health. Please see:

Michigan Association for Infant Mental Health. (2002a). Competency guidelines. Southgate, MI: Author.

Michigan Association for Infant Mental Health. (2002b). Endorsement for culturally sensitive, relationship-focused practice promoting infant mental health. Southgate, MI: Author.

Dr. T Berry Brazelton Awarded Presidential Citizens Medal 2012

Dr. Brazelton has been recognized for 60-years of pioneering contributions to pediatrics and child development.

President Obama awarded Dr. Brazelton the Presidential Citizens Medal, the nation's second-highest civilian honor. President Obama recognized Dr. Brazelton, 95, for his pioneering contributions to the field of pediatrics and child development. His ground breaking Neonatal Behavioral Assessment Scale (NBAS) is now used worldwide to recognize the physical and neurological responses of newborns, as well as emotional well-being and individual differences. His innovative, evidence-based approach to child development consists of practical tools and resources designed to strengthen parent-child relationships, help parents understand their child's strengths and behaviors, and encourage full communities to unite around promoting children's healthy development.

Dr. Brazelton's work reflects a critical focus of President Obama's agenda in the second-term. The President highlighted in his State of the Union Address on Tuesday the importance of promoting children's early learning and guaranteeing high-quality pre-school programs for all children, despite family income level.

The Brazelton Touchpoints Center was founded by Dr. Brazelton at Boston Children's Hospital in 1996 with the goal of promoting strengths-based, family-centered care.

About Dr. T Berry Brazelton

The author of more than 35 books and more than 200 scientific papers, Dr. Brazelton has spent his career focused on topics such as individual differences among newborns, the parent-infant attachment, the importance of early intervention to at-risk infants, and opportunities for strengthening families in early infancy. He also shared expertise as host of the popular TV show, «What Every Baby Knows,» which aired from 1983 to1995.

A renowned advocate for families with young children, Dr. Brazelton was a pivotal supporter of the enactment of the 1993 Family and Medical Leave Act, which guarantees three months of maternity leave, as well as Public Law 99457, which extends rights and protections of the Individuals with Disabilities Education Act to young children.

Dr Brazelton and Barack Obama. Photo by Robin Leeds.

Dr. Brazelton has served as Clinical Professor of Pediatrics Emeritus at Harvard Medical School since 1988.

About Brazelton Touchpoints Center

Founded by Dr. T Berry Brazelton at Boston Children's Hospital in 1996, the Brazelton Touchpoints Center® offers innovative, strength-based interventions and practices to equip and engage families, caregivers, and practitioners to successfully support all domains of children's development essential to successful early learning and lifelong success. The Center offers resources related to professional development, research and evaluation, practice innovation and technical assistance, as well as public advocacy focused on systematic change for children and families. Since its inception, the Brazelton Touchpoints Center® has brought Touchpoints principles and strategies to all 50 states, the District of Columbia, and eight American Indian Tribes. The Center's approach has been embraced by tens of thousands of providers in early care and education, health care, and early intervention, reaching more than one million families across the country. For more information, please visit: http://www.brazeltontouchpoints.org/.

Source: Brazelton Touchpoints Center