Reconceiving the field: Infant mental health, intersectionality, and reproductive justice

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ABSTRACT
The field of infant mental health is conventionally comprised of professional discourses including developmental science, psychology, and psychiatry, among others, and involves spheres of practice as wide-ranging as pediatrics, maternal/child health, early intervention, early care and education, and child welfare. The World Association of Infant Mental Health [WAIMH] put out its position paper on the rights of infants in 2014 (amended in March 2016) in recognition of the human rights implications of professional understanding of infants’ unique, yet universal, developmental capacities and needs. This article links the policy issues outlined in the WAIMH position paper with critical issues in the field of reproductive justice, extending the reach of WAIMH’s call to action on behalf of infants’ rights, and pointing the way toward potent alliances among interconnected movements. Connecting the dots among economic injustice, race-based health disparities, and gender inequities, the article demonstrates that it is not possible to safeguard infant mental health unless we make reproductive justice a reality.

KEYWORDS
diversity-informed tenets for work with infants, children, & families, implicit bias, intersectionality, reproductive justice

RESUMEN
El campo de la salud mental infantil está convencionalmente compuesto de temas profesionales que incluyen a la ciencia del desarrollo, la psicología y la psiquiatría, entre otras, e involucra esferas de práctica que van desde un extremo al otro como la pediatría, la salud materno-infantil, la intervención temprana, el cuidado y educación, y el bienestar del niño. La Asociación Mundial de Salud Mental Infantil [WAIMH] presentó su posición en cuanto a los derechos de los niños en un ensayo en 2014 (corregido y aumentado en marzo de 2016) en reconocimiento de las implicaciones de los derechos humanos sobre la comprensión profesional de las distintivas y universales capacidades y necesidades de desarrollo de los niños. Este artículo conecta los asuntos relacionados con políticas descritas en el ensayo que presentó la posición de WAIMH con asuntos críticos en el campo de la justicia reproductiva, extendiendo así el alcance de la llamada que hace WAIMH para actuar en beneficio de los derechos infantiles, y señalando el camino hacia fuertes alianzas entre movimientos...
interconectados. Conectar los puntos entre la injusticia económica, las disparidades de salud basadas en la raza, así como las desigualdades de género, el artículo demuestra que no es posible resguardar la salud mental infantil a menos que hagamos de la justicia reproductiva una realidad.

PALABRAS CLAVES
Principios para Trabajar con Infantes, Niños y Familias Basados en la Diversidad, (© Fundación Irving Harris), prejuicios implícitos, justicia reproductiva

RÉSUMÉ
Le domaine de la santé mentale du nourrisson est traditionnellement constitué de discours professionnels qui comprennent la science liée au développement, la psychologie, et la psychiatrie parmi tant d’autres, et inclut des sphères de pratique aussi étendues que la pédiatrie, la santé maternelle et la santé de l’enfant, l’intervention précoce, les soins précoce et l’éducation, et le bien-être de l’enfant. L’Association Mondiale de la Santé Mentale du Nourrisson et du jeune enfant, abrégée en anglais WAIMH a diffusé un exposé de position sur les droits des nourrissons en 2014 (modifié en mars 2016) en reconnaissant les implications liées aux droits de l’homme de la compréhension professionnelle des capacités et des besoins uniques mais aussi universels des nourrissons. Cet article lie les questions stratégiques délinéées dans l’exposé de position de la WAIMH à des problèmes cruciaux dans le domaine de justice reproductive, élargissant ainsi la portée de l’appel à l’action de la WAIMH au nom des droits des nourrissons, et montrant la voie vers des alliances fortes entre les mouvements reliés entre eux. Faisant le lien entre l’injustice économique, les disparités de santé basées sur la santé et les inéquités entre les sexe, cet article démontre qu’il n’est pas possible de protéger la santé mentale du nourrisson si nous ne faisons pas de la justice reproductive une réalité.

MOTS CLÉS
Préceptes de travail avec les nourrissons, les enfants et les familles basés sur la diversité (© Irving Harris Foundation), préjugés implicites, intersectionnalité, justice reproductive

ZUSAMMENFASSUNG
Das Themenfeld der psychischen Gesundheit von Säuglingen umfasst üblicherweise professionelle Diskurse, unter anderem aus den Bereichen der Entwicklungswissenschaft, Psychologie und Psychiatrie, und bezieht weitreichende Tätigkeitsbereiche wie die Pädiatrie, Gesundheit von Müttern und Kindern, Frühintervention, Frühförderung und Bildung sowie Kinderbetreuung mit ein. Die World Association of Infant Mental Health [WAIMH] hat ihr Positionspapier zu den Rechten von Säuglingen im Jahr 2014 (im März 2016 geändert) veröffentlicht, um die menschenrechtlichen Implikationen eines professionellen Verständnisses von den einzigartigen und gleichzeitig universellen Entwicklungskapazitäten und -bedürfnissen von Säuglingen zu würdigen. Dieser Artikel verbindet die im WAIMH-Positionspapier skizzierten politischen Fragen mit kritischen Fragen aus dem Bereich der reproduktiven Gerechtigkeit, dabei erweitert er die Reichweite des WAIMH-Aufrufs zum Handeln im Namen der Rechte von Säuglingen und weist den Weg zu starken Allianzen zwischen miteinander verbundenen Bewegungen. Der Artikel stellt einen Zusammenhang zwischen wirtschaftlicher Ungerechtigkeit, ethnisch bedingten Gesundheitsunterschieden und geschlechtsspezifischen Ungleichheiten her und zeigt, dass es unmöglich ist, die mentale Gesundheit von Säuglingen zu schützen, sofern wir eine reproductive Gerechtigkeit nicht verwirklichen.

STICHWÖRTER
von Diversität geprägte Grundsätze für die Arbeit mit Säuglingen, Kindern und Familien (© Irving Harris Foundation), implizite Verzerrung, Intersektionalität, reproductive Gerechtigkeit
1 | INTRODUCTION

The field of infant mental health is relatively young, although it is an area of specialization that grows out of long-established disciplines such as psychiatry, psychology, and developmental science. The emergence of the field has brought into focus the unique developmental capacities of infants and toddlers, expanded awareness of what is helpful in protecting and promoting these capacities, and deepened understanding of a broad array of issues impacting infant/family functioning. Research and practice domains contributing to and furthered by the field of infant mental health include not only those listed earlier but also pediatrics, obstetrics and gynecology, maternal/child health, early care and education, child welfare, early intervention, and family therapy. The vast majority of research and writing in the field
has unfolded under the auspices of social and applied sciences. But the reach of infant mental health is longer than this.

Recognizing the global scope of the influence and implications of the field, the World Association of Infant Mental Health (WAIMH) put out a position paper on the rights of the infant in 2014 that was amended in March 2016. This paper endorses the 10 principles of the United Nations Convention on the Rights of Children (UNCRC; as passed by the General Assembly of the United Nations in 1989, and activated in September 1990), but asserts that the UNCRC “does not sufficiently differentiate the needs of infants and toddlers from those of older children” (p. 3). The preamble continues, “there are unique considerations regarding the needs of infants during the first three years of life which are highlighted by contemporary knowledge, underscoring the impact of early experience on the development of human infant brain and mind” (p. 3). The WAIMH paper offers a declaration regarding “the Infant’s basic rights, that should be endorsed everywhere, regardless of society and cultural norms, and the principles for health policy that are more sociocultural and context-dependent” (p. 3). The authors note that the forming of the Declaration represents “a significant step WAIMH Board has decided upon, that is to be action-orientated and to take explicit ethical stance and advocacy positions” (p. 3). The paper constitutes a critical contribution to global discourse regarding infants, challenging nations and societies to assess and grapple with their own conceptualizations, standards, and track records vis-à-vis recognizing and/or upholding infants’ rights.

This marks a watershed moment for the field of infant mental health. Extending beyond the conventional research and clinical practice boundaries of the field and into a broad global policy and “action-oriented” advocacy arena, the WAIMH position paper clears the way for a powerful alliance between the infant mental health field and the reproductive justice movement. Itself situated within human rights discourse, the WAIMH position paper challenges this silence. It utilizes the language of “basic rights (p. 3),” “special safeguards (p. 4),” and “social and health policy (p. 4).” In light of this document, the highly charged political and ideological stakes of the ordinary concerns of infant mental health, such as developmental phenomena, parenting and caregiving, family constellation, socialization, and attachment patterns, become evident because each of these takes shape in a sociopolitical context.

The WAIMH position paper urges infant mental health professionals to reconsider the parameters of practice we may have taken for granted, implicitly encouraging all infant mental health professionals to become “action-oriented.” It also reveals a cadre of unaccustomed bedfellows such as the grassroots organizations and activist groups comprising the reproductive justice movement—constituencies often construed as being outside of the boundaries of the field of infant mental health that actually advance issues core to the field. The implications of the WAIMH position paper are incontrovertible. The field of infant mental health will benefit from avowing and furthering its implicit intersections with the reproductive justice movement, and will fall short of its ethical mandate if it does not do so.

At first glance, it might seem that the reproductive justice movement and the field of infant mental health are at odds, with the prior advocating for adult rights and freedoms and the latter concerned with meeting the needs of infants. Indeed, in many instances, “fetal rights” and the narrowly construed “best interests” of infants have been pitted against the rights of pregnant women and parents, to the detriment of all (Diaz-Tello & Greenlee, 2016; Lauen, Henderson, White, & Kohchi, 2017). On the contrary, however, an organic synergy exists in potentia between the two frameworks, wherein infants and parents are best served by collaboration, strategic alliances, and cross-pollination. The sections that follow outline some of the ways that the field of infant mental health might benefit from and contribute to the reproductive justice movement, as well as an analysis of what intersectionality—the approach that fuels the reproductive justice movement—means for infant mental health.

By contrast, as Ross and Solinger (2017) stated, reproductive justice is founded on three primary principles: “(1) the right not to have a child; (2) the right to have a child; and (3) the right to parent children in safe and healthy environments.” In addition, they added, “Reproductive justice demands sexual autonomy and gender freedom for every human being” (p. 9).

Social justice and the attendant language of rights and freedoms have historically not been central to infant mental health discourse, but the WAIMH position paper challenges this. It also reflects a cadre of unaccustomed bedfellows such as the grassroots organizations and activist groups comprising the reproductive justice movement—constituencies often construed as being outside of the boundaries of the field of infant mental health that actually advance issues core to the field. The implications of the WAIMH position paper are incontrovertible. The field of infant mental health will benefit from avowing and furthering its implicit intersections with the reproductive justice movement, and will fall short of its ethical mandate if it does not do so.
2 | THe Core Tenets Of Reproductive Justice: Implications For Infant Mental Health

2.1 | The right not to have a child

The move away from the narrowly construed, either/or logic of “right-to-life” versus “choice” is a hallmark of the paradigm shift from a reproductive rights framework to reproductive justice. Rights and justice are inextricable, but whereas reproductive rights agendas tend to be focused at the level of individual entitlements, reproductive justice agendas are broader, focusing on interlocking social justice and human rights issues (Asian Communities for Reproductive Justice, 2005). As Loretta Ross, a founding leader of the reproductive justice movement, recounted in remembering the moment when the term reproductive justice was coined by women-of-color activists, “We were dissatisfied with the pro-choice language, feeling that it did not adequately encompass our twinned goals: To protect the right to have—and to not have—children” (Asian Communities for Reproductive Justice, p. 5). The movement views these rights as inextricable; only if one is truly free to choose to safely have a child may one freely choose not to have a child (and vice versa), and every individual has a right for either choice to be a viable and respected option. The movement exposes the systemic forces that disproportionately weigh on disenfranchised groups along both axes, constricting choices, impeding autonomy, and foreclosing self-determination. The reproductive justice framework also brings historical and systemic analysis to each present-moment circumstance, so, for example, contemporary African American women’s choices and experiences around childbearing would be considered in light of the historical trauma of slavery, including the routine rape of enslaved women by White slave owners as a tactic of domination and a business practice, and the fact that the children these women bore in bondage would themselves be held as property. Short of brute force—which is not a relic of the past—the right not to have a child may be infringed or blocked via myriad mechanisms, including restricted representations of potential paths to self-actualization at all developmental phases (i.e., socialization); lack of protection from sexual violence, objectification, and exploitation; lack of access to reproductive health education and information as well as lack of access to reproductive health care (including, but not limited to, abortion); and/or lack of access to rewarding pursuits other than parenting. The field of infant mental health could protect the rights of disenfranchised groups not to have children by intervening around any and all of these junctures. Examples of possible infant mental health interventions in this arena follow.

2.1.1 | Socialization

More than any other field, the field of infant mental health is positioned to investigate socialization processes in fine detail. These capacities can be marshaled to elucidate the reproductive justice movement’s insights regarding the operation of reproductive oppression via ordinary socialization processes. Infant mental health research can shed light on gender, race, and class disparities in infants’ and toddlers’ socialization around parenting and caregiving. How do gender, race, class, and so on come to be incorporated into a small child’s sense of self, and how are their reproductive futures impacted? How do parents or early childhood educators, for example, respond when a female toddler versus a male toddler, or a Caucasian toddler versus an African American toddler, or a low socioeconomic status toddler versus a high socioeconomic status toddler select a baby doll versus a truck versus an abacus to play with? (A rich vein of scholarship in the “doll study” tradition could be tapped and extended to explore these questions; e.g., see Clark & Clark, 1947; Katz & Kofkin, 1997; Njoroge, Benton, Lewis, & Njoroge, 2009). What messages are infants and small children from varying groups given regarding their worth, the pathways open to them, the contributions that are expected from them, their positioning vis-à-vis others? Infant mental health clinicians could be poised to draw parents’ attention to such matters in their attributions toward, interactions with, and expectations for their children. In collateral work with other professionals serving infant families, infant mental health professionals could promote awareness regarding implicit bias and the power of providers to constrain or open up possibilities for infants’ eventual self-expression, self-actualization, and self-determination. By intervening in these ways, infant mental health practitioners would be upholding the third Basic Infant Right articulated in the WAIMH position paper:

The infant is to be considered as a vital member of [their] family, … having the right to identity from the moment of birth. Moreover, the infant’s status of a person is to include equal value for life regardless of gender or any individual characteristics such as those of disability. (p. 4)

Research conducted by Gilliam, Maupin, Reyes, Accavitti, and Shic (2016) revealing the role of implicit bias in early childhood educators’ decisions regarding expulsion, for example, provides an important opening for infant mental health systems-level intervention to reduce race- and gender-based disparities in preschool expulsion rates. Note that while expulsion rates are highest in the pre-K years for African American boys, African American girls may be treated in ways during these early years that go unnoticed, but lead to
difficulties in later school years. As Crenshaw, Ocen, and Nanda (2015) observed,

Research suggests that Black girls sometimes get less attention than their male counterparts early in their school careers because they are perceived to be more socially mature and self-reliant. The lack of attention can lead to “benign neglect” that may diminish school attachment in both high- and moderate-achieving female students. (p. 12)

Infant mental health systems-level intervention must therefore attend carefully to all vicissitudes of gender- and race-based disparities in early care and education.

2.1.2 | Sexual violence and exploitation

The right not to have a child may be blocked via rape or overt coercion and exploitation and/or undermined via persistent messaging that objectifies and sexualizes girls and women (and punishes anyone who is gender-nonconforming), reproducing a social structure and symbolic order in which activity, autonomy, and independence are associated with masculinity whereas femininity is associated with passivity, other-orientedness, and dependence. The reproductive justice movement is grounded in an analysis of such networks of meaning and structural systems that conspire to constrict possibilities for women and girls via a continuum from suggestion to pressure to force. An infant mental health field truly alert to the widespread and insidious presence of objectification, sexual violence, and sexual exploitation would be a field engaged in activism. There would be infant mental health contingents in take-back-the-night marches and infant mental health representation on task forces and committees organizing against sexual violence. Infant mental health practitioners can (and many do) collaborate with activist and service organizations fighting to end sexual violence and to intervene around intimate partner violence. Infant mental health clinicians can support parents who may be at risk of engaging in intimate partner violence—in either the “perpetrator” or the “victim” role—in making safety plans and establishing patterns of interaction based in respect and reciprocity. Infant mental health clinicians also can challenge and bring the awareness of parents and caregivers to the messaging and patterns of interaction that make objectification, sexual violence, and exploitation seem ordinary and inevitable in the society in which they are raising their children.

2.1.3 | Access to reproductive health education and care

Providing access to reproductive health education and information and supporting families with infants and toddlers in making informed choices about family planning—including supporting decisions not to have children—could be core to the work of infant mental health service delivery. Bringing a reproductive justice framework to bear in this effort would mean being mindful of the histories of medicalized violence against many constituencies of people of color (Roberts, 1997), where “family planning” has been code for limiting or extinguishing reproduction among particular communities (Ross, 2016). Infant mental health professionals could advocate at the policy level to ensure equal access to reproductive health education and information as well as equal access to reproductive healthcare, including abortion along with a continuum of options. Infant mental health researchers could explore the factors that influence child-spacing patterns in various social groups, or what methods of reproductive health education work best for whom, or what service-delivery elements make reproductive healthcare optimal for particular groups of women. Key to success with any of these efforts would be ensuring that women of color were leaders and decision makers at all levels—as policy makers, researchers, and service purveyors.

2.1.4 | Access to rewarding pursuits other than parenting

Finally, the infant mental health field can challenge the race-, class-, and gender-based disparities in material conditions and opportunity that limit the pathways to physical health and longevity, economic security, and personal fulfillment for certain social and cultural groups. Only when an array of promising pathways are open to a person may she genuinely elect not to parent a child in favor of an alternate route toward productivity, self-realization, and participation in the social world. In the absence of a reproductive justice framework, infant mental health professionals are at risk of perpetuating reproductive oppression by seeing women only as mothers rather than as whole people. Selma Fraiberg, Adelson, and Shapiro’s (1975) seminal paper “Ghosts in the Nursery” includes a case report of a young mother, Annie, who struggles mightily as a parent due in large measure to trauma and oppression that she has endured. At the end of the case report describing the fruitful, but arduous, work of infant–parent psychotherapy with Annie and her son Greg, it is revealed that Annie is expecting a second child, and the prospects for Annie and the family are painted optimistically, with confidence that the new baby will be “protected by the magic circle of the family” (p. 419). Birch (1994) contested this uncritical optimism, asking,

While it seems probable that Annie’s second baby may be more protected from Annie’s rages and resentment than was Greg, how can we feel that another baby is the best future for Annie? or
These questions challenge infant mental health practitioners not to lose sight of the whole woman when working with a woman who is a mother.

Despite shifting norms regarding social expectations of women with respect to reproductive and caregiving labor versus labor in the workforce in the decades since Fraiberg et al.’s (1975) writing, the tendency to idealize maternity is still pervasive in the field. Indeed, many people are drawn to the field because they find the maternal–child matrix compelling. Note that such idealization is always ideologically inflected such that particular (raced and classed) embodiments of maternity tend to be valorized while others are concomitantly de-idealized. Infant mental health practitioners must be alert to opportunities to support mothers in their extramaternal ambitions; to identify nonmaternal caregivers who are present in infants’ lives and include them in the infant mental health work to disperse the responsibility for child-rearing; and to participate in activism such as the worthy wage movement oriented toward freeing biological mothers from undue caregiving burden and honoring the labor of other caregivers. Infant mental health practitioners are uniquely well-positioned to help broaden social understandings of and deepen social responsibility for meeting infants’ needs, thus liberating women to make proactive decisions regarding where to invest their energies.

2.2 | The right to have a child

As noted earlier, the right to have a child is inextricable from the right to not have a child. Self-determination is the linchpin; however, interlocking forces of oppression impede self-determination for particular social and cultural groups. Just as the systemic forces described earlier may conspire to overtly or covertly push women and girls into having children in many instances without genuinely, freely choosing this, so too do systemic barriers prevent particular groups of people from becoming parents despite their wishes to do so.

Specific historical atrocities with contemporary sequelae impact racial and ethnic communities in relation to the right to have children. In their book Undivided Rights: Women of Color Organize for Reproductive Justice, Silliman, Fried, Ross, and Gutiérrez (2004) documented the groundbreaking reproductive justice organizing work undertaken by different communities of color. With respect to Native American women, they wrote:

for Greg, who must now share her with a sibling? How did the therapy contribute to Annie locating her fragile self-esteem in her mothering, and what role did the tender, solicitous, and supportive interest of the therapist in Annie as a mother play in the second pregnancy? (p. 11)

Infant mental health (in the sense of the health and thriving of infants) for first-nation communities and those who serve them must incorporate a reckoning with this staggering magnitude of historical trauma, which is also a contemporary trauma in light of the dispossession and oppression that continue to afflict native peoples. Distinct, but parallel, histories of atrocity and trauma impact other communities of color, constraining individual people’s choices and capacities to have children.

Loretta Ross (2016) offered “population control” as a lens for analyzing such forces of constraint. She wrote, “I urge attention to the multiple ways that Indigenous peoples and communities of color are constrained through a constellation of public policies that aim to maintain white supremacist economic, social, and political hierarchies [through regulating such domains as] food distribution, labor patterns, [and] migration” (p. 72). She asserted further that “peoples of color worldwide are targeted for containment and elimination in order to control their land and natural resources (p. 76).”

Policy-level forces of reproductive oppression are manifest in institutional practices that block access to safe and healthy conception, pregnancy, and childbirth for particular groups. Access to reproductive technology is blocked for many based on economic exclusion, but also based on overt racism or implicit bias on the part of healthcare providers who might support White women in pursuing pregnancy despite fertility challenges, but not do the same for women of color. In her article “What’s Killing America’s Black Infants?” Zoe Carpenter (2017) summarized contemporary research into the causes of the grossly disproportional infant mortality rates for Black infants. She noted that “a growing body of evidence points to racial discrimination … as the dominant factor in explaining why so many black babies are dying” (p. 6). Solomon (2018) summarized research documenting the fact that racism is also responsible for the disproportionate mortality rates of African American mothers. Julia Chineyere Oparah with the group Black Women Birthing Justice (2016) described the emergence of the birth justice movement (a branch of the reproductive justice movement) in this way: “The struggle for access to birthing alternatives is inseparable from struggles for racial, economic, and social justice and the

The colonizers killed Native American women and children as part of a strategy to conquer, subdue, and destroy Indian nations and take control of their lands. Andrew Jackson recommended that after massacres the troops should systematically kill Indian women and children to complete the extermination of Native peoples. Thus, for Native American women the issues of cultural survival, land rights, and reproductive rights cannot be separated. (p. 111)
fundamental transformation of global maternal-care systems” (p. 15).

Clearly, the field of infant mental health is part of global maternal-care systems. Opportunities abound for infant mental health practitioners to join with reproductive justice fighters in challenging oppressive practices that block individuals and groups from safe and healthy conception, pregnancy, and childbirth. Examples might include infant mental health professionals (who often have opportunities to engage around family planning) advocating for universal support for egg freezing and other reproductive technologies to open the same flexible pathways to parenting across race and class lines that are currently reserved in practice for a privileged class of women; ensuring universal access to a wide range of approaches to prenatal care and childbirth; and empowering birthing women to make active choices regarding the circumstances and management of labor and delivery. As Oparah and Black Women Birthing Justice (2016) noted, “the most vulnerable pregnant people” are the most likely to be disempowered and disrespected, including

incarcerated women and trans/gender nonconforming people, women in immigration detention centers, young women in juvenile halls … [and] people living with a mental or physical disability or drug addiction, who battle for the right to carry their pregnancies and to receive the support they need. (p. 15)

Infant mental health professionals can join forces with reproductive justice advocacy efforts to ensure access to respectful and culturally competent care for these vulnerable populations; eradicate coerced conception restriction and sterilization of incarcerated youth and adults; stop the criminal prosecution of pregnant and parenting women who struggle with addiction; and end shackling of pregnant prisoners during labor. Just as in the case of protecting people’s rights not to have children, infant mental health efforts to protect people’s rights to have children must be grounded in awareness of historical and contemporary forms of reproductive oppression, manifest in culturally competent practice, germinated and cultivated via preservice training and workforce development standards, and reinforced via advances at the level of policy.

2.3 | The right to parent children in safe and healthy environments

This third tenet of the reproductive justice movement is perhaps the most readily recognizable as overlapping with infant mental health. When environmental toxins related to industry disproportionately harm neighborhoods where people of color reside, for example, leading to high rates of asthma for infants of color, the infant mental health implications are clear. Infant mental health professionals might work to educate parents about asthma management, or to mitigate the potential adverse effects on parent–child relationships of the need to administer albuterol treatments, or advocate with pediatric providers regarding parent/caregiver inclusion in treatment protocols. What is newer for the field of infant mental health is the idea that the “upstream” work of environmental activism and policy is likewise within the purview of infant mental health, and that the core goals of the infant mental health field cannot be realized without engaging at these levels. The reproductive justice movement can teach the field of infant mental health how to gain ground upstream.

The reproductive justice movement builds coalitions among wide-ranging advocacy and activist groups to advance common causes. A prime example—and one that makes clear the links with the WAIMH position paper—is the issue of workplace leave. Bowman et al.’s (2016) report on paid leave advocacy efforts in the United States has documented “growing momentum in states and communities across the country to support workers and families by passing or improving upon workplace leave policies” (p. 1) emphasizing that “these winning campaigns are a testament to the power of organizing and worker-centered campaign strategies as well as diverse and robust coalition building” (p. 1). The WAIMH position paper calls for “policies that support adequate parental leave so that parents can provide optimal care for their infants during the crucial early years of life” (p. 4). This plea demonstrates not only that the field of infant mental health and the reproductive justice movement have overlapping concerns but further that protecting infant mental health depends on securing reproductive justice. Additional areas of overlap between infant mental health and reproductive justice relate to the third tenet, include repealing family caps in social welfare programs, eliminating race- and class-based disparities in child welfare involvement, ensuring food and environmental justice (access to potable water, support for breast-feeding when desired, access to healthy formula as needed/desired that is free of corn syrup and endocrine disruptors, access to organic food, breathable air, etc.), achieving universal access to childcare and preschool, and ending interpersonal and community violence.

2.4 | Sexual autonomy and gender freedom for every human being

This has come to be embraced by the reproductive justice movement as inextricable from and a necessary condition for the other three tenets. The implications for infant mental health are discussed later.
Reproductive justice is grounded in intersectionality theory. Critical race theorist Kimberly Crenshaw introduced the intersectionality framework in a groundbreaking 1989 paper that contested the tendency to pit race against gender in analyzing Black women’s issues and instead advanced an analytical methodology grounded in an understanding of the multiaxial nature of oppression. Crenshaw wrote:

*Black women are sometimes excluded from feminist theory and antiracist policy discourse because both are predicated on a discrete set of experiences that often does not accurately reflect the interaction of race and gender. These problems of exclusion cannot be solved simply by including Black women within an already established analytical structure. Because the intersectional experience is greater than the sum of racism and sexism, any analysis that does not take intersectionality into account cannot sufficiently address the particular manner in which Black women are subordinated.* (p. 140)

Originally conceptualized in the context of legal theory, intersectionality quickly gained traction in a broad range of disciplines.

The intersectionality framework was elaborated by Black feminist theorist and sociologist Patricia Hill Collins (1991), who demonstrated how systems of oppression, such as racism, classism, sexism, homophobia, able-ism, and xenophobia, are interlocking such that “each system needs the others in order to function” (p. 222). Collins noted that this framework “opens up possibilities for a both/and conceptual stance, one in which all groups possess varying amounts of penalty and privilege in one historically created system (p. 225).” The abiding broad and vital relevance of the intersectionality framework is reflected in an upsurge of contemporary intersectionality scholarship (Carastathis, 2016; Collins & Bilge, 2016; Crenshaw, 2018; Grzanka, 2014; Hancock, 2016; May, 2015, Romero, 2018). The reproductive justice movement has embraced the intersectionality framework as a key strategy of analysis and activism.

If the field of infant mental health is to move in the action-orientated, human-rights-focused direction advocated by WAIMH, the time has come for the field to take up intersectionality as well. This framework may be fruitfully deployed in three ways: (a) as a reflective tool that reveals the ways in which the field produces (and limits) itself; (b) as an analytical framework for critically examining covert as well as overt infant mental health knowledge-production projects; and (c) as a methodology for promoting social justice via infant mental health research, writing, and intervention, and also organizing, advocacy, and policy work. All three promise a deepening and broadening—and necessitate radical re-visioning—of the field.

### 3.1 Reflective tool

Intersectionality theory can function as a mirror for the field of infant mental health, enabling us to reexamine who we are. The intersectionality framework pushes for transparency regarding power structures and exposes how each of us is positioned within complex networks, holding (in the words of Patricia Hill Collins, mentioned earlier) “varying amounts of penalty and privilege” (p. 225) in diverse moments and contexts. As Banjeree Brown (2007) noted, “privilege and discrimination are made possible because of one another. Both are products of a paradigm and a mindset defined by hierarchy and exclusion, in which value is accorded to a few at the expense of the many” (p. 19).

Many fields and discourses obscure the operations of power, privilege, and discrimination in their own coming-into-being and day-to-day workings, promoting instead a myth of their organic emergence, apolitical nature, and progress based in inherent value. These Enlightenment-era ideas continue to shape the ways many contemporary areas of study and practice understand themselves, and they blind us to the vested interests, systematic exclusions, inequitable access issues, and uneven resource allocations that follow from the interlocking systems of oppression pervasive in the current social order (Flax, 1990). Critical race theory came into being by levying this critique of the field of law, demonstrating how the legal field and legal structures, rather than being outside of racism, are implicated in the reproduction of institutional and systemic racism. Undoing racism from a critical race theory perspective involves not only using the law to fight racism but, via intersectionality theory, exposing and countering operations of racism within legal discourse, institutions, and practices. Intersectionality can likewise be used to reveal blind spots, hidden inequities, and covert repetitions of injustice in the field of infant mental health.

The *Handbook of Infant Mental Health* defines infant mental health as “a multidisciplinary professional field of inquiry, practice and policy concerned with alleviating suffering and enhancing the social and emotional competence of young children” (Zeanah & Zeanah, 2009, p. 6), and states that “basic knowledge salient to infant mental health has been bolstered by research in genetics, basic neuroscience, child development, developmental psychopathology, and by studies of clinical disorders and their treatment” (p. 7). While these are apt definitions of the field of infant mental health as it has understood and represented itself, the intersectionality framework calls attention to what and who are excluded from this construal of the field. If alleviating young children’s suffering
and enhancing their social and emotional competence is what is at issue, then surely not only scientists but also parents, caregivers, and communities must be registered as central voices, recognized as holders of expertise, and looked to as authorities and decision makers. The slogan from the patients’ rights movement of the 1970s in the United States—“nothing about us without us”—is relevant here. Oparah and Bonaparte (2016) described holding such a line in their book on birth justice for Black women:

Social science and medical researchers tend to examine, theorize, and discuss our lives but seldom ask us for our own interpretations of our lived realities. In contrast, we conceptualize black women activists, mothers, and birth workers as thinkers, knowers, and doers, not merely as research subjects or medical conundrums. (p. 16)

Furthermore, researchers, writers, and cultural workers in a wide array of disciplines and traditions, including all of the arts and humanities, might be included in infant mental health discourse when their work is centered around infancy, parenting and caregiving, or related matters. Finally, grassroots organizations, community and advocacy groups, and activists striving to ensure infant/family well-being and counter forces of oppression negatively impacting infants and families ought to be regarded as leaders and authorities in the field of infant mental health. Reproductive justice has since its inception embodied such movement-based authority and approach to scholarship. As the authors of a classic reproductive justice text, Undivided Rights: Women of Color Organize for Reproductive Justice, reflected in the preface to the new (2016) edition, the book underscored “the potential and ability of the reproductive justice movement and its multiple constituencies to produce new theories, new knowledge, and new forms of activism” (p. vii). This community-based, overtly political, grassroots approach to theory-building, knowledge production, and agenda-setting offers an alternative to conventional infant mental health approaches, which have often imagined that infant mental health knowledge comes from the laboratory, the academy, or one profession or another and is dispensed from there to infants and families.

In addition to broadening the scope of which disciplines, practices, and voices might be considered germane to the field of infant mental health, the intersectionality framework as a reflective tool also exposes the ways in which intersecting forces of oppression limit, via systemic barriers, who enters particular fields, who excels within them, who gets published, achieves tenure, garners authority, and so on. Glass ceilings, compounded adversity factors, implicit bias, resource-hording, gate-keeping, and the like all contribute to an uneven playing field wherein not only economic wealth but also social capital, decision-making power, mobility, authority, and access are distributed in predictable, well-documented, grossly disproportionate ways across social groups. This is how racism, classism, sexism, able-ism, homophobia, xenophobia, and other systems of oppression work, both outside of and within the disciplines conventionally comprising the field of infant mental health (e.g., see Hanks, Solomon, & Weller, 2018). Embracing an intersectionality framework demands that representatives of the field of infant mental health take steps to change these patterns.

One tool available to guide infant mental health practitioners in the implementation of the intersectionality framework is The Diversity-Informed Tenets for Work with Infants, Children, and Families (Irving Harris Foundation, 2012; see Appendix). As described in the original Tenets article (St. John, Thomas, & Noroña, 2012), the Tenets are a set of guiding principles “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” (p. 14). Two Tenets are particularly relevant here. Tenet 9, “Make Space and Open Pathways,” counters forces of systemic racism by insisting that

Infant, child, and family-serving workforces will be most dynamic and effective when historically and currently marginalized individuals and groups have equitable access to a wide range of roles, disciplines, and modes of practice and influence. (p. 15)

The description of Tenet 8, “Allocate Resources to Systems Change,” asserts that:

Diversity and inclusion must be proactively considered when doing any work with or on behalf of infants, children, and families. Such consideration requires the allocation of resources such as time, money, additional/alternative practices and other supports and accommodations, otherwise systems of oppression may be inadvertently reproduced. (p. 15)

Oparah and Bonaparte (2016) offered an excellent example of this practice. As the editors described in their coauthored introduction, an initial call for contributions to this volume on birth justice yielded a wealth of material, but there were significant gaps as well, not surprisingly including some of the most disenfranchised constituencies. They wrote that, “after reviewing the proposals, we identified voices that were missing or underrepresented … and made efforts to recruit contributors who could speak about these particularly marginalized experiences” (p. 16). Tenet 8 demands exactly this kind of “effort” toward intentional inclusion, and suggests that exclusionary practices, even when they reflect the norm
or default procedures, must likewise be held accountable as being purposeful (A common feature of privilege involves a convenient naiveté regarding systematic exclusions and barriers to access.) Taken together, the Tenets offer a road map for implementing an intersectionality framework within the field, beginning with Tenet 1, “Self-Awareness Leads to Better Services for Families,” which calls on infant mental health practitioners to reflect on the impact that multiple systems of oppression have had on our own lives.

3.2 Analytical framework

In addition to serving as a reflective tool enabling a reexamination of who comprises the field of infant mental health, intersectionality theory can also function as an analytical framework guiding the field in critically examining its work. D. W. Winnicott (1960) once famously quipped that “There is no such thing as an infant” (p. 587), meaning that human infants cannot be understood separate of the caregiving relationships on which they depend for survival. It follows that as we develop understandings about infants, we are simultaneously—whether we are aware of this or not—developing understandings about other people and other things as well. Indeed, while the field of infant mental health produces knowledge about infants, it is also contributing to knowledge production regarding parents and caregivers, professionals of various sorts, systems of care, cultural practices, institutional structures, social norms, and global constructs. Sometimes these concomitant knowledge-production projects are explicit. Frequently, however, they are implicit and sometimes entirely unintended.

Intersectionality theory is a useful system for analyzing knowledge-production projects that the field of infant mental health engages in that may be inadvertent, but have significant and often harmful effects. A prime example of this is the heteronormative bias that exists in the vast majority of infant mental health discourse. Families are commonly imagined and represented as heterosexual, nuclear families despite the fact that as the Center for American Progress noted, “According to the Unites States Census, 80 percent of households today depart from the nuclear family model of a married couple and their minor children, as compared with 57 percent in 1950” (Bowman et al., 2016, p. 5). The field of infant mental health is thus grossly out of step with the lived reality of most families when it continues to represent heteronuclear families as a norm against which “other” family and household structures are defined as “alternative,” if not deviant. More complicated than simply failing to keep up with the times, this systematic representational distortion has the effect of regulating norms, reproducing processes of inclusion/exclusion, and assigning disparate values to different families. Adrienne Rich described the injurious effects of invisibilization in this way: “When someone with the authority of a teacher, say, describes the world and you’re not in it, there’s a moment of psychic disequilibrium, as if you looked into a mirror and saw nothing” (as cited in Burt, Gelnaw, & Lesser, 2010, p. 1). In addition to inflicting such psychological wounds, the consistent omission of a wide range of family structures has detrimental material consequences, as the needs and strengths of these “other” families go unaccounted for.

The field of reproductive justice is organized around exposing and redressing this kind of representational injury. As Dorothy Roberts noted, “Reproductive health policy affects the status of entire groups. It reflects which people are valued in our society: who is deemed worthy to bear children and capable of making decisions for themselves” (Asian Communities for Reproductive Justice, 2005, p. 4). Loretta Ross, often identified as the mother of the reproductive justice movement, describes (in her 2017 book coauthored with Ricki Solinger) how racism, sexism, classism, and xenophobia have conspired to constrain and coerce vulnerable groups around their reproductive lives:

> how some groups have been unable to prevent rape and its consequences; how some were unable to avoid official and unofficial programs of sterilization; how many people were unable to control when they got pregnant and whether or not to be the parents of the children they gave birth to. (p. 13)

The common theme is the assault to self-determination regarding reproductive experience, which can only be tolerated by a society that represents certain individuals and groups as less entitled to reproductive autonomy and well-being than are other groups. Infant mental health discourse contributes to this broader social project of meting out reproductive wrongness when it refers to such categories as “the family”, in ways that decontextualize, universalize, and idealize a particular family constellation while obliterating the existence of all others.

Closely related to the pattern of heteronormative bias in infant mental health discourse is what has been identified by the authors of the Diversity-Informed Tenets as “matricentric bias.” This is described as “idealizing (and conversely blaming) biological mothers while overlooking the critical child-rearing contributions of other parents and caregivers including second mothers, fathers, kin and felt family, adoptive parents, foster parents, and early care and educational providers” (p. 15). Terms such as maternal deprivation or maternal sensitivity, powerfully organizing concepts in infant mental health discourse, both signal and perpetuate the matricentric bias in the field, marginalizing nonmaternal caregivers and suggesting via closed-circuit logic that when such caregivers do demonstrate sensitivity or centrality as caregivers, they are functioning as mothers.
Nothing is gained by denying the fact that in most societies, women undertake the lion’s share of caregiving responsibility for small children (and indeed for elderly and ailing people requiring extensive care as well). According to Laslett and Brenner (1989), the term social reproduction refers to:

The activities and attitudes, behaviors and emotions, responsibilities and relationships directly involved in the maintenance of life on a daily basis, and intergenerationally. Among other things, social reproduction includes how food, clothing, and shelter are made available for immediate consumption, the ways in which the care and socialization of children are provided, the care of the infirm and elderly, and the social organization of sexuality. Social reproduction can thus be seen to include various kinds of work—mental, manual, and emotional—at providing the historically and socially, as well as biologically, defined care necessary to maintain existing life and to reproduce the next generation. (pp. 381–382)

To achieve gender equity, note the extent to which this kind of labor falls to women, freeing men to spend their time and energy otherwise—engaged in activities involving remuneration, for example, or in leisure or other self-fulfillment activities. Sociologist Arlie Hochschild’s well-known 1989 study The Second Shift documented the fact that even after many middle- and upper class White American women—that is, groups that had previously not worked outside of their homes—entered the labor force in the 1970s, they continued to be responsible for most of the work of social reproduction, maintaining roughly the same gendered division of labor as prior to their being employed, but working double time. Patterns of gender-based disparities in social reproductive labor persist in the 21st century around the globe.

But recognizing that women tend to be disproportionately responsible for childrearing and other aspects of social reproduction does not necessitate or justify representing biological mothers as the only salient caregivers. Indeed, the matricentric bias often impedes accurate perceptions of who is actually doing what kind of caregiving. Often the considerable childrearing labor of paid caregivers that is a reality for many families, for example, is entirely obscured in infant mental health accounts of typical socioemotional development, attachment patterns, family dynamics, and so on. Within an intersectionality framework, the experiences and contributions of paid caregivers would be registered and attended to, enabling a fuller understanding of small children’s actual relational matrix, but also laying the groundwork for understanding and advocacy on behalf of this workforce, which is easily exploited as long as it remains invisible, and has been referred to as a “shadow” labor force (Macdonald, 1998). The matter of paid childcare is a concern of the reproductive justice movement, as women comprising this labor force are frequently disenfranchised and face many barriers to self-determination around their own parenting. Patterns of globalization and immigration influence which groups of women contribute caregiving labor to which employing families where. As the field of infant mental health embraces an intersectionality framework, it becomes clear that the well-being of all the infants and caregivers in these scenarios, not just that of the employers and their offspring, must be safeguarded. This instantly moves the field in the “action-oriented” direction noted earlier, as gross class- and race-based inequities currently divide the families in question.

Closely related to the heteronormative and matricentric biases in infant mental health discourse is the common pattern of reproducing the gender binary system. Representing heterosexual nuclear families as the norm and biological mothers as default primary caregivers usually goes hand in hand with shoring up discursive and institutional practices that admit of only two preordained genders. As sex assignment typically occurs at birth (if not during pregnancy), and gender is often a highly charged construct for families and a prime axis of socialization and intergenerational transmission, it would seem that the field of infant mental health would be uniquely positioned to protect gender fluid and nonconforming people (both infants and parents) and to open up possibilities of understanding and insight related to gender for everyone. On the contrary, however, the facts of gender-diverse parenthood historically rooted in advocacy on behalf of women and girls, has rapidly incorporated a critique of the exclusionary logic of the gender binary system, and works to recognize, embrace, and give voice to transpeople around their reproductive agency and wellness. Ross and Solinger articulated several principles that guide the movement, stating:

As reproductive justice authors, we do not want to duplicate the prejudices that make transgender people invisible and vulnerable. Inclusive language reflects a commitment to the idea that not everyone who can get pregnant and have children is a woman … and, in addition, that not all women can or do get pregnant and give birth … [and], reproductive decision making is about the lived experience of individuals, including, for many persons, their drive to possess reproductive autonomy as part of their achievement of full personhood. (pp. 6–7)
Ross and Solinger advocated the use of people who can get pregnant and give birth as more inclusive than “women.” Oparah and Bonaparte (2016) similarly argued for the terms birthing parent and pregnant people “to remind us that people who give birth do not universally identify as women” (p. 16), and they also sought out and include the perspective of a “transdad” in their volume to counter the invisibilization of trans parents.

In his book Transgender Children and Youth: Cultivating Pride and Joy with Families in Transition, Elijah Nealy (2017) asserted that “neither parents nor children are required to justify their affirmed gender; it is understood that even young children are fully capable of recognizing and naming their gender identity, whether trans or cisgender” (p. 48). Nealy also described a historical shift in nomenclature from gender-variant or gender-nonconforming to the more affirming terms gender-diverse, gender-expansive, and gender-independent. The intersectionality framework enables the infant mental health field to recognize and support the healthy existence of trans and gender-expansive families, developing trans and gender literacy as a basic professional competency rather than a rarified area of specialization.

As an analytical tool, then, the intersectionality framework supports the field of infant mental health in critically examining the unintended by-products, implicit biases, systematic exclusions, and harmful repetitions of structural inequities in our research, writing, and practice. In so doing, this framework opens up possibilities for the field to work in more inclusive ways, center the experiences and voices of silenced and disenfranchised infant/family communities, and counter historical injustices.

### 3.3 Methodology for promoting social justice

In a recent volume documenting the history and contemporary applications of the intersectionality framework, Collins and Bilge (2016) emphasized its action-orientation. They wrote:

> Practitioners and activists are often frontline actors for solving social problems that come with complex social inequities… Teachers, social workers, parents, policy advocates, university support staff, community organizers, clergy, lawyers, graduate students, and nurses often have an up-close and personal relationship with violence, homelessness, hunger, illiteracy, poverty, sexual assault, and similar social problems. For practitioners and activists, intersectionality is not simply a heuristic for intellectual inquiry but is also an important analytical strategy for doing social justice work. (p. 42)  

Infant mental health practitioners likewise often have “up-close and personal relationships” with the devastating impact of interlocking systems of oppression on infants and families, and can draw on the intersectionality framework as praxis—as a strategy for doing infant mental health work as social justice work. Reproductive justice offers a road map.

In a recent article outlining the reproductive justice implications of infant mental health work, Lauen et al. (2017) posed the following questions of the field of infant mental health:

- How do racial, economic, and gender injustices show up in systems, policies, and practices, and can we mitigate their effect on the families we serve?
- What do racial and income disparities in reproductive, maternal, and infant health outcomes mean for how we approach our practice in IMH [infant mental health]?
- How, in our roles, can we best support access to all reproductive and maternal health care options and facilitate empowered decision making for our families?
- How does cultural and political stigma related to sexuality, reproduction, motherhood, fatherhood, and parenting affect our ability to support our families? (p. 43)

Answers to these questions offer springboards into infant mental health work as intersectional praxis. Race, gender, and class-based inequities are abundantly evident in health, well-being, resource, and access disparities impacting the infants and families served by infant mental health practitioners. Arenas sorely in need of intersectionality-based intervention by infant mental health practitioners include child welfare, the prison industrial complex, early care and education, immigration policies, and the field of obstetrics and gynecology. Points of departure must be grounded in recognition of the particular histories of oppression within each system, and the specific historical trauma suffered by diverse groups in relation to each system. At the heart of the matter is the radical conviction that the rights of infants articulated by the WAIMH must be upheld universally, and the recognition that this will entail a great deal more advocacy in partnership with and on behalf of some infant/families than others to counter historical and contemporary injustices. The promise, to borrow from Asian Communities for Reproductive Justice (2005), is no less than “the complete physical, mental, spiritual, political, economic, and social wellbeing” (p. 1) of all infant/families.

### 4 Conclusion

This article has offered just a few examples of how the intersectionality and reproductive justice frameworks can be deployed by infant mental health professionals to critically examine our knowledge-production processes and
institutional practices and to move in the “action-oriented” directions that our dedication to the well-being of infants and families necessitates. When diverse infants and families are centered in the field and their perspectives, voices, and interests directly registered, powerful things happen. Implicit bias, intractable as long as it remains inaccessible to conscious reflection, is exposed to the light of day. Stigma, always based in disavowal, and always corrosive, gives way to mutual recognition and pride. Historical trauma, perpetuated via silence and historical amnesia, becomes accessible to healing and reparation. And victimization gives way to agency. The WAIMH position paper endorses the 10 principles of the United Nations Convention on the Rights of Children, the last of which states that all children shall be “protected from practices which may foster racial, religious, or any other form of discrimination” (p. 5). The field of infant mental health came into being to serve a protective function on behalf of infants. By subjecting itself to intersectional analysis and deploying intersectional practices in all of its undertakings, the field will ensure that it is on the side of protection from, rather than reproduction of, practices that foster discrimination. The reproductive justice movement, which has spent the past 20 years linking international human rights laws to local issues and communities to create meaningful, relevant change for those whose rights the movement aims to protect, can teach the field of infant mental health how to scale its insights and hone its practices toward equity and inclusion. Already inherently interdisciplinary, the field of infant mental health can open its professional borders and recognize itself as part of a global movement for human rights and social justice.

CONFLICT OF INTEREST
The author declares no conflict of interest.

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**APPENDIX**

**DIVERSITY-INFORMED TENETS FOR WORK WITH INFANTS, CHILDREN, AND FAMILIES**

www.diversityinformedtenets.org

Irving Harris Foundation Professional Development Network Tenets Working Group

**CENTRAL PRINCIPLE FOR DIVERSITY-INFORMED PRACTICE**

1. **Self-Awareness Leads to Better Services for Families:** Working with infants, children, and families requires all individuals, organizations, and systems of care to reflect on our own culture, values and beliefs, and on the impact that racism, classism, sexism, able-ism, homophobia, xenophobia, and other systems of oppression have had on our lives in order to provide diversity-informed, culturally attuned services.

**STANCE TOWARD INFANTS, CHILDREN, AND FAMILIES FOR DIVERSITY-INFORMED PRACTICE**

2. **Champion Children’s Rights Globally:** Infants and children are citizens of the world. The global community is responsible for supporting parents/caregivers, 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 and children in their care. Privilege constitutes injustice. Diversity-informed practitioners acknowledge privilege where we hold it, and use it strategically and responsibly. We combat racism, classism, sexism, able-ism, homophobia, xenophobia, and other systems of oppression within ourselves, our practices, and our fields.

4. **Recognize and Respect Non-Dominant Bodies of Knowledge:** Diversity-informed practice recognizes non-dominant ways of knowing, bodies of knowledge, sources of strength, and routes to healing within all families and communities.

5. **Honor Diverse Family Structures:** Families decide who is included and how they are structured; no particular family constellation or organization is inherently optimal compared to any other. Diversity-informed practice recognizes and strives to counter the historical bias toward idealizing (and conversely blaming) biological mothers while overlooking the critical childrearing contributions of other parents and caregivers including second mothers, fathers, kin

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and felt family, adoptive parents, foster parents, and early care and educational providers.

**PRINCIPLES FOR DIVERSITY-INFORMED RESOURCE ALLOCATION**

6. **Understand That Language Can Hurt or Heal**: Diversity-informed practice recognizes the power of language to divide or connect, denigrate or celebrate, hurt or heal. We strive to use language (including body language, imagery, and other modes of nonverbal communication) in ways that most inclusively support all children and their families, caregivers, and communities.

7. **Support Families in Their Preferred Language**: Families are best supported in facilitating infants’ and children’s 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 when doing any work with or on behalf of infants, children, and families. Resource allocation includes time, money, additional/alternative practices, and other supports and accommodations, otherwise systems of oppression may be inadvertently reproduced. Individuals, organizations, and systems of care need ongoing opportunities for reflection in order to identify implicit bias, remove barriers, and work to dismantle the root causes of disparity and inequity.

9. **Make Space and Open Pathways**: Infant, child, and family-serving workforces are most dynamic and effective when historically and currently marginalized individuals and groups have equitable access to a wide range of roles, disciplines, and modes of practice and influence.

**ADVOCACY TOWARDS DIVERSITY, INCLUSION, AND EQUITY IN INSTITUTIONS**

10. **Advance Policy That Supports All Families**: Diversity-informed practitioners consider the impact of policy and legislation on all people and advance a just and equitable policy agenda for and with families.

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