# FROM TENET TO PRACTICE

## *Putting Diversity-Informed Services Into Action*


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The Diversity-Informed Infant Mental Health Tenets, created by members of the Irving Harris Foundation Professional Development Network, provide guiding principles for the infant mental health field to address some of the racial, ethnic, socioeconomic, and other inequities in our society (see St. John, Thomas, & Noroña with the Irving Harris Foundation Professional Development Network Tenets Working Group, this issue, p. 13, for a full discussion of the Tenets). The following vignettes will be used to provide examples of how the Tenets can guide practice when working with young children and families.

### MARCUS, JUSTIN, TIA, ANITA, AND JAMES

*Marcus, 50 months old; Justin, 31 months old; and Tia, 13 months old, were placed in kinship care after their mother, Anita, 24 years old, called the police to report an incidence of domestic violence. When the police arrived, they determined that Marcus had witnessed his mother and her boyfriend, James (Tia's dad) fighting. There had been other reports of domestic violence. James was arrested and would no longer be in the home, but the investigating social worker decided to remove the children from Anita's care because of her failure to protect him. Nine months later, although Anita has complied with all aspects of her reunification plan, she and her children have yet to be reunified. The social worker has told Anita that, unless she separates from James, she will not get her children back. Anita says she is not with James, but she notes that the court has given James visits with the children. Anita, James, and all the children are African American.*

### CLARA, SUSANA, AND MARISOL

*Clara, 28 months old, was recently diagnosed with mild autism. Her mother, Susana, 29 years old, was born and raised in the United States but speaks predominantly Spanish. She grew up in Texas near the Mexican border and now resides in Arizona. Both her parents were immigrants from Guatemala. As a single mother, she works long hours so she can provide for Clara; her other daughter, Marisol, 12 years old; and family members in Guatemala. Both medical and child care providers have made numerous referrals for Clara, but Susana does not follow through. They note that when they ask if they can help, she says only God can help, and she is praying that he will give her strength.*

### SAMMY, JOSH, AND DAVID

*Sammy was recently placed with Josh and David in the hopes that they might become his adoptive parents. Although Sammy is 30 months old, this is his fourth placement. He has significant speech and language delays; he gorges himself on food; and he walks up to strangers, especially women, and asks to be picked up. Sammy is Latino. Josh and David are White.*


### Abstract

**The Diversity-Informed Infant Mental Health Tenets provide guidelines for addressing inequities in American society. Embedding the Tenets into infant mental health systems requires intentionality and careful consideration. With the use of vignettes, this article examines each Tenet and how infant mental health practitioners, agencies, and systems can begin to incorporate the Tenets into their daily practice.**

**LUZ, TERESA, AND PAOLO**

*Luz, 44 months old, and her parents, Teresa and Paolo, are undocumented immigrants who left Mexico after a home invasion and robbery in which Luz's older brother was killed. Luz has missed many days at preschool because of a persistent stomachache. Her mother says that, on school days, Luz refuses to leave the house, cries inconsolably, clings to her mother, and says she's in pain. She has been seen by several different specialists, and no organic cause has been identified for her pain. A day care consultant has begun to work with Luz and her mother. During one meeting, the consultant said to Luz that she knows many children whose tummy hurts when they are scared. Luz got on her mother's lap and began to cry. "Qué te pasa Luz, qué te pasa?" ("What is happening Luz, what is happening?") her mother asked. Luz replied, "No quiero que la migra te lleve" ("I don't want 'la migra' [immigration] to take you away"). Luz's father is not sure he wants Luz to be in school. He feels she should stay home with her mother. He thinks Teresa has put her in day care so she can work, and he is not in favor of Teresa working.*

**KYLIE, KAYLA, AND GRANDMA NAT**

*Kylie was born premature, approximately 29 weeks gestational age, through an emergency C-section. She was intubated and remained in the hospital for 1 month. She was then released to her mother, Kayla. Kayla is 16 years old. She reportedly used drugs (methamphetamines, marijuana, and alcohol) during the first trimester of her pregnancy, but she says she has been clean since then. Kayla and Kylie reside with Kayla's maternal grandmother, Natalie. Grandma Nat does little with Kylie. She says that Kylie is Kayla's baby and her charge to raise. Grandma Nat is very religious. She believes that if Kayla prays hard, God will show her the way, both in sobriety and motherhood. At Kylie's 4-month pediatric visit, the doctor became concerned because Kylie was seriously underweight. Kayla had also missed some of the pediatric visits. The pediatrician sent a nurse to the home. The nurse observed that Kylie kicked and struggled as Kayla tried to feed her. Kayla looked distant, and Natalie refused to step in and help. Kylie, Kayla, and Grandma Nat are White. Grandma Nat is originally from Memphis, Tennessee.*

All infant mental health practitioners work with children like Marcus, Justin, Tia, Clara, Sammy, Luz, and Kylie. These practitioners may have different roles (e.g., direct service, supervision, administration, policy, or research) and different disciplines (e.g., mental health, early education, child care, home visiting, nursing, occupational therapy, child welfare), but the Tenets have important practice implications for them all. If they believe in the Tenets and choose to adopt them, they will need to think about whether what they currently do is consistent with the Tenets and other social justice values. Practitioners will need to consider changes they have to make to more closely adhere to these principles, and they will need time and support as they attempt to integrate the Tenets into their daily work.

## Implementing the Diversity-Informed Infant Mental Health Tenets

BELOW ARE EXAMPLES of how each Tenet acts as a beacon, guiding all of us in the infant mental health field and highlighting the challenges that might be faced and addressed in working with young children and their families. We hope that reflecting on the work in this way helps each of us begin to think about how to translate aspirations for "cultural competence" and a desire to eliminate racial and socioeconomic disparities that are so often found in all systems (Snowden & Yamada, 2005; U.S. Public Health Service, 2000) into real changes in practice.

**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.*

Working with families like the ones described earlier, Tenet #1 brings reminders of the importance of acknowledging and confronting biases that might affect a practitioner's interactions and decisions. Marcus' mother, Anita, is a young African American woman with three children from two different partners. Her current partner, James, is a young African American man with a record for being violent. They are individuals, yet they evoke racist stereotypes of lower income African Americans. Might these stereotypes, held by individuals and embedded in systems, be contributing to the protracted separation between Anita and her children? Anita was initially resistant to receiving the multiple services she was mandated to complete. Had her providers responded to her initial hostile affect and categorized her using stereotypes, she may not have completed her reunification plan. Instead, they listened to her, validated her perspective, and were able to engage her in services.

Each of the families described may bring up feelings for us as practitioners because of the challenges they face and what they represent. We may have a reaction to working with Luz and her parents because they are undocumented immigrants and we may have concerns about them utilizing U.S. resources and tax dollars. We may be frustrated with Susana. She was raised in the United States but doesn't speak much English. We might have feelings about whether Josh and David, two gay men, should be able to adopt a child or we might have a reaction as to whether they, as White men, should raise an ethnic minority child. Kayla is White, but she is not safe from bias. Many would view her as an unfit teen mother, a former substance abuser who is incapable of providing adequate care to a fragile infant.

How often do any of us in the infant mental health field seriously consider our potential biases and reflect on how they affect our work? Neurobiological research has shown that human's brains are hardwired to respond to people who are different from ourselves and to make instant associations and assumptions (Devine, 1989; Kubota, Banaji, & Phelps, 2012). As practitioners, we might try to banish certain thoughts, recognizing them as ugly, but we need to recognize that we are aware of stereotypes that are held in American culture even when they are inconsistent with our beliefs. What is less helpful is to give in to stereotypes, not challenge them, and fail to see the individuals and recognize their struggles. As we work with caregivers like those described in the vignettes, many of us as practitioners will need to recognize that we were fortunate to grow up with some forms of privilege and that this may have allowed us to make different choices than the caregivers with whom we work. If we craft interventions, design policy, or conduct research, thinking that these come from science or clinical experience and are therefore value neutral, we may see that we have unintentionally introduced our biases where we least wanted to do so.

**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.*

Tenet #2 is a reminder that, regardless of an individual practitioner's personal values, the field recognizes that the first 5 years of life are critical to the healthy development of all children, and as practitioners we do all that we can to support them and their families. Luz's distress is no less

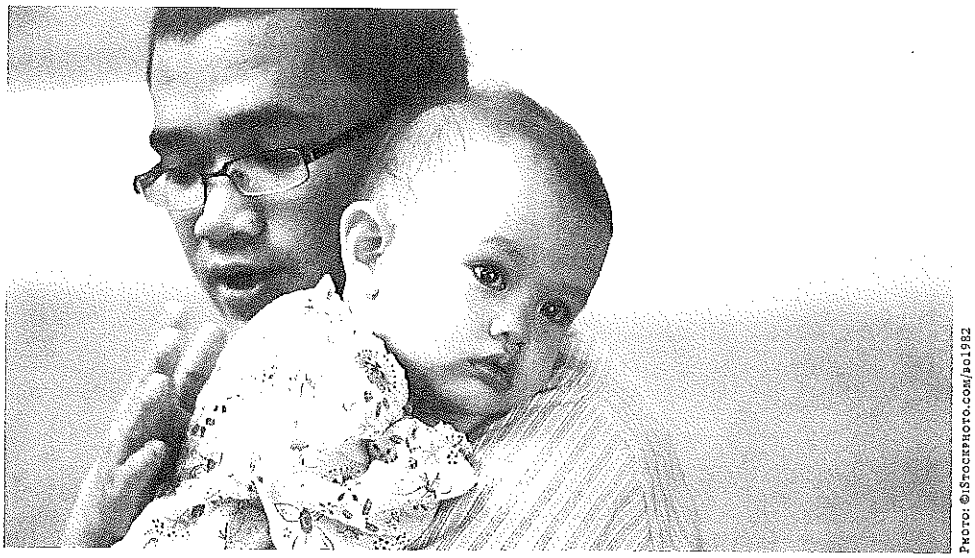
important because she is an undocumented immigrant. In fact, it is important to recognize that when young children or their family members are labeled and treated as "illegal," this presents numerous risks for their cognitive and socioemotional development (Gonzales, 2011; Potochnick & Perreira, 2010; Suárez-Orozco, Yoshikawa, Teranashi, & Suárez Orozco, 2011; Yoshikawa & Kali, 2011). Approximately 1.8 million children belong to what has been called the 1.5 generation (Gonzales, 2007). These children, like Luz, arrived at an early age to the United States, tend to be bicultural and predominantly fluent in English, and often have little attachment to their home country (Immigration Policy Center, 2011). Because of their immigration status, their lives are restricted and uncertain, and their "dreams are deferred" (Gonzales, 2007, 2011). Legal status does not determine need for services. Although it may be difficult, as infant mental health practitioners, we are committed to providing services to those in need, regardless of partisan politics and policies.

### 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.*

As described in Tenet #1, work to combat discrimination begins within each person. If we as practitioners find ourselves wondering whether Josh and David can be good parents to Sammy, we must understand how bias may be affecting our view. Do we see Josh and David as caregivers and not just as gay men or White men? Can we recognize their strengths? In what ways are the men connected to Sammy, and is he connected to them? Why might it be in Sammy's best interests to have them as parents, even if some practitioners may hold the opinion that they do not represent ideal parents? We do not want to make decisions based solely on race or sexual orientation; these are not the factors that determine whether a person is a good caregiver for a particular child.

The Tenets guide practitioners to be aware of potential discrimination in service sectors and address it. As practitioners we might inquire as to why Anita is still not reunified with her children given that she has complied with her reunification plan. We might wonder whether there are relevant facts we may not know or whether the decision is influenced by the fact that she fits a specific profile associated with risk. If this profile is based predominantly on external factors (e.g. race, socioeconomic status, the neighborhood where she lives), we will need to recognize that the profile, while potentially associated with risk, is also one that is likely to lead to discrimination both on a person-to-person level and on a systemic level.



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**Families may have different belief structures and different ways in which they believe healing occurs.**

### 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.*

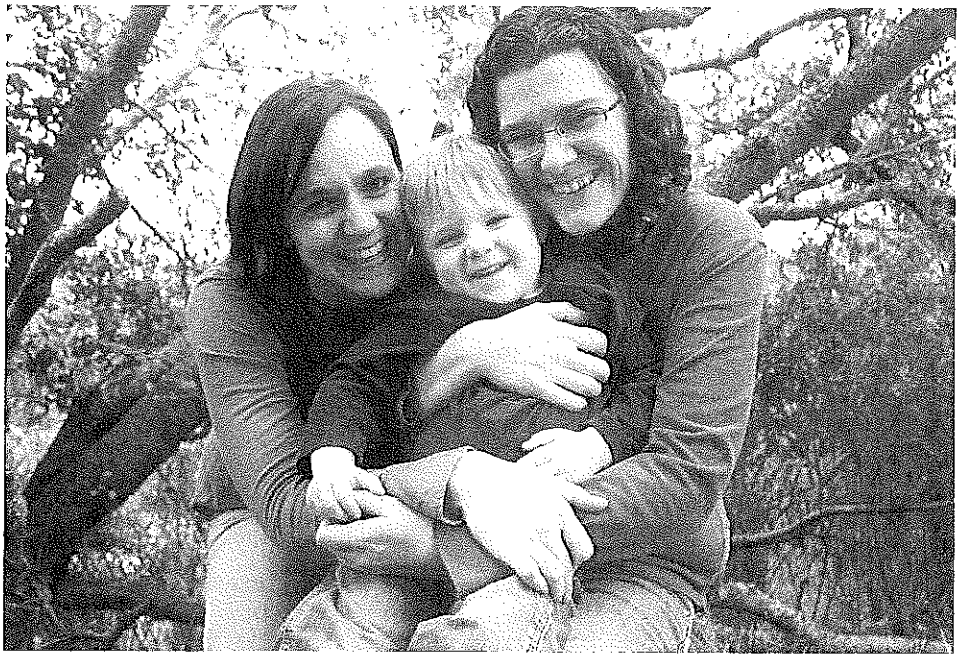
The families being served may have different belief structures and different ways in which they believe healing occurs. For example, David and Josh have different ways of parenting Sammy. They tend to engage in more physical rough play and have different strategies for helping Sammy when he gets hurt. When Sammy skins his knee, David uses a baseball metaphor: "You're safe," he calls out. When Sammy points at his knee, David smiles and says, "You're tough. Tough guys get up." Sammy, in turn, responds by dusting himself off. It may seem odd or unusual to consider that two White men have nondominant bodies of knowledge, but as the infant mental health field becomes increasingly female dominated, we and all its members will need to ensure that we are aware of our own biases and remain open to a male perspective.

Clara's mother, Susana, believes that only prayer and God can help with Clara's autism. As practitioners, we may not share her beliefs, but we need to recognize the incredible comfort and strength Susana derives from them. Through God, she finds the patience to parent Clara. She finds the strength to work long hours and then return home to interact with her children. Practitioners may support her in her beliefs because her beliefs offer her support and may also encourage her to become part of a church community and to visit with a priest to see how to help Clara. Beyond her religious beliefs, Susana may have other nondominant beliefs about autism. She was raised in the United States, but her parents are Guatemalan Mayans, and she grew up in a rural area near the Texas–Mexico border. It will be important to think about how her family and her community understand what it means that Clara has "autism." In her community, how are children with behaviors of this type typically seen and helped? Are there aspects of her culture that might be protective and could be integrated into medical or therapeutic treatment?

### 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.*

Of the families described earlier, only one—Luz's family—has a nuclear family structure. Susana is a single mother, and



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**It is not the structure of the family that determines whether the child will thrive but the quality of the relationships.**

her 12-year-old daughter, Marisol, serves as both Clara's big sister and a key caregiver. Marisol picks Clara up from day care and spends 3 hours caring for her until her mother returns from work. Susana wonders if Marisol could bring Clara to her appointments, get information from providers, and then pass it along to her. How do we as practitioners feel about a 12-year-old assuming the role of a key caregiver? It is the reality of their lives. Kylie, Kayla, and Grandma Nat are a family. Grandma Nat does not involve herself in Kylie's care, but she nevertheless plays a key role in the family, advising and teaching Kayla about her responsibilities. When a service provider works with the family, it is critical that they respect and engage Grandma Nat. Josh and David are Sammy's fathers. Sammy seeks out women, in part, because his biological mother abandoned him. Even if he were placed in a family with a heterosexual nuclear family structure, he would have to make meaning of this experience. Josh and David are more than capable of nurturing him and helping him as he expresses how difficult it is to have lost his mother. Anita and James both want to be involved in their children's lives. They are ex-boyfriend and ex-girlfriend and don't know if they want to be together, but they would like to be able to make this decision rather than have the courts or the child protective service system unilaterally determine their family structure. How do we as practitioners consider safety and simultaneously honor the parents' ability to make their own choices? Diversity-informed practitioners understand each family's right to determine both who is considered part of the family and their different roles. We understand that it is not the structure of the family that determines whether the child will thrive but the quality of the relationships.

Besides the caregivers described in the vignettes, Marcus, Justin, Sammy, Luz, and Clara all have day care providers who are partners in helping them develop. Any intervention with Clara will be strengthened if it involves both her family and her day care providers. Luz, Marcus, Justin, and Sammy's day care providers can provide them with better support if their parents feel safe enough to openly share their experience with them. Josh and David shared that they are two gay men raising a boy. They told the day care that Sammy was abandoned by his mother, has had multiple placements, and worries about being left. They want him to be able to have positive relationships with women. Sammy's teacher, Miss T., offers Sammy a different experience with women. She plays a critical role in shaping Sammy's beliefs about whether he can be loved and cared for by women. Josh and David recognize her importance and have asked her to babysit for them even after Sammy leaves her center. She is now part of their extended family.

### 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.*

Verbal and written communications convey information beyond words, including power and social status and one's implicit beliefs. What is not said or written as well as how we as practitioners say or display things often affects families, despite our best intentions. As adoptive fathers, Josh and David have noted that many of the forms they needed to sign—to get Sammy an individualized education plan, at the speech therapist's office, and as participants in a research study on adoption—had lines for the mother's and father's signatures. The forms they fill out remind them that their relationship is unacknowledged and even rejected by many in society. Kayla and Grandma Nat talk a lot about their former providers and the way the providers talked to them. Although they all spoke English, there were differences in the language that they used. There was the educated nurse who explained everything using technical terms. She made Kayla feel dumb. Kayla felt she was supposed to understand things, and so she just smiled and nodded even when she didn't understand. There was the "uppity" occupational therapist who came to the house. She only came once. Grandma Nat said she wasn't going to have anyone in her house who looked down her nose at them. Kayla noted, "It wasn't what she said, but the way she said it." Then there was Ariel, the second home visiting nurse. Ariel said that the medical terms were hard to understand for her, too. She talked in clear, simple language and even drew pictures to explain how Kylie's body worked. It seemed hard to think that she and the first nurse were saying the same thing. She called Grandma Nat by her last name, which Grandma Nat liked because it showed that Ariel had good Southern manners and knew how to respect her elders. Marisol, Teresa, and Paolo shared how confused they felt when they received forms and handouts in English. Although they wanted services, they didn't know what to do with all these papers they could not understand, and they felt that perhaps the services were not really for people "like them." The papers sent an unintended message of exclusion and negatively affected these families' engagement with services.

### 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.*

Tenet #7 clearly highlights the need for bilingual service providers when working with a monolingual non-English-speaking

family, but it also suggests the need to consider language when working with bilingual families. Clara's day care worked hard to integrate services for her. She was initially working with an English-speaking developmental specialist, but the day care staff advocated for her to change to a Spanish-speaking provider. They wanted to support her interactions and language development in Spanish, as this is the primary language of her home. It might be hard for the family if she progressed in English but was not able to connect in the same way in Spanish. Moreover, the Spanish-speaking provider could communicate better with her mother, Susana. Susana speaks fair English, but her emotional language is clearly Spanish, and when she is trying to help Clara and working through her feelings about Clara's autism, it is hard for her to share all that she is going through in English.

### 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 ongoing training or consultation opportunities are embedded in agencies, institutions, and systems of care.*

Many of the aforementioned examples present the careful thought and time it takes us as practitioners to become aware of our biases, craft service plans, conduct research, or set policies that consider diversity. Sammy's speech therapist heard Josh and David's remarks. She recycled her old forms and made changes because she wanted to eliminate the bias she now saw. It was a small but important change, despite the cost of new forms. Clara's day care providers were able to hold a meeting in Spanish, where they met with the developmental specialist and the mother and discussed the different options for Clara's treatment. They talked about how they each felt about Clara's getting services in English or Spanish and developed a plan, recognizing that it might change as Clara became older and would transition to an English-only school. Marcus, Justin, and Tia's social worker obtained consultation from an outside consultant. They jointly and openly talked about how the family's race affected the worker's perception of safety. It took considerable time, safety, and allocation of resources for this conversation to take place, but it resulted in a shift in practice. These small shifts that reflect justice and inclusion can deepen connections and provide a higher level of service for families.

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### 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.*

The work of enhancing diversity-informed practice is the work of a team, not of a few members of the team who perhaps are ethnic minorities. Luz's child care consultant, Andrea, typically has a higher caseload because there are more Spanish-speaking families in need of services. She believes that the families she serves require more case time because of immigration-related stress and fears related to their legal status and that this affects both their ability to use services and her stress as she works with them. Andrea's new agency seems different from the one she recently left. They recognize the need to hire and train more Spanish-speaking practitioners and are mentoring Andrea to serve as a leader. During case conferences, practitioners of all ethnicities actively talk about how the family's immigration status and cultural beliefs affect the work; she is not the lone voice highlighting diversity-related factors. As the agency works to be more inclusive, many practitioners have begun to recognize the tremendous privilege they enjoy and have started talking about how their assumptions about service delivery may not apply to those who have not shared a similar upbringing. They have also become more consciously aware of other communities they have not served as effectively. They are in an area that serves a large Vietnamese immigrant population. They are beginning to think about how they can recruit, train, and learn in partnership with Vietnamese staff to serve that population better. They understand that, as they do this, their agency and practitioners will likely need to change and grow. Andrea's current agency serves as an example of a diversity-informed system. They increase their capacity to effectively serve diverse populations by actively considering how diversity affects their work and by training, hiring, and mentoring staff from the underrepresented communities that they serve.

### 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.*

The ZERO TO THREE Policy Center motto is "I am a big voice for little kids" (zerotothree.org). As we and other practitioners identify discriminatory policies that harm young children and their families, we will need to raise our voice against these policies. For example, as can be seen with Luz, current policies around the deportation of immigrants have negative consequences for their children's development. Although individuals may have differing political views related to undocumented immigrants, policies allowing caregivers to be rounded up, detained, and sent back to their country—often without any ability to let their children know what has happened (Wessler, 2012)—are in opposition to the core values of the infant mental health field. This type of separation is traumatic to a young child, can negatively affect the child's development, and may lead to the need for costly services in the future. Moreover, practitioners might reflect on whether all undocumented immigrant families are treated this way through policy or procedure. Do similar things happen to families from France, England, or India who remain in the U.S. without visas, or is this much more common with lower income, Latino immigrants?

As practitioners, when we work with families like Anita and James, we may need to recognize that these are young, lower income African American caregivers who feel that they have little power or privilege to confront the immense power of the child welfare system that may perpetuate the historic systemic separation of African American families in the United States. How will we as practitioners lend our voices as advocates to the parents' struggle to stay together as a family? How will we as practitioners remain mindful of safety but develop service plans that give the family the best chance of healing from violence? How might we as practitioners use our experience to work toward changing policy? We might consider partnering with others to develop policies that help child welfare workers better understand the effect of historical trauma on African American families and help them develop service plans that can be used to reunite families with histories of domestic violence if those family members decide they want to be together. Using a diversity-informed lens, practitioners can strive to create policies that

ensure equal treatment regardless of race or socioeconomic status.

It is not easy to confront the aspect of human nature that leads an individual to embrace some groups and exclude others, but engaging in this struggle is key to the core values of the infant mental health field. We hope that the Tenets help us and all professionals in the infant mental health field clearly see pathways for change that move us toward diversity-informed practice.

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**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 neonatal intensive care unit 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.*

**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, 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, she partners with local and national grantees to build the capacity of organizations and systems to incorporate child development best practices into their work. She has been instrumental in creating the Diversity-Informed Infant Mental Health Tenets, a list of 10 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.*

## *References*

Devine, P. G. (1989). Sterotypes and prejudice: Their automatic and controlled components. *Journal of Personality and Social Psychology, 45*(1), 5–18.

Gonzales, R. (2007). Wasted talent and broken dreams: The lost potential of undocumented students. *Immigration Policy Center: In Focus, 13*(5), 1–10.

Gonzales, R. (2011). Learning to be illegal: Undocumented youth and shifting legal contexts in the transition to adulthood. *American Sociological Review, 76*(4), 602–619.

Immigration Policy Center. (2011). *The Dream Act: Creating opportunities for immigrant students and supporting the U.S. economy.* Washington, DC: Author. Retrieved from www.immigrationpolicy.org

Kubota, J. T., Banaji, M. R., & Phelps, E. A. (2012) The neuroscience of race. *Nature Neuroscience, 15*(7), 940–948.

Potochnick, S. R., & Perreira, K. M. (2010). Depression and anxiety among first-generation immigrant Latino youth: Key correlates and implications for future research. *Journal of Nervous and Mental Disorders, 198*(7), 470–477.

Snowden, L. R., & Yamada, A. (2005). Cultural differences in access to care. *Annual Review of Clinical Psychology, 1*, 143–166.

St. John, M. S., Thomas, K., & Noroña, C. R., with the Irving Harris Foundation Professional Development Network Tenets Working Group. (2012). Infant mental health professional development: Together in the struggle for social justice. *Zero to Three, 33*(2), 13–22.

Suarez-Orozco, C., Yoshikawa, H., Teranashi, R. T., & Suarez-Orozco, M. (2011). Growing up in the shadows: The developmental implications of unauthorized status. *Harvard Educational Review, 81*(3), 438–472.

U.S. Public Health Service. (2000). *Report of the Surgeon General's Conference on Children's Mental Health: A national action agenda.* Washington, DC: Department of Health and Human Services.

Wessler, S. F. (2012). Deported dad begs North Carolina to give him back his children. *Color Lines News for Action.* Retrieved from http://colorlines.com/archives/2012/02/deported_dad_begs_north_carolina_not_put_kids_into_adoption.html

Yoshikawa, H., & Kali, A. (2011). The effects of parental undocumented status on the developmental contexts of young children in immigrant families. *Child Development Perspectives, 5*(4), 291–297.