



## Teenage Childbearing, Reproductive Justice, and Infant Mental Health

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### Abstract

Reproductive justice advocates emphasize the rights of women to choose to have children, to decide the conditions under which they give birth, and to parent their children with support, safety and dignity. This paper examines what a reproductive justice perspective contributes to infant mental health work with teenage mothers and their families. It explores the historical framing of teenage pregnancy in which young mothers are the cause of a variety of social problems and in which the primary policy and practice approach is pregnancy prevention. The paper offers alternative framings of teenage childbearing, based on reproductive-justice principles, which focus on social conditions surrounding teenage parenthood and the meaning of motherhood in the lives of young women. These alternative frames shift the practice agenda to eradicating unjust social conditions and providing supports for young women in their roles as parents. The paper then describes ways in which two infant mental health programs have incorporated reproductive justice principles into their work with young families: Chicago's community doula model and Florida's Young Parents Project for court-involved teenage parents. Finally, the paper extracts a set of principles deriving from a reproductive justice perspective that are relevant to infant mental health work with young families.

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## Teenage Childbearing, Reproductive Justice, and Infant Mental Health

The reproductive justice movement was launched by feminist activists of color in 1994 to expand the conversation about reproductive rights beyond access to choice in reproductive health and to link to a broader set of social justice issues. The primary reproductive rights issue for white women in America has been access to birth control and abortion services. For women who hold marginalized social identities, an additional human rights issue is their right to be parents and to be considered “legitimate” mothers (Ross & Solinger, 2017, p. 4). The reproductive justice perspective has expanded the reproductive rights conversation to include, not only women’s rights to choose not to bear children, but also their rights to have children, to decide the conditions under which they give birth, and to parent their children with support, safety and dignity (Luna & Luker, 2013; Ross, Roberts, Derkas, Peoples, & Toure, 2017; Silliman, 2004). Through an emphasis on the conditions in which women have the right to parent, the reproductive justice perspective can inform approaches to infant mental health practice.

Central to a reproductive justice perspective is the feminist focus on intersectionality for understanding the complexities of women’s lives (Asian Communities for Reproductive Justice, 2005; Crenshaw, 1991; Mays & Ghavami, 2018; Rosenthal, 2016). All people have multiple interlocking social identities, including those related to race, class, gender, sexual orientation, ability, immigration status, ethnicity, social class, marital status, and the foci of this paper— young age and motherhood. Social hierarchies and structures use these markers of difference to confer power and privilege, but also to oppress and deprive. Social identities operate interdependently, and their meaning cannot be considered in isolation. Thus teenage motherhood is not a single issue, but a phenomenon that in America is deeply entangled with contemporary and historical issues of race, poverty, and marital status. The intersectional approach embraced

by the reproductive justice perspective demands that teenage mothers be viewed with respect to their multiple marginalized social identities and understood through the social, political, and historical contexts in which they live and raise their children.

The goal of this paper is to examine what a reproductive justice perspective might contribute to ways in which the field of infant mental health considers work with teenage mothers—a marginalized group that bears the burden of negative stereotypes and that many believe should not even be parents. The first section of the paper offers a historical view of the “problem” of teenage pregnancy and parenthood through which teenage mothers, particularly young mothers of color, became identified as a stigmatized group and then describes ways in which a social justice and intersectional lens can provide alternative frames for that problem. The second section of the paper describes two different settings in which infant mental health practitioners work with teenage mothers and how working to adopt a reproductive justice vision expanded the scope of their work. The third and concluding section of the paper offers thoughts about ways in which a reproductive justice perspective might alter how infant mental health practitioners more broadly might approach their work with teenage mothers.

### **Alternative Frames for Teenage Childbearing**

#### **The Teenage Mother as a Social Problem**

Although the stereotype of teenage mothers is an urban African-American young adolescent trapped in multigenerational poverty, there are as many faces of adolescent motherhood: a suburban nineteen-year-old single mother juggling work and college classes, a rural fifteen-year-old who has been neglected by an opioid-using parent, a married seventeen-year-old newly arrived in the US without English language skills. The demography of teenage childbearing in America can be summarized by a few key facts. Rates of adolescent childbearing

in the United States are markedly higher than in any other developed nation (Sedgh, Finer, Bankole, Eilers, & Singh, 2015), but are at a historical low. Rates of adolescent childbearing peaked in during the post-war baby boom and have been steadily on decline since then, with rates of ninety per thousand in 1960 falling to less than twenty-five per thousand during the current decade (Furstenberg, 2016). In the year 2016, only 2.03% of American women aged 19 and under gave birth, and only 5.3% of all U.S. births were to teenagers (Martin, Hamilton, Osterman, Driscoll, & Drake, 2018). In 2016, rates of childbearing for women between ages of 15 and 19 were highest for American Indian / Alaska native women (3.51%) and Hispanic women (3.19%) and lowest for Asian American (0.39%) and white women (1.43%) (Martin et al, 2018). The highest rates of teenage childbearing were in largely rural and southern states of the country and the lowest in New England states. Three quarters of births to American teenagers were to older teenagers, ages eighteen and nineteen.

Although the notion of adolescent mothers as a social problem runs deep in contemporary American thinking, teenage childbearing is actually a relatively recent concern. Throughout most of American history, adolescent pregnancy, so long as it was accompanied by or soon followed by marriage, was a family matter and not deemed to be of great public concern (cf. Vinovskis, 2003). The late teenage years, in fact, were considered a desirable time for marriage and family formation in many American contexts.

However, the last decades of the twentieth century were a time of rapid social and economic change in the United States, especially with respect to the roles and status of women. These changes provided a context for concern about teenage childbearing. Well-paying jobs increasingly were only available to those with higher education (e.g., Sassen, 1990), and opportunities for women to achieve higher education and enter the workforce were expanding

greatly (Toossi & Morisi, 2017). Rates of premarital adolescent sexual activity were rapidly increasing (Laumann, Gagnon, Michael, & Michaels, 1994). Some women had new opportunities to control their reproductive lives, with the emergence of effective methods of birth control, and some had access to safe and legal abortion for the first time in decades (Vinovskis, 2003). Women of all ages, including teenagers, were increasingly likely to give birth outside of marriage (Ventura & Bachrach, 2000) and to raise their children in single-parent households. The stigma of single motherhood was decreasing, and the numbers of unmarried mothers choosing adoption for their children decreased greatly (Lewin, 1992). The late twentieth century was also a time in which there were great expansions in the social safety net for low-income mothers through the Great Society programs (Gordon, 1994) and a time when urban African Americans were increasingly living in communities with high concentrations of social disadvantage (Wilson, 1987). In this historical context, delaying childbearing in pursuit of education and economic opportunity came to be considered desirable and normal, and women who become mothers at young ages increasingly were viewed as problematic.

Social problems are never recognized simply based on objective conditions; rather they emerge and become legitimized through a process of collective definition (Breheny & Stephens, 2007). The way in which thought leaders identify relevant information and construct frames around that information determines whether a phenomenon is seen as a problem and what action steps are most important for the problem's solution (Goffman, 1974; Johnson-Cartee, 1995). In the late 1970s, the media, policy leaders, and social scientists collectively came together to elevate the problem of teenage pregnancy and parenthood (see more detailed historical accounts in: Arney & Bergen, 1984; Furstenberg, 2007; Luker, 1996; Vinovskis, 2003). The new discourse was a story of how young mothers were doing harm to themselves, their children, and

society. Ironically, this interest in teenage pregnancy emerged after two decades of decreasing teenage pregnancy rates and numbers (Ventura & Curtin, 1999).

An early important description of teenage parenthood as a problem was in the monograph, *11 million teenagers: What can be done about the epidemic of adolescent pregnancies in the United States* (Alan Guttmacher Institute, 1976). Despite evidence to the contrary, the monograph declared adolescent pregnancy a crisis of “epidemic” proportions and described it as a growing problem. The problem was framed as one of girls becoming parents “before they became adults” and that teenage pregnancy led to a variety of health problems for mother and child and a future of school dropout, unemployment and welfare dependency for young women. The writers of the monograph were motivated by a desire to make reproductive health services more accessible to teenagers, and despite, or perhaps because of, its exaggerative style, the monograph played an important role in directing the attention of health and social policy makers to those important issues.

In the following decade, most major magazines and newspapers had features on the topic of adolescent pregnancy that conveyed similar themes (Chicago Tribune staff, 1986; Dash, 1989; Gleick & Reed, 1994; Wallis, Booth, Ludtke, & Taylor, 1985). The media widely concluded that teenagers were too developmentally immature to parent, and articles tended to have provocative headlines indicating that babies were having babies. Although teenage parents derive from diverse ethnicities, socioeconomic strata, and types of communities, the young women described in the press were primarily African-American inner city residents and dependent on social welfare systems for economic support, even though the largest number of teenage mothers at the time were non-Hispanic white women (Livingston & Cohn, 2010). The narratives in these articles increasingly shone a spotlight—not on young women’s need for

reproductive health services and parenting supports—but on their troubled backgrounds and deep personal connections to the woes of the inner city. Kelly (1996) has described the media coverage as a “stigma contest” to identify all the types of deviance involved in teenage pregnancy. The media narratives suggested that by becoming pregnant teenagers were perpetuating a host of social ills, including intergenerational social welfare dependence, school dropout, crime, and substance abuse (Luker, 1996). Interestingly, although the narratives sometimes hinted at the moral failings of these young mothers who engaged in premarital sex or bore children out-of-wedlock, the stories more typically conveyed a sense of the young women’s failure to plan their pregnancies and take a rational approach to shaping their future lives (Macvarish, 2010). The implicit message in almost all the media discussions was that young age at childbearing was the root cause of many social ills and that finding a way to eradicate teenage pregnancy would also solve a host of social problems.

The elevation of teenage childbearing as a social problem relied heavily on health and social science research that identified negative downstream correlates of adolescent childbearing (Koffman, 2011). These data suggested that adolescent mothers were at increased risk for undesirable outcomes throughout the life course regarding educational attainment, adult earnings, and need for cash social welfare assistance (e.g., Coley & Chase-Lansdale, 1998; Furstenberg, Jr., Brooks-Gunn, & Chase-Lansdale, 1989; Hotz, McElroy, & Sanders, 1997). Data also suggested that the children of teenage parents had poorer developmental, behavioral, and educational problems from infancy and beyond than children born to older mothers (Brooks-Gunn & Chase-Lansdale, 1995; East & Felice, 1996; Hardy et al., 1997; Haveman, Wolfe, & Peterson, 1997).

By the 1990s, policy thought leaders across the political spectrum had fully embraced the problem of “children having children” (Maynard, 1997; Pearce, 1993). Prominently, President Clinton, in his State of the Union address in 1995, referenced the epidemic of teenage pregnancy, identifying it as the nation’s “most serious social problem” (Clinton, 1995) and calling for renewed public and private efforts to be directed toward effective “anti-pregnancy” programs for teenagers. Politicians on the more conservative side of the political spectrum were also concerned about the increasing amounts of the public’s tax dollars that were being spent on teenagers and their children over their lifetimes in the form of Aid to Families with Dependent Children (AFDC) (Bonell, 2004).

Political action steps regarding adolescent pregnancy that emerged from these framings of teenage childbearing focused on encouraging personal responsibility, work, and above all, prevention of pregnancy in young women. The centerpiece of American social legislation during the 1990s was the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), which imposed lifetime limits on financial safety nets for low-income women and which built in work requirements for program eligibility. The legislation specifically targeted teenage mothers, making it more difficult for them to access social welfare support by requiring those under the age of eighteen to live with an adult and to stay in school in order to receive benefits. The policy analysis was that such restrictions might remediate the downstream negative outcomes associated with adolescent pregnancy by encouraging multigenerational residence patterns and might also provide economic incentives for young women to delay childbearing. Embedded in PRWORA were funds for abstinence-based teenage pregnancy prevention programs and a requirement that communities in each state have teenage pregnancy prevention programs. To this day, politicians at the national, state, and local levels continue to

debate whether the best way to address teenage pregnancy prevention is through abstinence prevention approaches or more comprehensive evidence-based approaches (Kohler, Manhart, & Lafferty, 2008; Santelli, Ott, Lyon, Rogers, & Summers, 2006; Dejean, 2017; Ryan, 2017; Watson, 2017), but there is generally bipartisan agreement that preventing teenage pregnancies is a goal of the highest importance.

Increasingly reproductive-justice activists are pushing back on narratives that equate teenage parents with social deviance and that shame and stigmatize young women, particularly within communities of color, for bearing children (Taylor, 2013). A critical turning point was a recent New York City poster campaign aimed at preventing teenage pregnancy that went too far. Those posters showed crying babies speaking to their teenage mothers with captions such as “I’m twice as likely not to graduate high school because you had me as a teen,” and “Honestly Mom, chances are he won’t stay with you. What happens to me?” Young mothers and their adult accomplices have begun pushing back on public health messages, public policies, and health care delivery practices that shame young women, increase their stress, diminish their access to health care, education, and social services, and ignore their needs for support with their parenting. Nationally and locally, organizations that promote women’s rights and adolescent health, in partnership with teenage leaders, are working to create more positive images of adolescent sexual health and teenage parenting in order to effect social change on behalf of young families (Illinois Caucus for Adolescent Health; National Latina Institute for Reproductive Health, 2015).

An important tool in creating just social change is finding new frames for old social issues (Snow, Rochford, Worden, & Benford, 1986). The dominant frame around teenage pregnancy is one that blames and shames the young women. The frame suggests that the young

mothers themselves are a problem, that the root of the problem is their age per se, and that early childbearing is the cause of a host of poor outcomes for young women, their families, their communities, and society more broadly. This frame has led to a critically important, but limited set of policy and practice solutions focused goals on pregnancy prevention, but with less attention and fewer resources focused on supporting teenage mothers and their children. The sections that follow present two alternative ways to consider teenage childbearing that derive from a reproductive justice perspective and are also consistent with the best available social science and public health data. These alternative frames shift attention to the social context of teenage childbearing and to the views of young women regarding the role motherhood plays in their lives.

### **Framing Teenage Childbearing as an Outcome of Structural Barriers, Disadvantage, and Adverse Experiences**

Since the first reports in the 1980s of the association between teenage childbearing and problematic outcomes for women and their children, large numbers of demographic studies have examined adolescent childbearing using increasingly sophisticated data analytic approaches. Although still indicating that teenage mothers and their children are a vulnerable group, the newer research shows that much or all of this vulnerability stems, not from mother age per se, but from poverty, minority status, and living in under resourced communities (e.g., Fletcher & Wolfe, 2009; Hoffman, 1998; Levine & Painter, 2003; Levine, Emery, & Pollack, 2007; Turley, 2003). Longitudinal qualitative data also suggest that when young mothers are relatively socially advantaged when they give birth, they fare well in terms of educational and economic attainment (SmithBattle, 2007b). Altogether, contemporary research strongly suggests that teenage childbearing does not cause social problems so much as it is caused by social

inequalities in income, education, and community. Additionally these social inequalities also alter young women's capacity to provide for their families and parent their children. Frank Furstenberg, a leading scholar of adolescent parenthood and an early and influential proponent of the view that teenage parenting is a social problem, has now shifted to believe that the problem is actually the "long shadow of disadvantage rather than age per se" (Furstenberg, 2016).

Of concern, however, is that over time, adolescent childbearing in the U.S. has increasingly become concentrated among young women experiencing social disadvantage (Pirog, Jung, & Lee, 2018). While rates of teenage childbearing are dropping most rapidly among young women of color, Latina and African-American women remain more likely than Caucasian women to begin childbearing as teenagers (Martin et al, 2018), meaning they are parenting with the intersectional disadvantages of young age and membership in groups stigmatized by race, ethnicity, and immigration status. Young women with multiple marginalities, such as those in the foster care system have exceptionally high rates of adolescent pregnancy, with more than half become pregnant as teenagers and nearly half having repeat pregnancies before the age of twenty (Boonstra, 2011)

Research in recent decades identifying that adverse childhood experiences have lifelong consequences for physical, mental and behavior health (Felitti et al, 1998) also has implications for the issue of teenage parenthood. Cumulative childhood adversity is associated with early age of sexual intercourse, higher number of sexual partners, and teenage pregnancy (Cheney et al., 2015; Hillis et al., 2004). In addition, a variety of specific, potentially traumatic types of adversity have been linked to adolescent pregnancy, including child maltreatment and partner violence, even after taking into account factors such as neighborhood disadvantage and other caregiver risks (Covington, Justason, & Wright, 2001; Kennedy & Bennett, 2006; Weinman,

Agurcia, Berenson, Volk, & Rickert, 2000). Women with childhood histories of maltreatment reports and who experienced childhood sexual abuse are at greatly increased risk of experiencing an early pregnancy (Francisco et al., 2008; Garwood, Gerassi, Jonson-Reid, Plax, & Drake, 2015; Madigan, Wade, Tarabulsky, Jenkins, & Shouldice, 2014; Noll, Shenk, & Putnam, 2009).

With this information, the “problem” of adolescent childbearing can be framed, not as a problem of the individual teenager, but as a problem of broader social problems, injustices, stigma in the lives of young parents. This reproductive justice frame shifts the focus to structural conditions that promote poverty, perpetuate racial and gender inequality, and tolerate family and community violence. The lives of many teenage parents are shaped by under-resourced schools, blocked access to health and mental health care, gender and racial discrimination, decreasing access to abortion and reproductive health care, and exposure to interpersonal and community violence. Black girls in particular are more likely to be subjected to policies that push them out of schools and criminalize their behavior (Crenshaw, 2015). Framing adolescent childbearing and parenting as embedded in structural factors requires that policy and practice move “upstream” (SmithBattle, 2012) to address unjust structural features of contemporary American society and to make available appropriate support and treatment to young parents who have experienced such conditions.

### **Framing Teenage Childbearing as an Important and Meaningful Life Transition**

In the framing of teenage parenthood as a social problem, it is easy to conclude that early parenthood is always a problem for individual mothers and children. Young parents know that the media presents negative images of them and that those views are often shared by people in their immediate lives, including family members, teachers, and health providers (De Marco, Thorburn, & Zhao, 2008; Gregson, 2009; Kaplan, 1997; Peterson, Sword, Charles, & DiCenso,

2007; Whitley & Kirmayer, 2008; Wiemann, Rickert, Berenson, & Volk, 2005; Yardley, 2008). Negative stereotypes of teenage parents may be internalized by young women in ways that can create feelings of shame, fear, insecurity, and frustration (SmithBattle, 2013; Yardley, 2008). Yet, the majority of adolescent mothers, even those from economically disadvantaged backgrounds, experience successful outcomes with respect to high school graduation and employment over their lifetimes (Furstenberg, 2007; Leadbeater, 2014), and the largest number of young mothers are responsive and caring parents for their children (Easterbrooks, Chaudhuri, & Gestsdottir, 2005).

Young mothers themselves, like older mothers, often come to experience parenthood less as a problem and more as an important life transition. For some teenagers living in economically marginalized and distressed communities, becoming a parent can be a transformative experience that provides meaning and motivation for positive life changes (SmithBattle, 2007a) such as a renewed commitment to achieve in school or an opportunity to stop substance abuse or other risky behavior (SmithBattle, 2008). While pregnancy and the birth of a child can be a disruptive transition for young parents and their families, young women often report that being a good mother provides value to their lives and allows them to provide value to others. Multiple qualitative research studies have shown that for adolescents, the transition to motherhood, while challenging, is often accompanied by increased self esteem, sense of purpose, pride, and joy (e.g., Arenson, 1994; Edin & Kevalas, 2011; Kirkman, Harrison, Hillier, & Pyett, 2001; Lamanna, 1999; Middleton, 2011; Phoenix, 1991; Salusky, 2013, Schultz, 2001; Williams, 1991). Young mothers often report their experience of motherhood as positively transforming (Clemmens, 2003).

From the perspective of young mothers themselves, the “problem” of adolescent childbearing can be reframed, young women doing their best to parent under the burden of stigma and often limited resources, but for whom motherhood is an important transition to meaningful adult lives. This reproductive justice frame shifts the focus to the rights of young women to parent with dignity. The role of policy and practice in this frame becomes, not solely to prevent pregnancy, but to provide opportunities, and supports for young women who are doing their best to be good parents. Efforts also need to focus on undoing the stigma of adolescent parenthood and recognizing the strengths that adolescents and their families bring to their parenting. A frame focused on the dignity of teenage parents and the developmental opportunity parenthood affords them is consistent with foundational infant mental health approaches in which the practitioner identifies family strengths, listens to the voices of parents, and provides nonjudgmental support to parents.

### **Reproductive Justice within Two Infant Mental Health Programs**

The remainder of this paper will consider how reproductive justice principles and alternative framings of teenage childbearing translate to infant mental health practice. Following are brief descriptions of two home-visiting programs serving different populations of teenage mothers: young mothers seeking voluntary health and parenting support from community organizations and young women mandated to parenting support services because of their involvement in the juvenile justice or child welfare system. Each of these programs has a long history of providing services to young mothers that were grounded in infant mental health principles. The following descriptions identify ways in which each program became aware of reproductive justice issues in their work and made changes in how they approached their work with teenage parents through this new awareness. These programs descriptions derive, not from

a formal research process, but primarily from the authors' experience and observation in implementing these program models, such as listening to the voices of young parents during clinical encounters and of staff during supervision and training sessions. Following the program descriptions, the paper concludes with a distillation of reproductive justice approaches that can be incorporated into infant mental health services for teenage parents.

### **Program Description: the Community Doula Model**

**Background.** In 1996, the Irving Harris Foundation was seeking innovative approaches for engaging pregnant teenagers in home-visiting services, especially the home-visiting services offered by their long-term partner in Illinois, the Ounce of Prevention Fund (the "Ounce"). The Ounce had long used lay workers to provide home-visiting services that were strongly infused with infant mental health principles (Bernstein, Percansky, & Wechsler, 1996). The Ounce programs had been early adopters of infant mental health practices such as relationship-based practice, identifying and building on family strengths, supporting parent-child relationships (including through review of video recordings), and reflective practice and supervision. However, the programs had provided little attention to pregnancy and postpartum health or to social justice issues.

The Foundation sponsored a partnership between the Ounce and the Chicago Health Connection, now HealthConnect One (HC One) to develop a model for incorporating doulas into home-visiting services for teenage parents (Glink, 1998). Doulas are women who provide support to other women before, during, and after childbirth. The centerpiece of a doula's work is to be with a mother during labor to offer continuous emotional support, physical comfort, and advocacy. Doula work is sometimes described as "mothering the mother" (DONA International, 2013; Klaus, Kennell, & Klaus, 1993). A body of research h suggests that the presence of a

doula in the hospital labor room leads to better birth outcomes (Hodnett, Gates, Hofmeyr, & Sakala, 2013).

The model that evolved in the partnership in Chicago became known as the community doula or community-based doula model. Women with close connections to the communities in which home-visiting programs were located were given extensive training on how to provide support to young mothers. Community doulas provide support during labor and delivery, but also accompany mothers to prenatal and postpartum clinic visits and provide health education during pregnancy and postpartum in mothers' homes. Doulas place emphasis on childbirth education, breastfeeding counseling, and early mother-infant bonding.

Community doula programs are now being implemented across the nation, both as stand-alone supportive intervention for mothers during the transition to parenthood and as enhancements to home-visiting and other ongoing programs serving pregnant women and new parents. HC One is working on national replications of the community doula model. The community doula program model has been well received by Illinois programs and the State is funding more than two dozen community doula programs that receive training and technical assistance through the Ounce. The model has been described in a variety of sources, including a book (Abramson, Isaacs, & Breedlove, 2006) and a documentary film (Alpert & Suffredin, 2005). Randomized controlled trials of the community doula model show positive impacts of the intervention on breastfeeding as well as early mother-infant interaction (Edwards et al., 2013; Hans et al., 2013; Hans, Edwards & Zhang, 2018).

At the start of the community doula work, it was anticipated that incorporating doulas into programs that relied heavily on an infant mental health model would offer mothers a broader range of information and support related to maternal and infant health topics. It was also

anticipated that incorporating doulas into the service team would help engage mothers during pregnancy (rather than after the birth), thus providing opportunities to focus on the developing relationship with the unborn child (Cardone, Gilkerson, & Wechsler, 2008). Not anticipated initially was how incorporating doulas into the home-visiting programs would introduce a social justice framework into their traditional infant mental health approaches.

HC One was founded by women with a vision for what is now called reproductive justice. They had a recognition that in low-income American women, and particularly low-income women of color, have disproportionate rates of infant and mother mortality and experience both barriers to accessing high quality care and discrimination within health care settings (Basile, 2012; Gay, 2014). Their organization was mission driven, based on a belief that low-income women and women of color should have access to culturally appropriate information and support to make health decisions for themselves and for their children. They believed that women should not be prevented from accessing health care and health information because of economic, geographic, historical, and sociocultural barriers. HC One understood that lay health workers, from the same communities they served, would have a deep understanding of women's life circumstances and could help bridge the gaps between a mother, her family, and the healthcare system.

The community doula model that was developed became an integration of the social justice perspective brought by HC One and the infant mental health perspective brought by the Ounce. The remainder of this section focuses on strategies used within community doula programs in Illinois to seek reproductive justice for pregnant and parenting teenagers. Four themes will be emphasized: 1) undoing biases regarding teenagers, 2) confronting stigma and

injustice experienced by teenage mothers, 3) valuing all pregnancies and families, and 4) building efficacy in young mothers.

**Undoing bias.** Community doulas and their colleagues in home-visiting programs are deeply aware of stigma and stereotype regarding mothers' age (as well as race, social class, and a variety of other issues not highlighted in this article). Many community doulas experienced bias themselves as young mothers. Doulas are expected to engage in self reflection regarding their personal beliefs about adolescents and adolescent parents and to work to see each parent through a positive lens.

Early in the community doula training process developed by HC One and the Ounce, trainees focus on understanding teenagers and, in particular, on understanding and dismantling biases and stereotypes that might interfere with their work. Training includes exercises such as trainees writing down reasons they think teenagers become pregnant or things they anticipate being difficult in working with teenagers, which are then used as topics of discussion among trainees (Abramson, et al., 2006). In their infant mental health training, doulas and all Ounce home visitors are taught to listen to mothers and ask questions that allow mothers to make observations about sources of joy and pride in their parenting and to identify the things that are working well for them and their babies. In ongoing reflective supervision, community doulas continue to examine and confront their own values, beliefs, and biases about young mothers. They are also encouraged, before discussing challenges in their work, to share with supervisors examples of positive actions that young mothers are taking. These discussions have the goal of helping doulas see the mothers as individuals who bring strengths to their parenting and to take a less judgmental stance in their work.

**Confronting stigma.** Community doulas, because of the intimate work they do in homes and health settings, often witness the bias young parents experience from professionals and family members. It is common during supervision sessions for doulas to bring up their observations of bias. For example, doulas report lactation consultants who believe teenage mothers are not likely to breastfeed and skip young mothers' postpartum hospital rooms in order to counsel an older mother. Doulas witness doctors who, believing that teenagers are not capable of making medical decisions, address their comments to the teenager's parent or do not fully explain procedures to young mothers. Doulas observe nurses who believe that teenagers should not get pregnant and ignore their cries in labor, thinking that the memory of labor pain might motivate them to "say no" to sex in the future. Doulas interact with grandmothers-to-be who are disappointed that their daughters are becoming parents as teenagers and choose to use the labor room as a site for lectures on abstinence. An important theme in supervision with community doulas is how to prepare young mothers to stand up for their rights in medical settings or with unhelpful family members, as well as when and how to intervene directly when clients are experiencing bias.

**Valuing young families.** Stereotype and stigma are particularly dangerous when young parents internalize those negative frames, believing their pregnancies to have been mistakes, that their futures have become limited, and that they cannot be good mothers. In using a reproductive justice approach, perhaps the most important work of the community doulas is to counter these stereotypes held in the minds of young mothers with beliefs that they have worth, competence, and efficacy (Glink, 1999) and that they can make the best choices for themselves and their babies. Doulas have many opportunities to convey to mothers that they are important and acknowledge that the pregnancy is an important event and a special time in the young woman's

life. Doulas have opportunities to witness and celebrate the most special and happy moments in pregnancy – seeing the first ultrasound pictures, laying hands on mothers’ bellies to feel the baby kick, and witnessing the miracle of the child’s birth. Community doulas each have created special activities that allow young women to share their joy in becoming parents. Doulas may help mothers to create scrapbooks for the baby, they may make plaster casts of the mother’s pregnant belly, they may encourage mothers to draw pictures of how they imagine their unborn child, and they may encourage mothers to write or dictate letters to their unborn babies. A central part of community doula work is to ask mothers to tell and retell their personal stories of giving birth. The doulas listen and affirm, and the mothers gain ownership over their stories. Most of these stories are ones of happiness and pride, but even if the story is not always a happy one, the doulas can convey that it is an important one. Perhaps the most significant way in which doulas communicate to teenage mothers that they and their babies are valued, is that when the mother goes into labor, the doula stops everything else she is doing at whatever time of day the mother calls to join her at the hospital.

Young families have many configurations, often with a maternal grandmother playing a very important role and most of the time with the father and mother not being married. An important aspect of valuing young families is understanding the different people who are part of the young mother’s support network and honoring their roles with respect to the birth of a new baby. Community doulas typically work to include all family members in their home visits and in the hospital births, often coaching family members with respect to how to best support the young mother in labor. Doulas often feel that some of their biggest successes come in those powerful moments around the birth when a father supports his partner and first sees his child (Bellamy, Thullen, & Hans, 2015). However, one of the most common topics that arises during

reflective supervision of doulas is working with family members when issues come up regarding doulas' personal biases about unmarried fathers, how to manage situations in which doulas and grandmothers hold different opinions, and how to keep the intervention focused on the young mother while the grandmother is present.

**Building parent efficacy.** Another important way that community doulas can undo the effects of stigma is to help build efficacy and confidence in young mothers. This process begins with models of training that empower the doula herself. Community doulas typically engage in a long training program that includes a combination of workshops and homework assignments that involve self reflection, journaling, observation in obstetric settings, and ultimately practice in doing doula work (Chicago Health Connection, 2000). The training model developed by HC One has social justice roots, drawing from Paolo Freire's emphasis on empowerment and building confidence (Freire, 1974). Trainers (called facilitators) do not lecture, but rather engage trainees around stories, pictures, movie images, role plays that will impact the way they view situations and themselves and build their confidence that they can be effective agents of change. Trainers not only provide technical information, but they serve as models for how doulas will work with their families in ways that allow parents to discover and internalize information and to engage in a process of self transformation and confidence building.

Community doulas learn how to take that training approach into their work with young parents to create parenting efficacy. An important part of their work is sharing information with the mothers about healthy pregnancies, about labor and delivery, and infant care. A skilled doula, however, knows not to lecture mothers or tell them what they should do as parents. Community doulas make it clear that it is the mother's job to make informed decisions on behalf of herself and her child. Doulas encourage mothers to take charge of their health care

by developing lists of questions they take to their medical providers at each visit. Doulas help mothers develop a “birth plan” regarding how they would like their labor and delivery to proceed. Although many doulas believe that natural childbirth is an empowering experience and share that view with the mothers, their main goal is to support the mother in choosing what kind of birth she would like to have and to coach them on how to achieve their goals. Doulas want mothers to “own” the birth experience (Glink, 1999). Ultimately doulas hope that these kinds of empowering experiences during the pregnancy and postpartum will help young mothers as they parent to be better prepared to seek and evaluate information, to be responsive to their children’s needs, and to make confident decisions about what is best for them and their child. For younger mothers, these decisions often relate to continuing to pursue their education; for older mothers, these decisions may relate to seeking employment to provide economic futures for themselves and their babies.

An important part of developing efficacy is making plans for subsequent births. Community doulas begin discussions about family planning prenatally. Doulas ask young mothers to articulate what their plans are, honoring young women’s personal opinions, but making it clear that having a plan is important. Because of their presence during health appointments, community doulas can insure that mothers have discussions with medical providers about birth control options. Doulas initiate conversations with mothers about the implications of the timing of a subsequent pregnancy for the mother’s ability to parent the child she already has. Some doulas share information about birth control, but many do not, either because of the faith orientation of their agency or their personal views regarding family planning approaches.

**Program Description: Serving Court-Involved Young Families**

**Background.** Among expectant and parenting teenagers, there are subgroups that have added layers of vulnerability, including those involved in the court system. The need for specialized services for these young families led to the development of the Florida State University (FSU) Young Parents Project, an intensive, gender-specific home-visiting program that addresses the complex needs of court-involved pregnant and parenting teenagers and their young children.

Court-involved teenagers include those involved in the dependency or child welfare system, or youth in the delinquency or juvenile justice system who have been charged with a crime. Twelve years ago, Judge Lester Langer of the 11th Judicial Circuit of Florida and a ZERO TO THREE Fellow, recognized that the court gave little, if any, attention to pregnant and/or parenting teenagers involved in the juvenile justice system. He observed that the children of teenagers previously in his courtroom were returning with delinquency charges. Concerned about the intergenerational cycle of teenage mothers in juvenile justice and the need to support their role as young parents, Judge Langer assembled a team of professionals to develop and implement an innovative pilot project in Miami-Dade County, Florida. He explained that judges were focused on the criminal behavior of the teenagers and did not “see” pregnant or parenting young mothers in their courtrooms. Judges would ask about topics such as educational progress or employment status, but would not inquire about prenatal care, parenting responsibilities, or the development of the baby. Most often, they did not even know if the teenager had a baby. Judge Langer understood the power of the court in recognizing teenagers as parents and respectfully supporting their parenting role, with the hope of interrupting the intergenerational cycle of criminal behavior.

As a leader in adolescent pregnancy initiatives for more than a decade, Florida State University's Center for Prevention and Early Intervention Policy (FSU Center) partnered with judges and other stakeholders in Florida's 11th Judicial Circuit and began implementation of a the Young Parents Project in Miami during 2005. Initially, center-based services were offered, but participation rates of the teenage mothers were low. As the complex needs of young families in a large urban area were understood and the voices of the teenagers were heard, home visiting with extensive community outreach was selected as the vehicle for provision of services.

An evidence-based model from Yale University entitled Minding the Baby® was selected and adapted for the FSU Young Parents Project to support court-involved teenage mothers and their children. Minding the Baby® is a relationship-based home visitation model that includes key components of the Nurse-Family Partnership and infant/parent psychotherapy (Sadler et al., 2013). This reflective practice model includes an intensity of intervention services over time that matches the needs of court-involved young families. All staff are master's or very experienced bachelor's level professionals who are respectful and supportive of the teenager's decision to parent. The families are visited each week utilizing a highly individualized approach and young parents are encouraged to "keep their baby in mind" as they make important life decisions, with the goals of reducing court recidivism and promoting positive outcomes for parent and child. The Minding the Baby model utilizes a nurse who educates young mothers about health, family planning and the development of both the teenager and the baby, and an infant mental health specialist who promotes the mother-infant relationship with a trauma-focused lens. For the court-involved mothers in the FSU project, a social worker was added to the model's team to provide care coordination and serve as an advocate for the young parent across multiple systems including the court, educational, and health care systems. Both the physical and mental health

needs of parent and child are addressed by the FSU Young Parents Project. Through this approach the program recognizes the deep commitment that young parents have to their children and their desire to move forward in ways that they may not have been able to do without support.

Over the past twelve years, the FSU Young Parents Project has served 437 court-involved young families in three judicial circuits in Florida, including two large urban areas and a smaller rural community. Both delinquency and dependency teenagers and their babies are involved.—The project is unique, as there are no other programs in Florida that target court-involved young parents. Referrals for the teenagers' participation come through the local Juvenile Assessment Center, juvenile court judges, juvenile probation officers, Public Defender's Office, child welfare agencies, sexual abuse treatment programs, and other community partners.

Although the entry point for services is specific to teenage mothers, young fathers and extended family are also encouraged to participate. It is vital to make space for the father's involvement through conversation and direct services whenever possible. Whether staff are able to actively engage the father or not, discussions take place with the teenage mother about the importance of children knowing their father and how to develop this relationship even when parents are not together. Grandparents are also valued and respected, and have stated that they wish these types of services had been available when they had their first child.

Understanding the chaotic lives of court-involved teenage mothers is critical to the program's intervention and key to each family's success. These teenagers have experienced multiple risk factors that go beyond those of other parenting youth in the community. High rates of physical and sexual abuse are well documented among girls in juvenile justice (Saar et al., 2015). Data collected at time of intake on participants served by the Young Parents Project in 2016, confirm the many challenges they face. Eighty-six percent (86%) of the project's

participants had a score of four or more out of ten on the Adverse Childhood Experiences (ACE) Questionnaire used by staff to consider experiences of childhood trauma and toxic stress. Over half, 58%, of the young mothers had been involved with the child welfare system at some point in their lives. The mean age at time of first arrest for the participants in the project during 2016 was 13.6, with 60% of recent arrests consisting of higher level crimes. Furthermore, 95% of the project participants were girls of color, consistent with the disproportionate representation of youth of color in the juvenile justice system more broadly (Puzzanchera & Hockenberry, 2015). Frequent family disruptions, housing instability, and lack of nurturing family support interfere with educational trajectories, and 45% of the young mothers were not enrolled in school at time of intake.

In order to meet the needs of program families, the Young Parents Project employs an infant mental health approach that emphasizes building nonjudgmental, trusting relationships that broaden the possibility that the baby may have a different life experience. The approach is about protecting, reflecting, strengthening, and empowering. The emphasis of the program is supporting the teenager's right to parent her baby and partnering with her to provide the supports, guidance and assistance to do so. Working effectively with the young families requires addressing past adversities and recognizing the strengths that are fully present.

Understanding young mothers' histories of risk and trauma also requires the program staff to confront systemic factors that stand in the way of parents getting the supports they need to effectively parent. As the program has evolved in its work with families who have severe and complex needs, it goes beyond traditional home-based family support services to engage in extensive outreach efforts, strong advocacy for teenage parents and their children across multiple systems, and efforts at changing those systems. This new work incorporates a reproductive

justice frame into the infant mental health approach by emphasizing the rights of young parents to the supports they need to parent their children with safety and dignity. The remainder of this section will focus on four strategies used by the Young Parents Project to seek reproductive justice for young court-involved parents:

**Offering supports not otherwise available.** Traditional systems of care for new mothers and their babies typically do not provide the types of services needed to meet the complex needs of court-involved teenage parents. It is striking how infrequently court-involved pregnant and parenting teenagers are engaged with traditional types of parenting or infant mental health services offered in their communities and the challenges they confront gaining entry into traditional systems of care. In 2016, only 9% of FSU Young Parents Project participants had ever received home-visiting services for expectant families in areas where these services are widely available. There are institutional expectations that parents will respond to the offer of home-visiting services in traditional ways. Programs send a letter, make a phone call, and perhaps attempt to make one introductory visit to the home without realizing the obstacles common to teenage parents who have experienced frequent moves, had their phones cut off due to overdue payments, and learned not to trust strangers. The program design and training, languages spoken by staff, and funding levels do not take into account the multiple challenges faced by court-involved teenagers parents, most of whom are women of color. Programs and their funders have not considered the extra time and resources required to do the outreach necessary to engage young families initially and to support them over time. When a young woman has no place to live and no means of support, and the judge is considering removing-the child from her care, her most basic needs for survival must be addressed so she can begin to rebuild a life for herself and her baby.

By providing more intensive services from a range of professionals, the Young Parents Project is designed to provide services for high-need young mothers. Within Minding the Baby®, the mother-baby relationship is the focus of treatment, ensuring safety and protection for the baby and care for the individual needs of the mother. Cultural and family values and goals are respected. The weekly home visits allow for family engagement, observation, assessment, and discipline specific content. In addition, concrete service needs are addressed and families are connected to early intervention and trauma services within the community. Interdisciplinary teamwork, reflective supervision and ongoing case discussions are essential components to support the deep investment of clinicians in this challenging work and to promote parental capacity and secure attachments. Reflective discussions are a part of all project activities with each young family, to bring the mother back to holding her baby in mind and supporting her child's growth and development.

Adolescent mothers may range in age from thirteen to nineteen when they come into the Young Parents Project, and the youngest mothers may require services customized to their developmental level. As teenagers develop their own identities and move toward adulthood, their physical, cognitive, emotional and social abilities are changing dramatically. Older teenagers, like adults, usually have capacities for abstract thinking and are able to reflect on how their actions impact their baby, given the time and opportunity to do so. In contrast, the youngest teenage parents may have different abilities and needs. While physical maturity may be taking place, the thirteen-year-old pregnant teenager may need basic information on sexuality and reproductive health, with an advocate by her side to interpret what is taking place during prenatal visits. She may not understand that early experiences of sexual exploitation are not a part of typical development or may not yet have the words to communicate her experiences. Work with

younger teenagers may require the sharing of concrete information, and patience on the part of home visitors to gently support teenagers in identifying emotions and identifying their hopes and dreams for their child. In the Young Parents Project, multidisciplinary case discussions take place each week to include discussion of age as well as the developmental capacity of both teenager and baby.

Services also need to be customized depending on the past trauma histories young mothers bring to their parenting. The program has noted that increasing numbers of young mothers have been victimized by another layer of reproductive oppression -- sex trafficking. Of the ninety-nine young mothers who participated in the FSU Young Parents Project during 2016, 31% had been trafficked. Of those who were in the custody of the state's child welfare agency, 79% had experienced the commercial sexual exploitation of children. The co-occurrence between involvement with the child welfare system and trafficking experiences reflects the lack of protection for these youth over time and the extensive experiences of victimization they bring to their parenting. Dating back to the program's initial understanding of this work in 2005, it was unanticipated that a primary focus of efforts in 2017 would be supporting the parenting capacity of trafficked teenagers. It is an area that requires staff time, resources, and intensive case discussions to provide the respectful services necessary for this population.

**Building trusting relationships using trauma-informed approaches.** Court-involved youth often were not protected by their families or societal systems that should have supported them, and in turn are cautious in trusting adults in their lives. In the Young Parents Project, building trust is done through a trauma-informed approach. For the individual teenager, it moves beyond the common question that is asked, "why are you acting this way?" The use of a trauma-informed framework instead asks the question "what has happened to you?" As young mothers

begin to share their stories, they often explain what brought them to their involvement with the courts and who has been by their side throughout their lives. Eventually, these young women begin to talk about when their right to healthy sexual development was taken from them at an early age. Sometimes this is expressed as factual information and other times with great emotion. They may describe the loss of a parent to death or incarceration and the impact that had on their lives. They share the importance of grandparents who took them in, provided both financial and emotional support, and encouraged them to continue their education and become a responsible parent. From a traditional infant mental health perspective, such discussions allow the team of clinicians to consider both the angels and the ghosts in the nursery as a part of the dyadic intervention. It is through these meaningful conversations that staff begin to understand the experiences of oppression, racism, and inequality, and in turn provide the respectful services needed to support the parenting journey.

The relationship-based approach also allows staff to address the common “fight, flight, or freeze” response to trauma that is triggered when walking into the courtroom. This is seen regularly when frightened young mothers react with angry words toward the judge, run from the courtroom, or go silent with tears streaming down their faces. Project staff must anticipate these triggering events so that this is not seen by a judge as defiant or unresponsive behavior, but rather a response to their trauma. The Young Parents Project social worker prepares the teenager for court ahead of time and supports her throughout the proceeding. The social worker ensures that the teenager understands why she is going to court and the court process, and she asks the young mother what she would like to share with the judge. If the young mother cannot find her words during the proceeding, it is agreed upon ahead of time whether the social worker can share

what the teenager wants the judge to know. Assurances are given by the social worker that she will remain by the youth's side throughout the court proceeding.

**Overcoming systemic barriers.** A reproductive justice perspective recognizes that structural factors often act as barriers to access and care. At a systemic level, the Young Parents Project has observed over time numerous structural obstacles faced by young families and the inappropriate, inconsistent, or lacking response from systems in addressing parents' needs. In one county, staff are able to support pregnant and parenting students' return to school by helping the teenagers find appropriate school placements with childcare provided for their babies. In another county, even with extensive advocacy, paperwork requirements, lack of regard for the teenager's desire to change, and unpleasant interactions with staff impact the possibility of finding appropriate school placements. Another field of great concern is interpersonal violence. Women younger than twenty years have the highest pregnancy-associated homicide rates, with the risk among young Black women being especially high (Chang, Berg, Saltzman, & Herndon, 2005). In Florida, domestic violence shelters remain largely unavailable to most teenagers under age eighteen and youth shelters will not accept teenagers with babies. The child welfare system struggles to find placements to co-locate both parent and child. Teenagers describe being alienated from family, without economic resources, and yet have limited options for protecting themselves and their baby. This challenge has required extensive advocacy on the part of the professionals within the Young Parents Project and an understanding of the stressors that must be identified and incorporated into intervention services.

Systemic barriers are particularly notable within the arena of family planning. In addition to being stigmatized for having children, teenagers face challenges in accessing family planning services. Within the Young Parents Project, ongoing discussions take place between teenagers

and home visitors on the timing of the next pregnancy, consideration of healthy relationships, and the needs of the new baby. When a teenager indicates interest in accessing birth control, home visitors are increasingly challenged in finding adequate resources. At the Federal level in the United States, funding for the Title X family planning program, was cut by 10% between fiscal years 2010 and 2016. The decrease in funding levels for this safety net program has meant reduced access to family planning clinics. In Miami-Dade County clinics specially designed to serve adolescents with sensitivity and care have closed. In addition, the State of Florida made the decision not to expand Medicaid under the Affordable Care Act, and the County Health Departments have lost \$14.2 million in funding since 2011. These policies have placed structural barriers to needed services that include appointments being scheduled months in advance, fee schedules that are not affordable, or multiple steps to complete the process of insertion of a long-acting, reversible contraceptive (LARC).

The FSU Center addresses systemic reproductive justice issues facing families in the Young Parents Project through meetings with school district superintendents, head of the departments of child welfare and juvenile justice, health department supervisors, and court officials. At both a county and state level, challenges are shared about the work and data are provided to bring attention to the need for reproductive justice for teenage parents in the state. Although progress has been made in some areas, new issues continue to arise.

**Interfacing with the justice system.** The system that directly impacts the wellbeing of all of the young women participating in the Young Parents Project is the justice system. The court work over the last twelve years has offered lessons about the importance of influencing those in positions of power and relentlessly pushing for them to understand and reframe the experiences of families and to create change at a local and state level. Judges make decisions

about people's lives and can see a pregnant teenager as a perpetuator of a cycle of intergenerational criminal involvement or as a young parent who desires to change a family trajectory through supportive intervention. The arresting police officer can see a teenager who is involved in criminal behavior or a fifteen-year-old pregnant youth who is required to do certain things by her trafficker. A Juvenile Assessment Center can send a young mother back into a community with limited resources or ensure a plan for prenatal care and follow-up services is in place before leaving the facility. A child welfare agency can place a pregnant teenager in a group home with other troubled youth or do the challenging work of finding a foster home where the teenager and baby will have the opportunity to grow together with the co-parenting support of foster parents.

These choices illustrate the opportunity in a reproductive health approach that recognizes what has happened to these young mothers and the opportunity to intervene with dignity, safety and respect. Training is provided for court-related personnel, meetings occur with judges, prosecutors, public defenders, and chief probation officers, and testimony in court highlights the strengths of each young parent and the next areas for growth to allow them to be safe and responsible in the community. Advocacy occurs within state and local governments to support trauma-informed systems of care.

### **Discussion and Implications for Infant Mental Health Practice**

The field of infant mental health has a key role to play in achieving reproductive justice for young mothers. Within a reproductive justice perspective, teenage parents have a right to choose whether and when they bear children, but they also have a right to parent their children with dignity, support, and safety regardless of their income level, ethnicity, legal status, and age. Infant mental health providers have important work to do in confronting the adverse social

factors and structural barriers that young mothers face as parents and in honoring and supporting, rather than shaming and stigmatizing, young women who are taking the important life step of becoming a parent. In reflecting on these ideas and the experiences of the two infant mental health programs described, the authors have identified nine interrelated themes/approaches used by these programs to incorporate reproductive justice into their infant mental health work.

**See each teenage mother as a unique person.** Stigma and stereotype operate when all people belonging to a group are presumed to be the same. In the United States, despite stereotypes of teenage mothers as urban unmarried girls of color, adolescent mothers are a heterogeneous group in terms of developmental maturity, race, ethnicity, education level, marital status, types of communities they reside in, and types of supports they receive from family and partners. Teenagers bring different personal histories and different strengths and vulnerabilities to their parenting. When embracing reproductive justice principles, infant mental health providers set aside preconceptions about teenage parents and explore each adolescent's unique story -- not presuming to know who she is, what she wants for her child, or how she will parent, based on the fact that she is a teenager. Infant mental health providers partner with the young mother to develop a plan for intervention that is interconnected with her personal goals, needs, and strengths and her hopes and dreams for her child. These goals may vary greatly depending on the mother's age, with younger teenagers focusing on finding a way to share parenting with family members and remaining in secondary school and with older teenagers focusing on employment, college, and building long-term co-parenting relationships with the baby's father.

**Recognize one's own biases.** Most Americans hold beliefs and opinions about teenage parenthood, many of those based on negative stereotype that frequently do not align with reality. Additionally, most Americans also hold biases regarding social class, race, ethnicity,

immigration status and other marginalized identities that teenage mothers may hold. Such beliefs, even when held by well-intentioned people, can interfere with the formation of working relationships with young mothers and can make one's work ineffective or even harmful, by reflecting back to young mothers the pathologizing images that society holds of them. Working to undo bias regarding work with teenage parents is an ongoing process that begins when staff are hired and trained, but continues to be a priority during regular reflective supervision sessions and in-service education. Undoing stigma can be an organizational goal as well, implemented by reviewing agency mission statements and websites and by seeking feedback from program participants about their experiences within the program. .

**Recognize the multiple adverse experiences teenage parents may have experienced.** Teenagers who are parents have complex needs regarding school, relationships, housing, finances, mental health, and child care, which they need to address while also providing safe and nurturing environments for their children. In addition, many young parents have complex personal histories of adverse experiences including exposure to violence and other traumas that may be part of their life stories. In utilizing a reproductive justice framework, infant mental health providers are prepared to support young mothers around a broad range of needs, but in particular, to be prepared to adopt trauma-informed approaches for work with their young clients.

**Honor and celebrate young parents.** Negative societal views of teenage parents are powerful and can be internalized by young women and those in their networks, including infant mental health providers. Through genuine concern for helping pregnant and parent teenagers who may not have chosen to become pregnant or who may be facing multiple struggles, it is sometimes easy to overlook the mother's genuine joy and pride in her parenting or to fail to

celebrate and honor the young woman's transition to motherhood in the ways that are routinely done for older mothers. When embracing a reproductive justice perspective, infant mental health providers work to shift their focus away from concerns to the opportunities the young woman has as she creates her family. This shift can be done through special celebrations, such as baby showers, but mostly through routine conversations that focus on the positive and deeply meaningful experiences parents have as they witness their babies' growth and development and understand their important role in that child's life.

**Uplift young mothers voices and listen to them.** Teenage parents too often have not had the opportunity to share their views or, when they do speak, to be heard. The scripts of their life stories have been written for them by powerful adults in the media, sciences, and policy world. When using a reproductive justice approach, infant mental health providers encourage young mothers to tell their stories and to retell them as they continue to unfold over time. Infant mental health providers are able to accept those stories, even if different from their own view, and to hold those stories, when they are joyous and triumphant, but also when they are painful or shocking. Part of giving young mothers voice can be encouraging them to hear the voices of other young mothers, either within the infant mental health program or to take advantage of the growing number of online communities that give voice to the views of young mothers (e.g., <http://www.noteenagershame.com>, <http://www.youngwomenunited.org>, <http://www.girlmom.com>; <http://strongfamiliesmovement.org/young-parents>).

**Empower and support the efficacy of teenage parents.** Although an important part of being a parent is accepting the large responsibility of caring for a child and making decisions for a child, teenage parents and the adults who surround them often believe that teenagers are too young to have the skills and abilities to take on those responsibilities. Many people hold power

over young mothers—family members, teachers, physicians, courts, child welfare agencies and infant mental health providers—and it is easy for teenage parents to see themselves as inadequate and to lack confidence as parents. Within a reproductive justice framework, infant mental health providers encourage young mothers to take agency and make responsible decisions for themselves and their children. Professionals have an important role in sharing information with young parents, but that sharing should not be done in a manner that presumes to know what is best for the teenager and her child or that tells the teenager how she should or must parent. Infant mental health providers assist young mothers in finding their own words to express their their hopes and concerns, words that are within them but they may not be confident enough to express. When necessary, providers coach teenage parents about how to be most effective in advocating for themselves and their children within various institutions and systems they need to navigate.

**Be prepared to advocate for young parents.** Although supporting young parents in advocating for themselves is important, it is also important that the infant mental health professional be available to advocate for young parents – whether it be in the courtroom, the labor room, or some other institutional setting such as schools or public aid offices. Simply being present with a young parent is a form of support as well as advocacy, conveying to other professionals that she and her child are valued. On occasion, the infant mental health provider, as someone who holds greater power than the young mother, may need, not only to be present with the mother, but to speak on her behalf. Such direct advocacy must be done in ways that do not undermine the young woman’s autonomy and are respectful of her wishes for herself and her family. Preparation for advocacy comes from planning conversations with the parent about her choices and views regarding herself and her child’s futures.

**Build supports and capacity across community organizations and systems.** Teenage parents have contact with a variety of organizations in their community including health clinics, social service agencies, public assistance offices, faith communities, social service agencies, schools, and sometimes courts. A reproductive justice framework demands that infant mental health providers, who often work individually with families, expand their role to building capacity within communities. Capacity building can take the form of hiring and training staff from within young mothers' communities, but also in creating deep partnerships with other community organizations interfacing with teenage parents, such as schools, employers, and health providers. Capacity building is knowing providers in the local community who will respectfully partner with young families as they gain confidence in moving forward. Capacity building also requires identifying the large variety of systems that serve young children and vulnerable parents and finding ways to integrate infant mental health services into those broader systems, whether they be health care, child welfare, justice, educational, or social welfare systems. Often those other types of services are the point of entry for families to infant mental health services (Osofsky & Lieberman, 2011).

**Fight to change systems that are oppressive.** Teenage parents frequently encounter organizations and systems that fail to support them and/or that harm them. Teenagers under eighteen, in particular, may be denied access to health, reproductive health, and social services that are routinely available to other mothers. Even if offered services, those services may not be provided in ways that are "adolescent friendly" (World Health Organization, 2012). Worldwide, adolescents want services that are accessible, acceptable, appropriate, and effective, where they are treated with respect and confidentiality. Although infant mental health providers do not usually consider themselves as social change makers, within a reproductive justice framework, it

is important to have eyes open to injustices that impact clients and to take action to change the systems creating those injustices. A variety of national and local policies and systems can threaten families' access to health care, economic wellbeing, opportunity for education, and community safety. From a reproductive justice perspective, infant mental health providers must be observant of the patterns of injustice being inflicted on the teenage parents they work with. They must recognize their own power as professionals and the strength of their voices. They must learn ways in which to create change effectively for young parents within their own communities and nationally by engaging in political activities, cultivating relationship with those who hold political power, educating the public about the strengths and needs of young parents, and being a voice for change.

In conclusion, all of the recommendations provided above derive directly from a reproductive justice framework and shift the emphasis of infant mental health services. However, most of these ideas, although important for securing reproductive justice for teenage parents, also reaffirm the importance of traditional infant mental health practice approaches—listening, asking questions, respecting parents' difficult past and current experiences, building on parent strengths, individualizing intervention, and reflecting deeply on one's work. The reproductive justice lens requires infant mental health workers to develop new visions of their relationships with their clients and to develop new outward looking skills, but the reproductive justice approach also empowers infant mental health workers to use their existing approaches to have broader impact on the lives of their young parents.

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