MONITORING MAD MOTHERS: UNMASKING VIOLENT INSTITUTIONAL SANISM

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ABSTRACT

Monitoring Mad Mothers: Unmasking Violent Institutional Sanism

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This qualitative research study explores the experiences, thoughts and feelings of mothers who have been given a mental health diagnosis. Using a narrative inquiry approach, semi-structured interviews were conducted with two mothers from Toronto. The study uncovers how sanist beliefs intersect with other sites of oppression, and the affect this has on mothers and their Mothering practices. Particular attention is paid to asking what the effects are on women who are assumed to be violent towards their children, due to a mental health diagnosis. It asks what this type of sanism and mental health profiling does to their sense of self, resilience and hope for their families and their futures.

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Lastly, I would like to thank my father, who finally came back into my life after so many years apart, and my wonderful and kind-hearted (step) Mother who tirelessly cooked big batches of healthy and delicious vegan meals for my children and I, to help ease my stress and to see me through my studies. The love and support I received were instrumental to my current success.

DEDICATION

I did this for us, for all of us, the too many fallen from the Town of Roses, who didn't make it and lay in perpetual youth buried in the ground (especially for you, my love, R.J.W).

I did it for us, for all of us that are still out there struggling, surviving, and just barely hanging on (hang on! I believe in you).

I did it for the little girl who still resides within me, who was told in so many different ways that she was worthless.

I did it for the heart broken young woman, I used to be, who believed there was nothing left to live for.

But mostly, I did this for the mother that I have become, and for the two most precious human souls I have had the privilege of walking through this part of my journey with. Thank you to my two children who continually amaze me with their kindness, patience and support above and beyond their years. I will never know how I got so lucky. I am truly blessed.

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CHAPTER 1. INTRODUCTION

Writing this Master Research Paper has been an excruciatingly painful process for me. There have been days where I have tried to write this introduction a hundred times, but each time resulted in tearful laments that my writing and my thoughts were not enough; not academic enough, not interesting enough, and not enough to satisfy the carefully crafted image of myself that I so desperately maintain and display to the world around me. Upon days, hours, and minutes of tearing myself down and reflecting profusely on my struggle to produce this piece of writing, I stumbled upon a burgeoning issue that had at first been gently gnawing at the recesses of my mind but then, suddenly, almost forcefully, seemed to pour out of my very being with each new research paper I read on my topic and each new conversation and interaction I came upon in my personal and professional life. The missing piece that was desperately yearning to come out was, and is, authenticity.

Originally, the main focus of this MRP was on the subject of motherhood and mental health and on all the messy ways that these two identities intersect and overlap to co-construct both societal and personal held beliefs of what it means to be a mother who lives with a mental health diagnosis. Juxtaposed with the dominant discourses surrounding these issues, I wanted to look into how mothers who have been assigned a mental health diagnosis interpret and prescribe their own meanings to both their mothering abilities and the labels of mental 'illness' they have been ascribed. I was particularly interested in the meanings, narratives, and labels (or not), that these mother's give to themselves and adopt in order to form a

resistance to the influences of sanism in their lives, in which they form a buffer, or rather layers of resiliency that enable them to mother in mutually satisfying and authentic ways for both mother and child.

However, whilst I am still interested in pursuing my original declared topic, I have stumbled across an intuitive feeling that both motherhood and mental health issues have everything to do with performance and with cloaking our true selves with masks, silencing our voices and surveilling ourselves and each other, so that we appear to comply with the appropriate ascribed societal norms. All realms of society have long monitored mothers; from the medical industries to pop culture portrayals of motherhood and we can all easily bring up in our heads the image of what constitutes a 'good' mother versus one who is deemed 'bad'. Likewise, those who are deemed 'mentally ill' are also monitored by societal structures and systems. When combining the two together, Mothering and the experiences of Madness, competing narratives are birthed. Coupling the adopted roles that must be performed, with the thoughts and behaviours that must be concealed from the greater public's judgmental gaze, creates an added layer of performance. Additionally, this performing, donning masks and hiding, results in the metaphor of a Mad mother's panopticon (Foucault 1979, 1989), a figurative embodiment of the incarceration that enslaves mothers under an omnipresent and malignant surveillance. Within the panopticon reigns all the dominant and marginalizing discourses and ideologies that serve to regulate and monitor the lives of mothers, especially those mothers who have also been given a psychiatric diagnosis. Therefore, is it any wonder that the natural outcomes and reactions to

imprisonment in a Mad Mothers panopticon would result in self-doubt, competition and comparisons to other mothers, judgments, low self-esteem, depression, anxiety and the regulation of the self and other mothers? Consequently, these oppressive ideologies and discourses, for example the 'bad' mother myth, summons mothers to monitor and self-regulate their actions and behaviours because they can never, and will never be, good enough (Caplan, 2000). Inevitably, the 'bad' mother proclamation subversively works to undermine women and no matter how perfectly applied and tightly fitted, the false veneer of the motherhood mask will be criticized and scorned by society and/or the self for failing to reach and maintain the gauntlet of an ever evolving and moving target; the optimal performance of femininity and sanity via the embodiment of the so called 'good' mother.

The problem with my prior failed attempts at writing this MRP were that they were sterile and cold and safely written behind my own mask of protection, that of the researcher, untouchable and unobservable, calculatingly researching and observing the 'other' behind the shield of academia. I expected others to answer my questions and bare their secrets, while guarding mine for fear that everything that I have worked so hard to build would crumble and both society and my peers would deem me defective and my achievements delegitimized. There is a saying: We are only as sick as our secrets, and I was becoming sicker and sicker as each graduate class and semester passed. Therefore, in the pursuit of authenticity and a vested self-interest in getting 'better' and no longer hiding in shame, I am choosing to situate myself within this piece with full self-disclosure and transparency.

Mothering and Madness¹ is a topic that I am passionate about as it reflects the personal identities that I embody. I am both a mother and a person who was proclaimed mentally ill² by the psychiatric industry. Whilst I wholeheartedly cherish and embrace my identity of mother, I rebuked the stigmatizing label of being called 'mentally ill' and despise and fight against both the internalized and public stigmatization that comes with being announced as such. I also recognize the place of power I hold within this research as a white presenting social worker and an academic. I know that the paleness of my skin affords me a certain amount of unearned respect, and leeway when it comes to how my identity as a Mad mother is perceived by others. I am also acutely aware that while at the moment I am currently precariously housed, struggling as a single mother who does not have much monetary funds, sleeping on an old worn out couch while my children share a room in our cramped one bedroom apartment, that by obtaining my Master of Social Work, my social location will move upwards to that of the comfortable professional middle class.

I acknowledge the privileges that come with those titles and have critically reflected on how those roles exist together to form an interlocking space of oppressions that often work towards hindering and subjugating the already marginalized identities of those who are mothers and who have been given a psychiatric label. I am in no way claiming that this research will be, or is objective.

¹ Both Mothering and Madness/Mad will be capitalized throughout as they refer to resistance movements and identities.

² The usage of the term 'mentally ill' or mental illness is only used to connote the language employed by the medical model and psychocentric framework.

My very being and my experiences as a Mad Mother are embedded throughout this paper. They have to be. I aim to delve into a search for not only resiliency practices when Mothering whilst Mad, but also into the search for authenticity. I must follow my nagging hunch that therein lies the keys to a revolution and a reformation in the ways in which those who like me, are Mad Mothers. I must embrace Fanon's (1968) sentiment: "I have not wished to be objective. Besides that would be dishonest, it is not possible for me to be objective" (p. 64).

CHAPTER 2. THEORETICAL FRAMEWORK

It is impossible to look at Madness and Mothering and how these constructed concepts overlap and intersect without recognizing that there is a multi-dimensionality to the marginality that these designations often incur. This leads to levels of disadvantage, each resting upon and supporting the other, much like scaffolding supports material structures. Building a theoretical framework through which to view these social issues is the tool, or the proverbial key, that may be used to unlock new ideas that will act to dismantle social constructs that serve as mechanisms of control and oppression. In order for there to be a reformation, a new language must be used to create alternate ways of seeing that push back against the discourse and manifestations of what is deemed 'truth' and accepted ways of being. Viewing these phenomena through the multi-faceted lenses of Social Constructionism, Anti-Oppressive Practice (AOP), Anti-Sanism, and Matricentric Feminism works to crystallize a differing vantage point of knowing, and approaching Mothering while Mad.

Going forward, using a Social Constructionist lens requires an acknowledgement that within the institutional world, objectivity, no matter how concrete it may appear to the individual is constructed or humanly produced (Berger, & Luckmann, 1966). There exists a dialectical paradox in which despite the assumption of objectivity that colours the social world in human experience, an ontological status is not thereby acquired apart from the very human activities and

behaviours that produced it (Berger, & Luckmann, 1966). In this way it becomes vital that I further situate myself within this work, by addressing my own ontology of Mothering and Madness.

In heeding Mullaly's (1993) words that individuals are the creator of the social world whilst simultaneously being created by the social world, I choose to construct my own reality and honour my own knowingness of truth. I challenge the accepted dominant discourse of what constitutes truth and reality (Brown, 2013) by calling into question the descriptive terms that are applied to mental health. It is precisely because language has the powerful effect of shaping how we view ourselves and often encourages an enactment of the roles that popular discourse proscribes (John, 1994), that I choose to identify as Mad, instead. The self-identifier of Mad and the embracing of Madness culture along with the drive to provide a well lived life for my children, both materially and emotionally/psychologically are what has led to my yearning to obtain a professional designation such as, Social Worker. I seek to explore the ways in which Mad Mothers who, like me, were assigned a psychiatric label, yet continuously resist, whilst embodying resiliency in their struggle against a system that adheres to the discourse of medicalization, enacting systemic and structural exclusions, oppressions and marginalization against those who are Mad (Poole, Jivraj, Arslanaian, Bellows, Chiasson, Hakimy, Pasini, & Reid 2012). Although claiming the identifier of Mad as my own personal form of resistance feels freeing for me, as if I have finally broken out of the shackles of shame, I wish to acknowledge that claiming the identifier of Mad, is a privilege. For some bodies, particularly those who hold Black and Indigenous identities, differing

and dangerous consequences may occur when challenging psychiatric discourse and institutions that have long been steeped in racism, heteronormativity, classism, sexism and other visibly intersectional identities.

Anti-Oppressive Practice (AOP) operates in the context of recognizing the multiplicities of oppressions and the need for structural changes at every level of society (Baines, 2011). Choosing to use an AOP lens is a strategic way of approaching social problems, as it refuses to ignore the many structural, intersectional, and complex facets that are incumbent to the human experience. AOP follows along a post-modernist trajectory in that it makes room for multiple epistemologies and ontologies, and does not rely on a singular approach. Instead, AOP is “an umbrella term for a number of social justice-oriented approaches to social work, including feminist, Marxist, postmodernist, Indigenous, poststructuralist, critical constructionist, anti-colonial, and anti-racist” (Baines, 2011, p. 4). Taking a dynamic approach, AOP is constantly evolving to address new social problems, tensions and the underlying structural and systemic factors that sustain them (Baines, 2011). Consciousness raising is an integral component of AOP that helps individuals, and communities realize that their problems are connected to social inequality and helps them find ways to mobilize, resist and fight for change (Baines, 2011).

Although I am choosing to utilize AOP as a theoretical framework, it is important to note that AOP is not without its faults. For example, Wilson & Beresford (2000) have argued that although AOP is committed to issues of social justice it continues to rely on the medical model when it comes to mental health. As

well, the perspectives of service users are left out entirely from the framework, or are not given the same credence as academic perspectives. As well, Yee & Wagner (2012) note that anti-oppressive practice has lost its radical position and has moved towards becoming more supportive of the values of the neo-liberal state. Additionally, there is a danger in over simplifying oppression creating narrow binaries of identities, that the individuals belonging to those categories are expected to fit into.

Much like AOP, using an Anti-Sanism approach also works to challenge systemic and structural inequalities whilst embarking on a journey of consciousness raising, albeit with a singular concentration. The ‘parents’ who brought to light sanist discourse were Morton Birnbaum, a physician, lawyer and mental health advocate who helped establish safeguards against involuntary commitment (Ingram, 2011), Michael Perlin, who writes about sanist attitudes that dominate both social and legal discourse (Perlin, 1993), and Judi Chamberlain (1975) who coined the alternate term “mentalism” in a book chapter in *Women Look at Psychiatry*. Mental health/distress is the main focus along with bringing to light the stigmatizations, marginalization and oppressions that follow a medicalized and pathologized psychiatric prognosis. The oppressions that people who have been given a mental illness diagnosis face are so commonplace, routine and embedded in everyday practices and language that they are rarely questioned. Instead, there are band-aid campaigns that encourage combating the stigma associated with mental health issues rather than initiatives that target the underlying causes of the

stigma. Until we name an issue we cannot begin to discuss it and it becomes very easy to ignore and deny its very existence.

Poole et al (2012) write that sanism is a form of prejudice. Sanist ideas are:

1. Insupportable of valid research and evidence to the contrary.
2. Based on 'gut feelings' or intuition.
3. Supported by hyper-unusual anecdotes portrayed by the media.
4. Based on how we segregate ourselves (emotions, thoughts, behaviours) from those labelled with a mental disability (CASA, 2011 as cited in Poole et al, 2012, p. 25).

Sanism represents ideologies that are so deeply embedded within the narrative of society that they become ingrained and entrenched ways of knowing that elude questioning or challenge. In her 2014 TEDX talk, Jennifer Poole points out the pervasiveness and often subversive nature of sanism in the ways in which we see sanist beliefs being acted out. For example, when we move our children to the other side of the sidewalk when coming upon a person talking to themselves, or when we say that 'those' people are different and we condescendingly believe that they are capable of less and are not able to make their own decisions. Everyday English language is littered with pejorative terms such as "she's crazy" or "that's insane" when referring to an event or an idea. It is these micro-aggressions that serve to maintain the sanist system that makes it acceptable to discriminate, otherize and be violent in words and actions to those deemed mentally 'ill' (Poole, 2014).

Just like Anti-Sanism focuses on a specific area, so too does Matricentric Feminism. Andrea O'Reilly (2016) makes the argument that the category of mother is distinct from the category of woman. She coined the term matricentric feminism to highlight that mothers require a feminism that centers the many problems mothers face; social, political, cultural, economic, psychological, and so forth as specific to women's identity and roles as a mother. O'Reilly calls for a feminism that positions mother's concerns at the forefront of theory in order to enact political empowerment (2016). Within third wave feminism we see that the intersectionality of gendered oppression when it comes to race, class, sexuality, etc. is recognized and spoken upon, yet there is a blatant erasure of the role and affect motherhood has on women. Matricentric feminism makes space for maternity identities where third wave feminism does not. "Mothers do not live simply as women, but as mother women – just as Black females do not live simply as women but as racialized women – and mother's oppression and resistance under patriarchy is shaped by their maternal identity just as a black woman is by her racialized identity" (O'Reilly, 2014, p. 6).

Similarly, Rich (1995) using the feminist adage of turning the personal into the political, examines the usage of the word Mothering versus using the word motherhood to describe maternal roles, wherein she distinguishes between the two meanings, one superimposed on the other: "the potential relationship of any woman to her powers of reproduction and to children" and "the institution which aims at ensuring that potential –and all women- shall remain under male control" (p.13). Rich (1995) defines motherhood as the patriarchal institution which is male

controlled and male defined and acts as a deeply oppressive force against women, whilst the term Mothering refers to the epistemologies of Mothering which are female-centered and defined with the potentiality of empowering women, through the practice of Mothering. By rejecting the reality of patriarchal motherhood as a male defined site of oppression, women can reclaim Mothering as a source of empowerment and a venue for social change wherein women become “outlaws from the institution of motherhood” (Rich, 1995).

These theoretical lenses require that I look at all the differing ways in which Mad mothers are constructed by the dominant discourse. I am tasked with uncovering the racism, sexism and sanism that live below the surface of popular cultures understanding of, and portrayal of Mothering and mental health. Lastly, and central to the heart of this research, these frameworks implore me to explore all the effects that these ideologies have on Mad mothers sense of self, resilience and hope for their families and their futures.

CHAPTER 3. LITERATURE REVIEW

Within the literature, I was able to find over-riding themes that were interwoven into each of the twenty-five peer-reviewed, empirical articles that I reviewed. The themes are as follows: Mental 'Illness' as a Gendered Concept, Mother Role Centralizing Personal Identity, Mental Health and Adequate Parenting, Importance of Social Supports/Connections, Fear of Child Apprehension, Gaps in Services, and lastly Stigma and Stereotypes.

Mental 'Illness' as a Gendered Concept

Tillman (2012), using Auto-Ethnography, explores how the surrounding culture in the 1950's and 1960's contributed to the gendering of mental health services. She laments that "psychiatric medicine could offer nothing more than a succession of pills to quell my righteous anger and strategies to put me in the place offered by the misogynistic Freud" (p. 219). Tillman (2012) heard sentiments from the psychiatric nurses and therapists that she should not want for anything as she has a husband and children and that she was incapable of being 'normal' due to her inability to ascribe to, and settle into her role as a mother" (p. 19).

Moving away from the 1950's and 1960's we are brought to the 1990's with Caplan's (1992) article that further reinforces Tillman's assertion that mental health is a gendered phenomenon. Caplan (1992) argues that the sexism embedded within the mental health profession has resulted in "serious oversights, inadequate

treatment, and even mistreatment and harm primarily to females but also sometimes to males” (p. 71-72). An example is given discussing the medicalization of Premenstrual Syndrome in which she notes that little to no improvement can be had through psychiatric treatment when the key to improvement lays in physiology not psychiatry (Caplan, 1992).

Further reinforcing the gendering of mental health, Krumm and Becker’s (2006) article looks at family planning and reproductive issues in women with illness. The assumptions used in the article that it may be “hypothesized that women with mental disorders favour traditional models of a ‘normal reproductive biography,’ including marriage and motherhood, to a higher degree than women in the general population” (Krumm & Becker, p. 452), serve to further reinforce the gender stereotype that normalcy is obtained in correctly performing femininity which is tied to motherhood as the end goal. This reduces women to their biology rather than looking at the myriad of reasons women who are deemed neurotypical, and those who are not, choose motherhood.

Mother Role Centralizing Personal Identity

Motherhood is described as an enriching experience of personal growth and a core component of personal self-identity (Oyserman, & Bybee, 2004) that enables a sense of belonging, pride and meaning to the lives of mothers whilst providing opportunities for fulfilling responsibilities (Shor & Moreh-Kremer, 2016). This sentiment was further echoed in Diaz-Caneja and Johnson’s (2004) study where motherhood was described as rewarding and central to participants’ lives by instilling purpose and fulfilment. Further echoing the latter two studies, Mother’s

with Schizophrenia in a 2006 study said that “having children had given them a purpose in life, made them feel fulfilled as women or had increased their self-esteem” (Krumm & Becker, p. 453).

As mothers, there is often a “shared primal sense of parental responsibility to protect their children regardless of the circumstances” (Montgomery, Mossey, Bailey & Forchuk, 2011, p. 6). However, feelings of guilt and shame were ascribed to motherhood when children saw the mothers were unwell (Montgomery, Mossey, Bailey & Forchuk, 2011). It was noted that guilt and shame also resulted when mothers perceived they had failed due to the inability to immediately experience intense bonding with their newborn baby (Krumm & Becker, 2006). A failure to experience the “rush of mother love” also resulted in feelings of shame and guilt (Taylor, 1995, p. 30).

For Tillman, it wasn’t until she carved out a renewed model of womanhood that allowed for pursuits other than only selfless caring and nurturing of others that she began to heal (Tillman, 2012). In another study, a request was made by a participant emphasizing the centrality and importance of the parental identity with the statement “they should recognize first and foremost that we are parents” (Parrott, Macinnes, & Parrott, 2015, p. 265), in response to how they wished the psychiatric industry would engage them. Furthermore, the development of a maternal identity is an opportunity for the internal narratives to move away from the identity of an ill person and towards a new identity role, which offered a more hopeful internal dialogue (Shor & Moreh-Kremer, 2016).

Mental Health and Adequate Parenting

According to the literature I read, the identity of mother and the act of mothering contributes to a positive identity and to the management of mental health issues (Shor & Moreh-Kramer, 2016). Furthermore, if current symptoms are under control and community functioning is positive then there is not necessarily a higher risk factor for problematic parenting (Mowbray, Oyserman, Bybee & Macfarlane, 2002). However, in a study conducted by Parfitt, Pike and Ayers (2013), it was found that a high proportion of new parents, both with and without mental health diagnosis, presented with high rates of inept or at risk interactions, which may imply that regardless of mental health diagnosis, people are not natural parents. A clinical implication from this is that all families, not just those with mental health issues should be assessed for risk. In addition, Parfitt and Ayers (2013), noted that no differences were found between parents without and with mental health diagnosis in regard to impulses to treat their babies roughly, shake, strike, or to stop the babies breathing. These impulses were found in one fifth of all parents. In fact, mother's with a mental health diagnosis who had positive self-construct possessed parenting styles and behaviours that were beneficial to their children and were more likely to be nurturing (Oyserman & Bybee, 2004). Furthermore, both mental health symptoms and being an adequate parent are dependent on the influence of contextual and structural factors, which serve to diminish the association between mental health and parenting (Kahng, Bybee, Oyserman & Mowbray, 2008; Borre & Kliewer, 2014).

Importance of Social Supports/connections

Supports play a critical role in helping mothers use strategies to balance motherhood and mental health recovery (Awram, Hancock, & Honey, 2017) and participating in a group with other parents with mental health issues facilitates comfort and engagement for participants (Coates, Phelan, Heap & Howe, 2017). Parents who reported feeling supported were able to make social connections and a significant reduction in symptoms occurred (Muzik, Rosenblum, Alfara, Schuster, Miller, Waddell & Kohcer, 2015). Therefore, the importance of providing tools to expand and stabilize social networks is of importance for improving parenting with mental health issues (Gelkopf & Jabotaro, 2013).

Fear of Child Apprehension

Taylor (1995) touts the danger that stigmatization plays in obstructing women's ability to safely reach out for help within the community and even amongst family members. Mothers did express their need of support with parenting but were hesitant to disclose their need for supportive help. Fear of losing custody of children was at the forefront of mothers choosing to remain silent about their mental distress (Taylor, 1995). The removal of children from the care of mothers was shown to only further their distress and some mothers spoke of great sadness, frustration and anger over the loss of their children, even when many years had passed (Taylor, 1995). Montgomery, Mossey, Bailey and Forchuk (2011) acknowledge "requests for help heighten the risk of child removal" (p. 2). Fear of disclosure inevitably contributes to mothers parenting without a support system which may in turn lead to a further decline in the ability to parent in a way that is beneficial to both mother and child (Montgomery, Mossey, Bailey & Forchuk, 2011).

Gaps in Services

There is a lack of comprehensive and integrative services for parents with mental health issues and there is a need to not only treat mental illness but to provide parenting skills and practical supports such as child care to promote the usage of mental health services (Hilton & Turan, 2014). Lack of childcare options (Diaz-Caneja & Johnson, 2004) and daytime programming that interfered with work schedules were insurmountable barriers for parents wanting to access mental health services (Isobel, Meehan & Pretty, 2016). As well, lack of follow up for parents with mental health issues who were able to access services, greatly impeded their recovery (Isobel, Meehan & Pretty, 2016).

Stigma, Stereotypes & Labels

For women diagnosed with a mental illness, perceptions of stigma being attached to their ability to mother were experienced with feelings of family and society suspecting them of abusing their children and feeling as if they are being monitored constantly (Krumm & Becker, 2006). There is a great fear of negative stereotypes with one mother expressing her need to hide her diagnosis for fear of bringing stigma upon her daughter "If I tell other mothers [about the illness] they might not let their children play with my daughter..." (Awram, Hancock, & Honey, 2012, p. 9). Along with having to cope with disrespectful messages from their social surroundings that serve to uphold assumptions of mothers with mental illness not being adequate and capable, mothers must also deal with professionals who view them as the illness label and do not recognize their identity of mother (Shor & Moreh-Kremer, 2016). Taylor (1995) brings up Self-Labeling Theory and how that

contributes to mental health being conceptualized as emotional deviance, and then analyzed the experiences women associate with a Postpartum Depression diagnosis. Taylor (1995) also ascertains that it is an “individual’s own recognition of the discrepancy between their private emotions and the emotional states perceived as normative that triggers self-attributions of mental illness” (p.27).

The vast majority of the research articles I came across used a positivist epistemology, which assumes that observable facts are distinct from ideas, theories, or values. Facts are seen as existing as their own entities apart from personal thoughts or ideas (Neuman, 2006). The researcher, then, is positioned as the expert, the knower, and the value free observer and judge of what constitutes knowledge and what knowledge is important enough to be studied and/or included. For example, in Parfitt & Ayers (2014) study of transitions to parenthood which used a mixed method of information gathering, the findings did not take into account structural and gendered reasons for mental health problems such as parenting roles generally being ascribed to the mother, a female, and how the added workload could affect her stress levels, thus leading to mental distress. As well, natural feelings such as anxiety which could be produced by lack of sleep along with being an inexperienced parent was viewed as a pathology rather than as existing on a continuum of human emotions. Similarly, medicalized epistemologies were elevated and given precedent in multiple studies such as mental health nurses who ran a structured emotional awareness based parenting group, whose field notes from their facilitations were used to calculate the research studies findings, with

little representation of meaning given to actual participants (Isobel, Meehan, & Pretty, 2016).

Lack of representation of the people who were affected by parenting with a mental health concern was a common theme throughout the positivist approach, for example, often times participants were asked about their experiences but not about how those experiences could be made better, or how they came to be. The researcher, instead, would ascribe the recommendation/solution going forward and was the arbiter of best practices sometimes calling for more focused therapy (Parrott, MaCinnes, & Parrot, 2015) and even prescribing that professional direction was needed to improve parenting confidence (Gelkopf, & Jaboraro, 2013). There was never a suggestion of exploring alternatives such as peer and informal networks of support. As well, much of the positivist research methods had a tendency towards a mixed method approach, with one being entirely quantitative (Hilton & Turan, 2014). The studies tended to be highly structured, methodical and detail oriented (Muzik, Rosenblum, Alfafara, Schuster, Miller, Waddell, & Kohler, 2015).

Addressing Knowledge Inclusion and Exclusion

It becomes clear that certain voices are privileged in not only defining what counts as knowledge but also disseminating and legitimizing said knowledge within academia and then, to the broader public. There is a clear positivist paradigm, which centralizes the professional as the expert. There is also a secretive bent with the professional as the ultimate knower, in that none of the researchers ever situated themselves within the literature. We don't ever find out what their

personal connections, if any, are to the subject and participants that are being researched. This serves to further mystify, and in a sense builds a barrier between those who are professionalized, those who are reduced to mere subjects being researched and the general public.

Consequently, professionalized language is used, furthering the divide and ultimately dehumanizing the participants by shaping them with medicalized jargon. For example, in every single study, the term mental illness is used to describe mental health distress and/or alternate ways of experiencing reality. Revisiting Mullaly's (1993) description from earlier on in this paper, of individuals as the creator of the social world whilst simultaneously being created by the social world, we can see that language has the powerful effect of shaping how we view ourselves and often encourages an enactment of the roles that popular discourse proscribes. We then have to wonder; how does this affect the research participants? And does this serve as a way to muzzle their voices? Little has been written that directly addresses the actual real, lived experiences, struggles, adversities, and experiences with the helping professions, as well as coping mechanisms, authenticity and tools of resiliency and resistance.

CHAPTER 4. METHODOLOGY

Going forward, to combat positivist research and to add a differing lens from which to view Mothering and Madness, I will be prioritizing the personal narratives of mothers in this MRP. I will also prioritize the stories that they wish to share to build a new narrative, or a re-storying, of the popular discourses that exist in regard to mothers who identify and/or are deemed Mad. Strength, authenticity and resiliency are the foci instead of deficiencies, inadequacies, and medicalized psychocentric pathologies. In order to do this, I worked with two participants who, through a general call out on social media, agreed to be a part of this research. These two individuals are past acquaintances of mine, whom I no longer have a relationship with. Both were former classmates of mine, one having attended elementary school with me, and the other from college. Whilst there is some risk that the interviews may be considered 'compromised' due to our past relationships, I am confident that enough time has passed without each of us having real contact, that the participants would be able to speak freely, especially since both expressed enthusiasm with the subject matter. Additionally, as previously stated, this researcher makes no attempt to pretend to be objective as I am deeply situated within this research.

Knowing the participants, albeit superficially, helps to set the scene for the methodology I believe best gave voice to the participants; Narrative Inquiry, which is first and foremost interested in experiences as stories (Connelly & Clandinin, 2006). This allows for rich descriptions of experiences to be told, and since the participants and myself do have a prior connection I hoped that there would be some ease in which we explore their experiences. The main rationale for the usage of Narrative Inquiry for this Major Research Paper is that “humans are story-telling organisms who, individually and socially, lead storied lives. The study of narrative, therefore, is the study of the ways humans experience the world” (Connelly & Clandinin, 1990. p.2).

Similarly, to Shor, & Moreh-Kremer’s (2016) study in which they invited a mother with a mental health diagnosis to examine the interview guide and to critique the questions included within the interview guide, to make certain that the questions reflected pertinent issues involved in developing maternal identity of women with mental health distress, I too worked in collaboration with the mothers who agreed to join my Masters Research Project. I was not interested in assigning, exclusively, my own meaning and interpretations to the research, but in amalgamating my personal epistemologies, ontologies and axiologies with those of the research participants to create a dynamic knowledge base that honours the multiplicities of the human experience and different ways of knowing.

Before delving into the heart of the findings and analysis section in the following chapter I want to touch on the challenges brought by the Research and Ethics Board (REB). It came to pass that the REB, upon review of my research

proposal, deemed the subject matter that I had wished to explore on Mothering and Madness to be dangerous, and informed me that in order to proceed with this project a clause would need to be included within the consent forms stating that I have a duty to report any and all suspicions I may have, or that may be revealed to me, within the interviews about current and past abuse by the participants towards their children.

Given that the three questions I had submitted to the REB as guiding my research were benign inquiries strictly looking into how North American society perceives mothers who have been given a mental health diagnosis, How the mothers perceive themselves and lastly how they enact strategies of resiliency whilst Mothering, I was shocked and dismayed at the stipulation to include a duty to report abuse clause. The questions I had submitted for review were as follows:

1. How do the dominant discourses frame motherhood, mental health, and the combination of child rearing with a mental health diagnosis?
2. How do mothers who have been given a mental health diagnosis make personal meaning of, and find identity (or not) in the terms Mothering/motherhood, mental health/Madness and how do they navigate or combine those labels?
3. What are the coping methods employed and ways they are resilient while caring for their children?

It was apparent that sanism with all its stigmatizing, damaging and painful misconceptions was at play here. There was the automatic assumption that people like me, who have been labelled “mentally ill,” are dangerous and violent.

Furthermore, mothers who are Mad were not to be trusted with their offspring, another sanist notion. The REB were purposefully complicit and wilfully ignorant in their supporting of sanist violence against Mad mothers despite having been provided with a review of the literature in which several studies effectively dismantled the myth that a mental health diagnosis equals abusive practice (Mowbray, Oyserman, Bybee & Macfarlane, 2002; Kahng, Bybee, Oyserman & Mowbray, 2008; Borre & Kliwer, 2014). Instead they chose to follow and maintain the popular North American discourse that ‘those’ types of mothers couldn’t possibly be trusted to raise children with love, with warmth, and with safety in a nurturing and abuse free home.

With the help of my MRP advisor, Jennifer Poole, I was able to challenge the Research and Ethics Board stipulation and consequently the duty to report clause was promptly taken off the table. I shudder to think what would have happened if my anti-sanist research inquiry had involved sanist reporting.

The participants – An Introduction

With REB approval, the research sample consisted of two mothers who were the full time custodial parents of their children. The names of the participants have been replaced with pseudonyms³ and any identifiable details that were divulged in the interviews have been changed in order to protect the privacy of the participants.

Elizabeth: Elizabeth is a White presenting thirty plus year old woman who has a young daughter that she had with her ex-partner. She is currently pregnant with a

³ The participants chose pseudonyms to use in this study.

different partner. Elizabeth's ex-partner has consistent and regular contact with their daughter. Elizabeth has a strong family support system.

Jenelle: Jenelle is a racialized 30 plus year old woman who identifies as Black. Jenelle has two twin boys. Jenelle's ex-partner is not involved in their lives and left when the twins were very young. Jenelle has little to no familial support system.

Upon completing the interviews with both Elizabeth and Jenelle, I transcribed the sessions and then began picking out common themes that both the mothers had touched upon. I left much of the responses the participants gave to me, in whole chunks, instead of just utilizing a line here or there from their interviews. Following Narrative processes, this was done purposefully in order to ensure that the participants' voices were given a strong platform. The themes are as follows: Acceptance/Rejection of Mental Health Diagnosis, Institutional Sanism and Fear, Stigma, Surveillance and Lowered Expectations, The Mythical Imagined Perfect Mother Role, Shame, Guilt and Internal Policing, and lastly Mothering as A Healing Tool/Source of Strength.

CHAPTER 5. FINDINGS/ANALYSIS

Findings

Acceptance/Rejection of Mental Health Diagnosis

Both of the participants expressed acceptance of their mental health diagnosis and adherence to a proscribed psychotropic regime at one point or another in their journeys. However, at this time, only one participant currently identifies as having had a mental health diagnosis and the other, although having done so in the past, now rejects her mental health label along with the medications that went with it. There was a genuine push and pull narrative that developed surrounding acceptance, rejection and even resistance to the diagnosis/labels the women had been given throughout the interview process. This speaks to the fluidity of mental health and helps to frame the phenomenon on a continuum rather than the 'set in stone' proclamation that the medical model of mental health adheres to.

Elizabeth shared that at the age of twenty she was diagnosed with Bipolar disorder, "I did identify with it [Bipolar Disorder] for quite a bit and then I wasn't so sure if other factors were complicating things and whether or not I really had what they said I did" (Elizabeth: 6-8). Elizabeth had been using substances such as

marijuana, cocaine and alcohol and she wondered if her initial diagnosis could be attributed to those substances, as she was aware that “drug usage often mimics signs of mental illness” (Elizabeth: 9). When Elizabeth became pregnant with her daughter, she stopped all illicit substance use and weaned herself to very low doses of her psychotropic medications. Elizabeth reported feeling great while pregnant with little to no mental distress but as soon as she gave birth to her daughter she became severely ill with Postpartum Psychosis and was later re-diagnosed with Bipolar Disorder. “I agree with that now. I no longer look for other reasons I may be feeling unwell and I do what my doctor tells me to do” (Elizabeth: 10-11).

Jenelle had the opposite trajectory of Elizabeth, with acceptance of her diagnosis in the beginning stages and then outright rejection and resistance to the label.

I remember coming home from the hospital and I had just finished nursing, and both boys were sleeping when this sheer wave of panic came rushing over my entire body. I curled up in a little ball on the couch, closed my eyes, and it was like I was falling over and over again into this dark hole. (Jenelle: 14-17)

After that initial first episode, Jenelle would often have moments of sheer terror “if I couldn’t get to a quiet space away from other people I would get physically sick, sometimes vomiting and shaking. It got so bad that sometimes I couldn’t even take my babies outside” (Jenelle: 23-25). When her boys were six months old, Jenelle went to a walk-in clinic that had a psychiatrist on staff. There, she was diagnosed with an anxiety disorder and prescribed medications. “I will never forget the doctor telling me that this would be a lifelong illness. I went home and was devastated thinking that this was it for me, this would be how I would spend the rest of my life”

(Jenelle: 29-31). Jenelle reports taking the pills she was given for a year but not feeling much better. "I often felt like I wasn't myself, like I was a shell or a walking zombie. I was always just dead inside and couldn't even love on my babies properly" (Jenelle: 45-46). When Jenelle could no longer stand feeling "drugged all the time" (Jenelle: 48) she told the psychiatrist that she needed to stop taking the medications. Jenelle was strongly warned against doing so, and was reprimanded, with the psychiatrist telling her that she had children she needed to put first above her desires. Jenelle describes this as being the pivotal moment in her rejection of the mental health diagnosis she had initially been given:

All of a sudden I just felt this rush of anger or maybe it was frustration building up. I mean who the hell are they to tell me that I should keep taking something that I told him was not letting me the best mom I could be and then try to tell me that I had children to take care of. I said no! I'm going to do what is best for me and mine and I'm going to stop all of this! I asked the psychiatrist why he never even bothered to get to know me? and I laughed at him and told him that I would like to see how well he managed all by himself, day and night with no help and two little ones. I asked him how he would feel knowing that he had two Black babies that will grow up to be looked at like thugs? He was white and I was mad because he was just staring at me, like I was a bug or something, and I just knew he could never get it. (Jenelle:173-183)

Jenelle stopped taking her medications, however, she did so abruptly without tapering slowly off and reported feeling sick and experiencing withdrawals from "those devil drugs" (Jenelle: 50). Although Jenelle was confident in her decision to no longer identify with her mental health diagnosis, she did say "if I could go back and do it differently, I would have held my tongue and played the nice girl because I have three strikes against me; I'm Black, I'm a single mama and I have a mental

illness. And I knew that doctor was mad at the way I spoke to him and he made sure I paid because he contacted the authorities” (Jenelle: 198-201).

Institutional Sanism and Fear

Women’s lives, especially mothers’ are organized and regulated through multiple social practices and institutions (Weigt, 2006). Some bodies are, dependent on social locations such as, (dis)ability, race, and other factors, subjected to multiple oppressive institutional discourses and penalties. Often these monolithic institutional powers render deep fear in mothers, especially Black and Indigenous mothers, due to the ever-present threat of child apprehension. This is evident with the issue of racial disproportionality and overrepresentation of Black and Indigenous youth within child welfare agencies across Ontario (OACS,2015).

Jenelle had her very first taste of institutional sanism and the resulting fear that ensues when she challenged the opinion of the ‘experts’ by refusing to comply with ‘doctors orders’ and stopped taking her medication.

It was a couple of weeks after I had told the psychiatrist off and I’m lying in bed with my children cause its nap time and all of a sudden I hear a loud BAP, BAP, BAP at the door. I know that’s a cop knock and I can hear their radios. My boys are awake and crying and I’m looking all a mess because I’m in a dirty nighty and my hair hasn’t been fixed all day. I go answer the door and it’s two police with a lady, saying she is from Children’s Aid. (Jenelle: 205-210)

Jenelle was told that they were there to do a welfare check on her children and her.

Jenelle described the initial visit as demeaning and embarrassing:

She searched my entire apartment. I mean, she walked into my home with her shoes on, no respect, and started opening up my fridge and cupboards without even asking if she could. And the whole time the cops and her were just looking at me with eyes that, like I just knew, they were judging me. (Jenelle: 212-215)

Jenelle was made to sign a contract in which she promised to keep taking her medications and agreed to having the Children's Aid Society conduct home visits. This contract was signed under duress, under the threat of her children being apprehended and removed from her care.

I just remember being so shocked and so scared. Like, I couldn't believe this was actually happening to me, you know? Like, I had done nothing wrong and had always done everything for my boys. And I would never hurt them, ever, not in a million years. I breathe for those angels so I couldn't understand why they would think that I was going to harm them. (Jenelle: 219-223)

Jenelle became visibly upset at this point in our interview and her body began to tremble. I asked if she needed to take a break and she replied:

No, it's just that all of that was so hurtful and now I'm always looking over my shoulder. I can't never relax. It's like every time I hear a knock at the door I jump out of my skin because I think it's them coming to take my boys away. Everything I do and say now, I always have to be careful, so careful not to slip up in case someone is gonna get it in their heads to report on me...I learned my lesson and I don't ever want to sign paper like that again. (Jenelle: 225-230)

Elizabeth, as well, in the first minutes of our meeting brought up her fear that I would report our conversation to the Children's Aid Society. She asked me multiple times before we began if I was certain that the Research and Ethics Board could not insist that I hand my recording of the interview over to the CAS. I assured her that they could not, nor would I allow that to happen. Elizabeth then wanted me to know that she did not believe all Social Workers were "evil" (Elizabeth: 16). "It's not like they are the big bad wolf or something out to snatch people's children and I know that. I don't want you to think that I dislike you because you are a Social

Worker” (Elizabeth: 17-19). When I openly acknowledged to Elizabeth that the Children’s Aid Society is an organization, that in my opinion, has too much power and abuses that trust, Elizabeth visibly relaxed and began to open up about her experience within the sanist mental health systems and Institutions:

I went through something with her father that triggered my mental health issues and I was trying to get into the hospital where my psychiatrist is but they sent me to CAMH [Centre for Addiction and Mental Health]. The nurse there wanted to call CAS because I was seeking help with my mental health and I have a daughter. The thing is, that I’m not even the only person who can care for my daughter, she has her father, she has my mother. It wasn’t really a safety issue and I was only there for twenty-four hours and then I left, even though I was so depressed because I was scared about CAS.
(Elizabeth: 168-174)

Elizabeth admitted that ever since that experience, there have been multiple times when she was unwell but was too fearful to reach out for help, lest the Children’s Aid Society would be informed. Elizabeth vocalized the perils of being a mother in mental distress, “It can be very dangerous to be a mother and ask for help or admit that I am feeling a certain way” (Elizabeth: 178-179).

Stigma, Surveillance and Lowered Expectations

An insidious function of sanism is to paint those who are deemed mentally ill as unintelligent and lacking in self-efficacy (Poole et al., 2012). This can lead to a ‘buying in’ to sanist ideologies and often times internalizing those limiting beliefs. Likewise, mothers, especially those deemed mentally ‘unwell,’ are subject to what Foucault (1979, 1989), conceptualized as the observational gaze, or a panopticon, which is the metaphorical representation of a prison in which each person is being monitored and in turn surveilling the other and the self, resulting in each person being regulated while at the same time becoming the regulator.

Both Elizabeth and Jenelle spoke about how being a mother with a mental health diagnosis meant that they were flagged by society, institutions, and even friends and family as flawed and needing to be monitored constantly, lest they become violent towards and hurt their children. Jenelle tells about a time when her children were infants:

I wasn't getting any sleep, I mean I would go nights and days where I was lucky if I got two, maybe three hours total. When one would finally fall asleep the other would wake up and be needing attention. The worst part was that James had colic and he would be screaming in pain off and on every night from about eight to three in the morning. Every time I put him down to feed his brother the crying got worse. It got to the point where I was so tired that I thought I was losing my mind. I called my mother and asked her if she could come over and watch them because I needed a break. She said to me 'why? what are you going to do to them?' and then when she came over she said 'what would you have done if I hadn't shown up? Were you going to hurt them?' I know she wouldn't have said that to me if she didn't see me as weak and someone to be afraid of just because some doctor said I have an illness. (Jenelle: 107-117)

Jenelle told me that she often experiences her own form of internal surveillance, in that she tries to make sure everything appears perfect on the outside because she knows that having dishes in the sink from the night before, or going outside without a full face of makeup could be interpreted by others as her being "crazy" (Jenelle: 92) and needing intervention. "I don't think the other mothers, the ones who aren't labelled, have to be so worried that every little thing they do will be attributed to them being crazy. And they can do normal mom stuff like take their kid to the park without being judged and watched and expected to fail all the time" (Jenelle: 91-93). Jenelle then shared an incident she had when her CAS worker stopped by for a home visit:

First she comes late, as usual not respecting my time and then when she gets here, I'm outside my apartment with the boys ready to head to the park because it's been a half hour and I was tired of waiting. She asks me where I was headed to? and so I tell her that I was taking them to the park. She looks shook up and concerned and says in a fake voice like I'm a child 'but there are two of them you can't do that all by yourself. What if one wants to go on the slide and the other on the swing?' She was waiting for me to admit that I don't watch them and can't handle looking after my boys. I looked her right in the eye and told her, my children know how to take turns I teach them patience. (Jenelle: 97-105)

Elizabeth also spoke about internally monitoring herself when she told me that when she found out she was pregnant she signed up for every parenting class she could in order to demonstrate to her doctor and her family that she wouldn't be a "terrible mother because I am Bipolar" (Elizabeth: 24). When Elizabeth's family doctor found out that she was pregnant, Elizabeth was referred to a special program for high-risk mothers. Elizabeth identifies as a recovering addict and noted that even though she had a year of sobriety under her belt, she was forced to undergo weekly drug tests in the program. Elizabeth also spoke about the Social Worker she encountered in the hospital High Risk Pregnancy program:

As soon as I met her one of the first things she says to me is 'we would like to have CAS look at the situation and meet with you and talk with you just to make sure that it's safe for your baby. She didn't even get to know, or take the time to get to know me and instead made an immediate snap judgment. (Elizabeth: 314-318)

After giving birth Elizabeth said that she "went into immediate psychosis"

(Elizabeth: 280) and was diagnosed a week later with Postpartum Psychosis.

I called an ambulance for myself and was brought into the hospital. I didn't want to harm my child, I knew what was going on and I just wanted help. I had to meet with a CAS worker in the hospital when I was in active psychosis and they just wanted to make sure I was safe to be around my baby. They asked me questions like, how do you know when baby has a fever? And I was able to answer all of the

questions correctly. The CAS worker didn't understand how I was able to answer everything and kept saying this out loud in front of me to the Social Worker. It was like they thought I was dumb because I was sick and didn't expect much of me. (Elizabeth: 290-297)

The Mythical Imagined Perfect Mother

Myths about mothers can be categorized into the two opposite dichotomies of the 'good' and 'bad' mother. These designations work to keep mothers in their place, properly behaved and docile, lest they be designated the 'bad' mother. This can be seen in the cultural phenomenon described as the "mommy wars" and deemed the "new momism" (Douglas & Michaels, 2007) which has embedded itself into the popular narratives and ideologies of what motherhood should entail. New momism is comprised of the dominant images reflected in the popular media that idealize mothers and promote a form of intensive mothering which demands constant vigilance regarding the health, safety, entertainment, development and happiness of children, whilst at the same time demanding a cheerful, self-sacrificing intensely engaged mother who has complete mastery of the latest parenting techniques popularized by child care experts (Douglas & Michaels, 2007). It is therefore understandable and no wonder, that mothers, who after withstanding a constant barrage of perfectionist demands and ideals that undermine and endanger psychological health go Mad or are deemed 'mentally ill.'

The consensus from both Jenelle and Elizabeth is that Mothering was a rewarding endeavour, but as Jenelle puts it, "the outside noise from everyone else's expectations of what the perfect mother should be sets up expectations that can never be fulfilled" (Jenelle: 20-21). Both women agreed that the pressure to be the 'perfect' mother came from media, their friends and family and from their own

internalizations of those messages. Elizabeth notes that there is “so much pressure to be the park mom or the soccer mom to keep your kids active, and then feed them organic, and keep the house clean, and it just never ends” (Elizabeth: 228-229). Elizabeth tells me of the times where she takes her daughter to the pool for a swim and how it is the only activity that she accomplishes for the day.

I know my daughter loves the water so I do it [take her for a swim] but then I’m just so tired after because it’s a big production getting ready, getting there and getting back home. By the time we get back I’m too exhausted for anything else and I feel like such a bad mother. Maybe I can’t keep up the way the other moms do and I’m not cut out for this. (Elizabeth: 232-236)

Jenelle recounts a time when her boys were infants and she would make the effort every weekend to visit her sick grandmother. She described her grandmothers’ house as “the hub of the family where everyone gathered and a place that I felt safe. I wanted to share my babies with her, maybe bring her some joy, because she was the only person in my family who was never judging me for having a mental illness or being on my own” (Jenelle: 123-126). Jenelle did not have access to a vehicle and it would take her a total of four hours there and back to make the trip.

It was two buses and a subway to see Grandma, and that meant lugging the double carriage upstairs and onto buses and then pushing through snow when it was winter. Sometimes the boys would cry and people would give me the nastiest looks because here I was taking up space with the carriage and now they had to listen to us too. Sometimes people would tell me I shouldn’t be on the bus with that thing [carriage]. (Jenelle: 126-131)

Jenelle confided that she felt as if she were a failure because she didn’t have a minivan like the successful moms she sees on the television. On one of these trips after a particularly gruelling trek, Jenelle arrived at her grandmothers’ house

mentally and physically exhausted. She had just finished nursing both the boys when she realized it was time to change their diapers.

I just sat on the couch and I could barely move, I just felt so heavy. I was so tired of everything and the thought of changing any more diapers at that moment...I just couldn't. My Aunt was sitting beside me and I asked her, 'Auntie could you change their diapers for me?' And I never asked anyone for anything because I'm independent, so this was the first time you know? She said to me 'you're the one that wanted them, you can handle them,' got up and walked away. I felt so alone but also so demeaned as a mother like I wasn't doing my job properly or something, I wasn't a good enough mom. (Jenelle: 138-144)

Shame, guilt and Silence

Throughout both interviews, a common theme was the overwhelming feelings of shame and guilt which led both Jenelle and Elizabeth to remain silent about their struggles when interacting with others and of being wary of reaching out for help, especially when that help could result in further restrictions, surveillance and/or the removal of their children. Jenelle demonstrates how shame, guilt and the resulting silence create barriers that prevent supportive and meaningful relationships developing with the other mothers she encounters.

Sometimes it's like there is this thick wall of glass that I can look through standing on the outside of the group of mothers and it separates us. I seem all right, I mean... mostly I don't think they can tell that I get sick and overwhelmed sometimes. But there is this thing...this embarrassment and shame that keeps me holding back and I don't want that to affect my kids. Like, I don't want the other mothers to not let their little ones play with mine. And sometimes I wonder if other mothers feel the same way as me? Even if they don't have a mental illness. I wish we could just all come together and just be...real. (Jenelle: 383-390)

Elizabeth also worries about how her mental health diagnosis might affect her daughter and tries to keep it hidden from both her child and the other parents.

“I don’t want my daughter to be worried or sad about me all the time and I don’t want how I am to affect how she is treated at school. People talk and I don’t want her overhearing another parent saying ‘oh, she has a crazy mother’” (Elizabeth: 244-246). It is interesting to note however, that Elizabeth does have other mothers from her daughters’ school on her social media account, where she often shares about her involvement in Twelve Step sobriety groups. When asked why she felt comfortable sharing her struggles with addiction and not mental health Elizabeth rationalized:

You can recover from doing drugs and drinking but I’m always going to be Bipolar, there’s not really a sobriety from Bipolar Disorder, you either have it or you don’t and I really don’t want to have to explain that to them in the context of my daughter. It’s not something I’m proud of, whereas, I’m proud to have overcome my drug use.
(Elizabeth: 150-153)

Mothering as A Healing Tool/Source of Strength

Motherhood is a socially constructed concept that requires mothers to perform in very specific, prescriptive ways that do not make room, or allowance for Mothering with ongoing mental health issues. Within the medical discourse of disability, mothers who are Mad, are mainly perceived as patients and not as women capable of successfully rearing children. Rather they are viewed as passive receivers of help and social services, not as competent mothers (Grue & Laerum, 2002). What the literature often failed to speak upon, was all the ways in which mothers who are Mad are not only surviving, but are also thriving, right along with the children they are tasked to raise.

When Elizabeth and Jenelle were asked in the interview to speak upon new abilities and strengths they had discovered in their Mothering trajectories, the energy in the room changed. There was a shift away from the heavy and serious

mood in the room and a move towards a more jovial feeling of hope. This was the part in the interviews where both participants came alive, their faces brightened and they sat up straighter. This was where Jenelle told me, “I’ve never actually thought about myself as having strength before. I’m always just go, go, go because it’s what I know I need to do for my boys...so in a way I guess that is a strength to just keep pushing through even when I’m feeling like I’m dying on the inside. I don’t ever give up” (Jenelle: 319-323). After pointing out her resiliency and drive, she acknowledged that she did indeed possess a strength that she had not had before becoming a mother.

In the past when things didn’t go right, I would fall apart. When I would have a fight with let’s say my best friend or my boyfriend I would crumble. I would literally spend an entire day curled up in bed crying. Now, I don’t let things get me down. I don’t let anything take me down. I am a strong woman. (Jenelle: 323-326)

Elizabeth shared that becoming a mother had been a catalyst of sorts in her healing, or rather as she described it:

Managing my symptoms is easier now that I’m a mom. I actually think they have gotten better because there is more of a motivation to stay clean and sober, but also to treat my mental health. I’m more diligent in looking after myself because I have somebody else to look after and I like the direction that my life is now. Whereas before I was really entrenched in my mental health symptoms. (Elizabeth: 77-81)

Analysis

Initially I had wanted to research how mothers who are labelled ‘mentally ill’ ascribe meaning to their mental health diagnosis together with their mothering practices. I had wanted to focus on the resiliencies Mad mothers possess and delve into their personal expressions of resistance against prevailing sanist discourse. However, the trajectory of this MRP took on a different tone when the Research and

Ethics Board enacted sanist micro-aggressive, institutional violence against myself, as well as the participants in this project. Consequently, much of the conversation became centered on all the differing ways in which institutions abuse their powers, reify sanist ideologies and stereotypes, and maintain anti-black racist practices.

The participants repeatedly spoke about the ways in which they were forced to monitor, regulate and enact surveillance upon their words, thoughts, feelings and actions in order to survive within the sanist systems and structures North American culture embodies. They spoke of having to protect themselves, and their children, from the psychocentric systems that were constantly looming over them, as an omnipotent threat, working to undermine who they are as mothers with the power to define, and then to decide their competency as mothers. Both participants expressed a palatable fear of the oppressive institutional powers capability of violently ripping away and stripping their status as mothers, through the act of child apprehension.

When the REB chose to perpetuate the insidious stereotype that people with mental health diagnosis are violent, and that mothers with said diagnosis pose a risk of harm to their children, they perpetuated the shaming narratives the participants in this study described as a constant theme in their daily lives. The misperceptions that correlate violence with a mental health diagnosis contribute significantly to the participants having to hide their authentic selves from the public and from the institutions that are charged with helping them. They enact further harm by upholding the established oppressive, racist and sanist status quo. This serves to force mothers with mental distress into isolation, socially excluding them and

exacerbating and intensifying feelings of being separate. We know that people living with mental health conditions are no more likely to engage in violent behaviour than the general population (CMHA, 2011), yet the push to correlate mental health with violence persists. Despite the evidence to the contrary that mental health distress does not equate to violence, this discourse remains strongly ingrained into both the lay persons and the professionals' ontology, in a not so innocent and deliberate act to ensure that long standing and established North American institutions of patriarchal, white supremacist dominance remain in control.

Meerai, Abdillahi, and Poole (2016) beseech us to remember that institutional and systemic oppression is a socially constructed tool wielded in domination and control practices that serve to maintain certain social roles used to separate us into power up and power down groups. We are presented with an example of this, when Jenelle shares her experience of resisting the medications that actively impeded her ability to successfully mother her children. Jenelle recounts feeling as if she were detached and a former shell of herself, yet, when relaying this to her psychiatrist, she was told that she did not know what was best for herself and her children. The psychiatrist used his psychocentric and bio-medicalized position of privilege to adopt the role of the 'expert,' the 'knower' in order to both define Jenelle as a mother, and to simultaneously delegitimize Jennelle's innate authentic knowing of how best to take care of herself. Jenelle's refusal to comply morphed into a power struggle, in which Jenelle and her Madness were constructed as posing a threat to her children. Furthermore, Jenelle's Blackness also equated to being seen

as threatening and violent in an act of anti-Black macro-aggression. We see this when the psychiatrist chose to utilize the Children's Aid Society as a mechanism of control in an attempt to regulate Jenelle's Black body and mitigate the insult that Jenelle, a Black woman, had caused to his male psyche when she refused to comply with his psychiatric regime and had the audacity to challenge his authority. In turn, we see the Children's Aid Society utilizing the police force to maintain the white supremacist state regime that regulates, monitors and maintains power over Black, Indigenous and Mad bodies.

During the interview Jenelle spoke about having read a 2016 Toronto Star article, which exposed that there was a disproportionate number of Black children who had been apprehended by the Children's Aid Society. Jenelle knew that presenting as a Black single mother diagnosed with a mental health condition, was "three strikes" (Jenelle: 199) against her and that this made her children vulnerable to being, as she succinctly puts it, "kidnapped by the baby snatchers to make them white and follow along with how they want us to behave according to their white ways" (Jenelle: 188-190). Jenelle further speaks upon the coercion that took place forcing her to sign an agreement with the CAS in which they have access to her home, her children and her mental health by way of "dropping by any time they want, and monitoring what I have in my fridge and what I put in my body, if I'm taking the pills for my head or not" (Jenelle: 217-218).

Both women alluded to a lack of structural/environmental analysis when the so-called 'experts' came into contact with them. They dictated what the correct prescription to take was, and what the formula to follow for optimum mental health

and functioning of the participants should be. The explicit problem being that these magic formulas and quick pill fixes to health were conceived by the 'experts' and not the participants themselves, who know their true selves and the structural challenges they are faced with better and more intimately than the 'expert' who can only ever be an outside observer of the inner workings of the participants. This was made glaringly obvious in Jenelle's recounting of utilizing a multi-disciplinary walk in clinic, in which upon the initial superficial meeting with the psychiatrist, she was instantaneously supplied with psychotropic medications without an investigation into Jenelle's environment and support systems having taken place.

There were no discussions about Jenelle being a single parent to young twins with little familial or outside supports and no exploration into how these were key precipitating stressors and mitigating factors in her feeling overwhelmed and unwell. Had the psychiatrist probed further into really finding out who Jenelle was, really listening to her story, it would have been unequivocally obvious that she was not herself a danger, but that it was her racist environment that was a violent danger to her psyche and inner well-being. Having realized this, the psychiatrist could have worked with Jenelle to create a network of support to quell her feelings of anxiety, instead he chose to take the easy uncritical route of prescribing medications that further led to Jenelle's feelings of unease and distress.

Elizabeth, as well, was confronted with complete disregard from the 'experts' when the systems she had set in place to help mitigate her mental distress symptoms effects on her daughter were ignored. The social worker, the so-called 'expert,' when faced with a mentally distressed mother who voluntarily presented to

the hospital, dismissed the strength and resiliency that Elizabeth showed in actively seeking help, and did not search for the protective factors Elizabeth had set in place, such as ensuring her daughter was being cared for by her partner and mother, before going to the hospital. Instead the social worker chose to threaten Elizabeth with unwarranted child apprehension despite there being no safety concerns. Had the social worker delved into Elizabeth's situation, he would have realized that Elizabeth was not the stereotype of a 'crazy' mother out to harm her child, but was instead, a mother who was in distress and was doing everything in her power to care for her daughter by caring for herself first.

Mothers are systematically held to unrealistic standards and the 'good mother' ideology acts as a form of oppressive control where mothers internalize that they are primarily to blame if their child is unhappy, bored or underperforming. Adding the layer of a mental health diagnosis to these pervasive and unrealistic expectations only further complicates the issue with the end result being that mothers feel deep shame and guilt. Both participants spoke about sitting their kids down, in front of the television, when experiencing mental health distress, utilizing the T.V. as a babysitting and distraction device to occupy their children while they took care of their mental health symptoms. Both mothers expressed great distress over using the television in this way instead of "being on the ball" (Elizabeth: 223) and providing stimulation and engagement for their children. Elizabeth and Jenelle expressed their internalization of popular 'good mother' discourse and conveyed feelings of anxiety, self-doubt and a pervasive sense of

failure when not being able to embody and meet all of the impossible expectations, actions and behaviours that being a 'good mother' required.

Jenelle and Elizabeth agreed that in order to live up to the 'perfect mother' ideal, their children had to always come first. This was exemplified in Jenelle's recounting of feeling too tired to change her baby's diaper and with Elizabeth being exhausted and not able to do other activities with her daughter after taking her swimming. This impossible ideal is a belief that runs rampant throughout North American culture, that if the mother does not immediately meet a child's needs, then she is inflicting damage unto her offspring. These oppressive and impossible to achieve standards of the mythical perfect mother are internalized by mothers which only further perpetuate feelings of guilt, shame, and failure, which in turn result in mothers shrouding themselves in secrecy and isolating themselves from others lest their transgressions and perceived inadequacies be discovered.

Numerous studies have shown that social isolation and lack of informal support networks increase mental health distress (Cacioppo, Hughes, Waite, Hawkley, & Thisted, 2006; Goldsmith, Pellmar, Kleinman, & Bunney, 2002; Mgunshini, 2010), where conversely, people who reported greater informal social supports have been found more likely to recover from distressing mental health symptomologies (Calsyn & Winter, 2002). In her interview, Jenelle metaphorically described a thick wall of glass that she likened to looking in from the outside at the other mothers, where she would often wonder if they too, shared similar feelings as her. Jenelle never approached them to find out and instead remained in isolation.

Likewise, Elizabeth recounts hiding her mental health struggles from the other mothers at her daughters' school for fear that her Bipolar diagnosis would somehow taint how her daughter would be perceived and treated. Neither Jenelle, nor Elizabeth, are able to break free from the toxic shame that the 'good' versus 'bad' mother patriarchal dichotomy and the stigmatizing sanist discourse create. Instead, they remain shackled to a false presentation of self in order to exist with some semblance of safety for themselves and their children. It is the shame and guilt that keeps us separate and further isolates us and it is this isolation that keeps us sick. We can't come together to create networks of mutual support and healing because we are too busy hiding from dominant institutions that tell us we are dangerous, tell us to monitor each other for any semblances of deviation from the acceptable 'norms' and status quo, and works to pit us against each other lest we unite recognizing our power and our worth.

Each theme in this MRP are the threads that weave together a quilt of consequence in which without one stitch the other cannot originate. Institutional power leads to how we are defined, how our friends, family, society, see us, and how we internalize that gaze. We know that we must don our masks and that even a slight misstep leads to our bodies and selves being regulated, monitored and surveilled with intensity. This in turn bolsters our feelings of inadequacy and shame, which leads to hiding, silence, and a pseudo unauthentic self, presented to the world. This sense of shame keeps us disconnected from each other, from ourselves and from our children. We are too busy adhering to the rules of engagement and jumping through the never-ending hoops that the patriarchal,

racist and sanist institutions set up for us. We become distracted. We become docile. We become compliant. We are fearful, we are shameful and we are exhausted. And this is exactly what the system needs from us in order to survive.

Dr. Brene Brown (2010) defines shame as an intensely painful feeling or experience of believing that we are essentially flawed which therefore renders us unworthy of love and belonging. She further breaks down shame into three main components:

1. It is universal. It is primal. We all have it.
2. We are all afraid to talk about shame.
3. The less we talk about shame, the more we remain silent, the more control shame manifests over our lives.

Shame thrives in secrecy, judgment and silence. Shame keeps authenticity away by telling us that who we are and the stories that have shaped our being will lead people to think less of us. It's all about fear and the expectation that once people know who we really are they will no longer like us. Shame is the enemy of authenticity and connection. Both Elizabeth and Jenelle expressed a yearning to be authentically themselves in all venues of their lives, with Elizabeth wistfully wishing to stop pretending and having to split different aspects of herself into shattered fragments dependent on who she is around "oh this is the Mom version, and this is the Bipolar version and this is the fake smiling version when the social worker asks me how I'm doing, but none of them are all of me, because I have to separate the parts instead of being whole" (Elizabeth: 44-47).

The opposite of shame is authenticity and the ways in which the oppressive ideologies around Madness and Mothering work, are to enable and create silos of shame that work to isolate us, silence us and to squash any semblance of authenticity we possess. The networks of real human connection that authenticity could birth, if only we had the freedom to remove our masks of perfection, have the potential to transform into powerful hubs of strength, in which through support and understanding, mothers could come together to build each other up and to tear down the oppressive institutions that do not serve us. Coalitions of mothers working together to create 'me too' moments could have the potency to create forces of resistance against the institutions and systems that bind us in silence, secrecy and fear with the eventuality of overflowing outside of the hearth and into the political socio cultural landscape.

CHAPTER 6. IMPLICATIONS

If the antithesis to shame is authenticity, then a movement of resistance that works to dismantle systems, structures and institutional powers that insidiously work towards telling us we are inadequate, and unworthy must be initiated. However, that is easier said than done because the victims, or rather survivors, of these systems live with the real threat of having that which is most precious to them removed; their children. It is also important to note that certain bodies take less of a risk when fighting against the system due to race, class, gender, ability, and sexuality privilege to name a few. The question then becomes, how do we as social workers move towards eradicating these bastions of injustice that purposefully keep us separated from each other and force us to don masks of deception? And how do we as social workers, make room for the people we work with to reach self-actualization, become their true authentic selves, and to navigate this world with authenticity and safety?

The answer, I believe, lays within each of us, as practitioners, and how we choose to buy into sanist ideologies, or not. This requires of us to remain critical at all times and to name sanism wherever and whenever we may find it. This implores

us to truly listen to the stories of the people we come into contact with, to truly hear them and not impose our own 'expertise' upon them. Mostly, this requires us to practice self-reflexivity at all times, even when it makes us uncomfortable. I was reminded of the latter, when Elizabeth was hesitant during the initial moments of our interview to open up to me about what her true thoughts and feelings of social workers were. She sat rigid, not meeting my eyes with a strained smile on her face as she told me that she knew social workers were not out to take peoples children. I could tell that she was nervous, and was not forthcoming with her thoughts. She was telling me what she thought I wanted to hear. When I decided to drop my own mask of 'expert' researcher/grad student and allowed my authentic truth to shine through by revealing to Elizabeth my own experiences with social workers in my private life, a real connection was born and real sharing began to happen. Later, I wondered why Elizabeth, having known me in the past, and having experienced me as non-judgmental in our previous encounters, had been so initially closed off. It wasn't until I did some serious self-reflection that I realized, to Elizabeth, I am the institution.

Social Workers, aside from having the ability to demean clients with mental health by holding low expectations of them, also have the ability to destroy the lives of mothers who are Mad and the lives of their children. Mothers are often hesitant to reach out for support both within the community and within their family, for fear that in doing so they risk having their children apprehended. Fear of losing custody of children is often at the forefront of mothers choosing to remain silent about their mental distress (Taylor, 1995) and the apprehension of children from a mothers

care was shown to further their mental distress (Taylor, 1995). Seeking help heightens the risk of child removal and inevitably contributes to mothers parenting without a support system, which may in turn lead to a further decline in the ability to parent in a way that is beneficial to both mother and child (Montgomery, Mossey, Bailey & Forchuk, 2011).

Poole et al. (2012) make a plea to their colleagues within the social work profession to admit that our adherence to the discourse of medicalization has caused us to turn away from acts of exclusion, oppression and marginalization against those who are Mad. Medicalized discourse is so deeply embedded in social work practice that the pathologizing of Mad bodies and psyches has become so dominant that “offensive and injurious practices are integrated into everyday procedures to the point where we no longer recognize them as discrimination” (Kalinowski & Risser, 2005, p. 2). If social workers are to truly serve the people they come in contact with, in the spirit of social justice and empowerment, then the sanist system must be made visible and brought to the forefront of practice when working with people who are Mad. Doing so will work towards the liberation and emancipation of social work from sanism.

In my race to innocence, I failed to see that, although I identify as a Mad mother, I also am a social worker, and to Elizabeth that translated into me being a potential threat to her daughter and herself. I hold a position of power within the system, and I have the ability to, if I’m not careful and if I don’t engage in self-reflexivity, become a tool of the state enacting violence upon the people I am charged with ‘helping.’ Elizabeth told me that she wished the social worker at the

hospital had seen her as a person, a human being and a mother, not as a “disordered mentally sick woman” (Elizabeth: 311). All Elizabeth had wanted was the social worker to take the time to get to know her before she made the rash decision to contact child protective services. Elizabeth left me with a profound piece of advice

Just because I am Bipolar does not mean that my Bipolar will look the same as someone else’s. I am my own person and how I present will be different than how you present when you are not feeling well. So social workers should forget what they think they know when hearing that someone has a certain diagnosis and go in just trying to find the humanity inside. (Elizabeth: 266-270)

Elizabeth’s musings beseech us as social work practitioners to do just that, look for the soul within the distress and not look for the distress within the soul.

CHAPTER 7. CONCLUSION

It is important going forward, as a soon to be new Master of Social Work practitioner in the field, for me to realize that social work acts as both a form of social service, while at the same time functioning as a form of social control that serves the systems and structures in upholding multiple oppressions that allow for the marginalization of my fellow Mad and Mothering peoples. This makes it imperative that I navigate and negotiate between these dialectical tensions with my eyes wide open. What this means going forward is that I cannot allow myself to be fooled into complacency by swallowing the simplistic moral categories of 'bad' and 'good.' For there is real danger in becoming blind to the "dichotomous conceptual frame which allows those who self-identify as anti-oppressive (and hence morally 'good') to find comfort in their sense of innocence and to avoid examining their implication in domination and oppression" (Wong, 2004, p. 3). Additionally, as a person who identifies as Mad and a mother, I must hold those identities close to my heart when working with others, so I may always know and remember what it feels like to be on the other end as a service user and not allow the corruption that often envelopes those who hold power over others, to render me ignorant.

What I wish nurses, psychiatrists and social workers would understand about myself and other Mad identified people, are the very things I plan on incorporating into my social work practice, both as an act of resistance against my marginalization as well as the marginalization of other Mad folks. I will remember that mistakes in diagnosis happen regularly and that this often results in mistreatment. There are real, legitimate, and justifiable reasons why people might

not want to take their medications or attend therapy and this does not make them 'non-compliant.' I will remember that there is no such thing as a 'hopeless' person and that there is no one beyond healing, and that often times that healing comes from a person, digging deep within themselves, for the key to freedom and recovery, and not from a cocktail of drugs and the latest therapeutic technique. I will remember that forced institutionalization is traumatic and often adds to the multitude of traumatic experiences that people who are Mad have already endured. Mostly, I will remember that what is seen as violent, irrational and/or erratic behaviours are often reactions and symptoms to conditions, be they human, structural and/or systemic that we, as a culture, have created in a world that could be classified as ill. Lastly, I will remember, as Mel Starkman, a fellow Mad person, and the first person in Canada to advocate for the creation of an archive on the Mad movement history in the early 1980's said: "Psychiatric inmates are victims, not of their 'madness,' but of those (no doubt well-intentioned) efforts to pigeonhole them and solve their problems in a 'scientific' way (1981).

APPENDICES

APPENDIX A – Interview Guide

1. Tell me how your experience of being a mother has been influenced by your mental health? Can you give me an example?
2. What does being a mother with a mental health diagnosis mean to you and what does it look like for you?
3. Do you believe that becoming a mother has been helpful in managing your mental health issues or has it exacerbated your mental health symptoms? Could it be both helpful and exacerbated?
4. Could you give examples of what ways becoming a mother has helped your mental health and/or hindered your mental health?
5. In what ways do you mitigate any distressing mental health symptoms in order to parent your child?
6. What do you consider a more dominant part of your personal identity, being a mother? Having a mental illness? Or do both identities intersect to make up the identity of a mother with a mental health diagnosis?
7. How do you think society, family, and friends view you? How do you view yourself? Is your view of yourself affected/influenced by the outside societal/familial/and social circle views of yourself as a mother who also has a mental health diagnosis?
8. Has motherhood changed the way you relate to your mental illness?
9. What new abilities and strengths did you discover once you had become a mother?
10. What if any support systems do you rely on?
11. Is there anything else that you would like to add?

Appendix B – Recruitment Transcript

YOU ARE BEING INVITED TO PARTICIPATE IN A RESEARCH STUDY! MOTHERS AND MADNESS: STORIES OF RESILLIENCY AND HOPE

This research study is being conducted by Celina Dycke and supervised by Dr. Jennifer Poole from the School of Social Work at Ryerson University. If you have any questions or concerns about the research, please feel free to contact Celina Dycke at cdycke@ryerson.ca

I am looking for participants who self-identify as women, mothers and as primary caregivers of their child(ren). Participants must be 18 or older and diagnosed with a mental health issue.

PURPOSE OF THE STUDY:

This study will look at 3 mothers who are 18 and/or older who are the main caregivers of their child(ren) and who have been diagnosed with a mental health issue by a doctor. This study will explore what mental health and mothering means to mothers who are parenting their child(ren) and how they cope with childrearing. This study is open to any mother that identifies as a woman. The results of this study will contribute to the Major Research Paper required for the partial completion of the Master of Social Work degree at Ryerson University.

WHAT PARTICIPATION MEANS:

If you volunteer to participate in this study, you will be asked to do the following things:

- Meet with myself for up to 90 minutes to discuss what being a mother with a mental health diagnosis means to you, and how it feels for you. We will also discuss strategies you use to parent successfully and what that looks like.
- We will meet in a library room at Ryerson University or in the Master of Social Work Graduate Lounge at Ryerson University.
- All information gathered will remain confidential and names and identifying information will be changed. Upon completion of the final paper you will be given a copy.

INCENTIVES FOR PARTICIPATION:

A twenty-dollar gift card for a local grocery store will be given to participants. If at any time you choose to withdraw from participation you will still receive the gift card.

COSTS TO PARTICIPATION:

Travel costs will be compensated up to the amount of \$10.00 in the form of bus fare/TTC tokens. If at any time you choose to withdraw from participation you will still receive the travel compensation.

Appendix C – Referrals for Participants

1. Spectra Helpline- 416-920-0497 or 905-459-7777

Address: 7700 Hurontario St. Brampton, ON L6Y 4M3

Hours: 9:00 am – 5:00 pm Monday to Friday

<https://www.spectrahelpline.org>

2. Distress Centres of Toronto - 416-408-4357

Address: 31 Adelaide St E, Toronto, ON M5G 1B1

Hours: Open 24 hours a day, 7 days a week

<https://www.torontodistresscentre.com>

3. Gerstien Crisis Centre- 416-929-5200

Address: 100 Charles Street East, Toronto, ON M4Y 1V3

Hours: Open 24 hours a day, 7 days a week

<https://www.gersteincentre.org>

Appendix D – Consent Form

Ryerson University Consent Agreement

You are being invited to participate in a research study. Please read this consent form so that you understand what your participation will involve. Before you consent to participate, please ask any questions to be sure you understand what your participation will involve.

Mothering and Madness: Stories of Resiliency and Hope

INVESTIGATORS:

This research study is being conducted by Celina Dycke and supervised by Dr. Jennifer Poole from the School of Social Work at Ryerson University. If you have any questions or concerns about the research, please feel free to contact Celina Dycke at cdycke@ryerson.ca.

PURPOSE OF THE STUDY:

This study will look at 3 mothers who are 18 and/or older who are the main caregivers of their child(ren) and who have been diagnosed with a mental health issue by a doctor. This study will explore what mental health and mothering means to mothers who are parenting their child(ren) and how they cope with childrearing. This study is open to any mother that identifies as women. The results of this study will contribute to the Major Research Paper required for the partial completion of the Master of Social Work degree at Ryerson University. Please note that all interviews will be audio-recorded, transcribed immediately and the recordings deleted immediately after transcription.

WHAT PARTICIPATION MEANS:

If you volunteer to participate in this study, you will be asked to do the following things:

- Meet with myself for up to 90 minutes to discuss what being a mother with a mental health diagnosis means to you, and how it feels for you. We will also discuss strategies you use to parent successfully and what that looks like.

- Here are some sample questions: What are some of your parenting strengths? What does the role of 'mother' mean to you? Tell me about a time when you were experiencing mental distress while caregiving and how you persevered?
- We will meet in a booked room at the Ryerson University library or in the Ryerson University Master of Social Work Grad Lounge.
- All information gathered will remain confidential and names and identifying information will be changed. Upon completion of the final paper you will be given a copy.

POTENTIAL BENEFITS:

I cannot guarantee that you will receive any benefits from participating in this study. However, I hope that participation will allow for your strengths to be realized and act as a form of personal empowerment for you. I hope that this study will encourage other researchers to study resiliency in mothers with a mental health diagnosis.

WHAT ARE THE POTENTIAL RISKS TO YOU AS A PARTICIPANT:

The risks to you are very low, however, due to the personal nature of some questions asked, a participant may reflect on some unpleasant memories and/or feelings. If at any time, you feel uncomfortable we can stop and/or skip that question either temporarily or permanently. I will also provide a list of local mental health services that may be of interest.

CONFIDENTIALITY:

All efforts to maintain strict confidentiality will be adhered to. All names and identifying information will be changed. All material will be kept in a password protected file that will be destroyed upon completion of the final paper. I will anonymize all identifiable characteristics in the transcripts including names and organizations. The final MRP will follow suit.

DATA STORAGE:

Signed consent forms will be held in my supervisor's office. After the transcripts are complete, I will destroy the audio files and keep the transcripts on a password protected and encrypted USB. Participants may access the final results/MRP through the Ryerson digital repository. A link to this will be provided to them at the interview.

DATA DISSEMINATION:

The final MRP will be completed in late August and read by my supervisor, a second reader and then sent to Ryerson digital repository.

INCENTIVES FOR PARTICIPATION:

A twenty-dollar gift card for a local grocery store will be given to participants. If at any time you choose to withdraw from participation you will still receive the gift card.

COSTS TO PARTICIPATION:

Travel costs will be compensated in the form of bus fare/TTC tokens. If at any time you choose to withdraw from participation you will still receive the travel compensation.

VOLUNTARY PARTICIPATION AND WITHDRAWAL:

Participation in this study is completely voluntary. You can choose whether to be in this study or not. If any question makes you uncomfortable, you can skip that question. You may stop participating at any time and you will still be given the incentives and reimbursements described above. If you choose to stop participating, you may also choose to not have your data included in the study. Your choice of whether to participate will not influence your future relations with Ryerson University or the investigator Celina Dycke involved in the research.

QUESTIONS ABOUT THE STUDY:

If you have any questions about the research now or later about the research please ask. You may do so by contacting:

- Celina Dycke, M.S.W Student, cdycke@ryerson.ca.
- Jennifer Poole, Research Supervisor, 416-979-5000, ext. 556253
jpoole@ryerson.ca

This study has been reviewed by the Ryerson University Research Ethics Board. If you have questions regarding your rights as a participant in this study please contact:

Research Ethics Board
c/o Office of the Vice President, Research and Innovation
Ryerson University
350 Victoria Street Toronto,
ON M5B 2K3 416-979-5042
rebchair@ryerson.ca

Mothering and Madness: Stories of Resiliency and Hope

CONFIRMATION OF AGREEMENT:

Your signature below indicates that you have read the information in this agreement and have had a chance to ask any questions you have about the study. Your signature also indicates that you agree to participate in the study and have been told that you can change your mind and withdraw your consent to participate at any time. You have been given a copy of this agreement. You have been told that by signing this consent agreement you are not giving up any of your legal rights.

Name of Participant (please print)

Signature of Participant

Date

I agree to be audio recorded for the purposes of this study. I understand how these recordings will be stored and destroyed.

Signature of Participant

Date

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