

THE MISSING VOICES-MOTHERS RAISING CHILDREN WITH ADHD:
A QUALITATIVE INQUIRY

By

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ABSTRACT

THE MISSING VOICES: MOTHERS RAISING CHILDREN WITH ADHD

Master of Social Work, 2020

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Attention Deficit Hyperactive Disorder (ADHD) is a behavioural disorder commonly diagnosed among children. The symptoms associated with the diagnosis not only affect the child, but everyone connected to the child. For mothers raising children with ADHD there are often various demands and pressures placed on them. This major research paper addresses some of these mothering experiences through a qualitative methodology known as narrative inquiry (NI). This study centers mothers' stories of everyday encounters at home, school, in medical clinics, and within the community. It also takes up these narratives through the framework of critical feminist race theory (CRFT), with a pinch of Foucauldian philosophy addressing knowledge, power, and governmentality through bio-politics. Jonathan Gottschall said it best, "We are, as a species, addicted to story. Even when the body goes to sleep, the minds stays up all night, telling itself stories." I invite you on a journey of stories through the eyes of every loving mother raising a child with ADHD.

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Thank you!

DEDICATIONS

I would like to dedicate this Major Research Paper to my wonderful grandson Gabriel. I was encouraged to write this paper because of your narrative, “It’s difficult to be me!”. Gabriel you are the centre of my world! My darling grandson you give meaning to my life. I love you to the moon and back my superhero! This paper is written to shed light into the many children who struggle with ADHD and the strong mothers who envision them as heroes in everyday encounters.

This Major Research Paper is also dedicated to my loving best friend Betty who passed away in 2019. She was more than a mother to me, always challenging me in a loving way to be the best person I could be. I miss you so much my dear friend. The completion of my MSW is for the both of us as this was also your dream--we did it!

A very important thank you to the completion of this Major Research Paper goes to the loving mothers who participated in this research. This paper would not be possible without their strong voices to challenge the master narrative of ADHD. I admire these strong women for the enormous commitment they show as mothers to their children and their fierce advocacy skills in raising a child diagnosed with ADHD. I wish each one of you much success in all future endeavors may your children grow with the abundance of love. I also want to thank you for the wonderful gift you gave me--the fellowship of womanhood, motherhood and the belief that united our voices will raise our truth to the narrative of ADHD!

You are a witness to the inner strength of their efforts.....

I am the mom who sees her child off to school each morning praying he will have a good day
I am the mom who walks into work with a smile on my face to hide the pain and fear
I am the mom who reluctantly answers the phone when I see the school calling
I am the mom who fights back tears on my way to pick him up because he is in trouble yet again
I am the mom who acts as though I am so highly disappointed in his behavior in front of the school staff yet all I want to do is hold him and make his sadness and pain disappear
I am the mom who listens to others tell me it's a discipline issue, he will grow out of it, he's just a boy while invisibly rolling my eyes into the back of my head....because they have no idea what they are talking about
I am the mom who walks into school and signs another behavior slip like it's just another day
I am the mom who spends her school pick time rummaging through the lost and found because he forgot his jacket on the playground.....again
I am the mom who has to leave work abruptly because "he can't stay here today"
I am the mom who spends hours in school conferences with teachers, counselors and administrators
I am the mom who gets home and cuddles up with him on the couch
I am the mom who holds him when he is having a bad day
I am the mom who wonders what is going on in that little head of his
I am the mom whose heart is pained by what he goes through on a daily basis
I am the mom who lays down with him at night and tells him what a good boy he is and how perfect and loved he is
I am the mom who watches him sleep so calm and sweet and wishes his days could be equally as peaceful
I am the mom who begs and prays for him to just have a happy, easy, enjoyable life
I am the mom who wakes up and does it all over again....for him...because I know his greatness and I know his heart and I understand him and will love him through it all. He is my baby and I will fight for him until my last breath.

(Crystal, 2019; ADHD stories)

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CHAPTER 1: INTRODUCTION

My journey into writing this Major Research Paper (MRP) has taken many twists and turns along the way-- arriving at an awakening of the self by deconstructing the master narrative of my internalized oppression. Therefore, it is especially important that I speak my truth that what we come to know is “socially constructed”. I gave importance and value to the medical model as the one way of knowledge creation. My thinking was supported by the assumptions I carried, the workplace culture I was in, and how dominant understandings filtered throughout the mental health system to various agencies I knew. Thus, it is important to critique the dominant narratives in society in raising a child with ADHD. It is my duty as an AOP social worker to raise the voices of oppressed mothers advocating for those who are silenced through everyday practices of disablism and micro-aggression.

I have worn many hats throughout twenty plus years in my career working in various mental health agencies, all who embraced the medical model. I have worked as a child and youth worker, and as a social worker applying evidence-based models with families who have difficulty with their children with ADHD. Models such as Cognitive Behavioural Therapy, Dialectic Behavioural Therapy, Dyadic among others, all of which embrace the medical way of knowing. Many agencies across Canada embrace these models and direct their therapists to use these practices for the enhancement of therapeutic “knowledge” supported through an academic and quantitative positivist research framework. I embraced the medical model in my role as a mental health worker; this was considered powerful, unquestionable evidence-based knowledge, and I knew it well, and so I felt accepted within the circle. I wore the “expert hat” comfortably looking from the outside in, separating myself from those who did not have this expert knowledge, this truth, this powerful pedagogy. I put my individual success above all, compromising my own beliefs

by not critically looking at underlying oppressive dynamics that created the problem for mothers raising a child with ADHD. I was too busy looking at various flaws within the “individual’s cognition”. I did not think that I could be wrong, given that evidence-based models support this one way of knowing. I did a U-turn in this way of thinking when I was confronted with a large life changing event. A twist of fate uprooted me from this way of knowing from my original position as the “expert” by challenging my perception of power and knowledge, a lens through which I had comfortably viewed my clients and work. I realized that my previous experience in raising a child who did not have mental health issues was a different kind of mother role. I felt proud as a mother who had raised a healthy child, and my parenting was not as questioned back then.

My life changing event propelled me to a new identity, a new role from the expert to one of “client”. I was not just a social worker looking from the outside in, but I was now looking from the inside out-- these two worlds collided when I was awarded custody of my grandson. Moreover, the role of “motherhood” was transformed to the role of both “grandmother/mother” because I was now raising a child diagnosed with Attention Deficit Hyper-Active Disorder (ADHD). This joyous gift brought a new relationship with myself and with my grandson by embracing a new lens through which I gained a better understanding of raising a child with ADHD. The knowledge and power I held as a social worker in practice was immediately dismantled because the experience of raising a child with ADHD would outline a new way of “knowing” which revealed a new narrative of mothering a child with ADHD. I position myself within these pages and share my reflexivity, as I joined the many mothers who feel so lost, and so defeated at times. It is only through [reconstructing] master narratives that we raise our voices and begin the process of dismantling our own internalized oppression.

My focus was on mothering this little boy who came into my life with the gift of (what has been labelled as?) ADHD. Together we encountered various obstacles/struggles which revealed society's' basic understanding of neurological disability- not taking into consideration the narrative of mother and child. My old ways of knowing omitted that both client and therapist hold certain aspects of "knowledge" they can share in the process of resolving difficult everyday situations that come up when mothering a child with ADHD. This new role challenged my epistemological view of the medical model and evidence-based practices because I [now]saw through the lens of the client. This new ontological lens developed along the way through school meetings, doctor's meetings and various assessments required for a diagnosis of ADHD/LD.

A mother's role is never an easy one, but when you parent a child with a mental health diagnosis all eyes are on you, waiting for you to fail in some way. Feminist scholars outline that throughout history mothers have been under the watchful eyes of society, oppressive ideologies and discourses putting additional pressures on the role of mother to self-regulate her everyday parenting. Through social media, mothers consistently compare themselves to other mothers, "who's doing the better job?" and "who is the better parent?" (Chae, 2014). Several magazines such as Maclean's, Parent magazines, various websites, blogs etc. all emphasize the correct way to parent your child. Additional cultural pressures come into play when you are mothering a child diagnosed with ADHD. Mothers are put in a position of fear, as children with the diagnosis of ADHD come with extra challenges. Therefore, the mother needs to surveil her child very closely because any misbehaviour may come with additional diagnoses on top of the ADHD diagnosis. A mother's actions are constantly under surveillance as she is to provide the best support for her child even at the expense of her own mental health. Additional pressures are put on mothers raising a

child with a diagnosis of ADHD particularly around medication use for her child, a tremendously difficult decision with potential harm to the child.

The main difficulty in writing this major research paper, and why it took so many twists and turns along its starting point is because [I] was challenged on two grounds--as a mental health worker and as a mother to [deconstruct] the understanding of 'self'. The knowledge framework to which I had previously ascribed was the medical model and related positivist and evidence-based practices revealed that this model does not incorporate my lived experience, nor the experience of my grandson or the many mothers parenting a child with the diagnosis of ADHD. I was now questioning everything I had previously learned, and I questioned myself as an individual along this process, thus, I was [reconstructing] my narrative. The old way of knowing no longer benefited my new role in mothering a child with a diagnosis of ADHD. Hence, in re-constructing my narrative I realized the power language held over me as it filtered through me, as a mental health worker.

Since I was a little girl the power of language has transformed me. My own cultural ancestral language (Quechua) was erased and replaced with Spanish—asserting colonial power. This powerful process became instilled in me in my formative years. I felt that I was using language wrong, which took away my power; I felt that I must write and speak like the various professionals with whom I worked with---to be accepted. When I started working within a multidisciplinary team, we conducted all our meetings with importance placed on how we use language. Most importantly, we focussed on how language was used for policymaking, funding programs, and how it assisted in promotions. I used this knowledge of powerful language by putting words together strategically which opened doors for me and my grandson to receive the necessary

supports. I maneuvered through the system with ease and confidence that my use of language would obtain the necessary results which ultimately was acceptance.

When we struggle with internalized oppression the first step is awareness, but equally important is awareness of the language we use. By working from a medical model perspective for many years I got used to speaking and writing in a certain way. In the process of formulating my MRP I had to revisit the medical model which brought back a particular language in the writing of my paper. Hence, the vocabulary I use within some of these pages' stems from my familiarity and comfort with the language used in the medical model. However, what I have recently come to realize in revisiting AOP and embracing CRFT is the conscious choice one makes as to whose language one speaks. I realized that it is important to analyze the words we choose to use to either empower ourselves and others [or] disempower through language, because we build our own imprisonment or liberation!

The topic of mothering a child diagnosed with ADHD is of large interest to me because it carries a personal narrative. I recognize the place of privilege I come from as a mental health case worker, as someone employed and economically able to afford various costly assessments needed to support my grandson. I held tightly to the knowledge I gained, the language I used in the mental health field as a formulation of my identity. All these years I have worn various hats along the way, but only one hat challenged me—parenting a child diagnosed with ADHD!

CHAPTER: 2 LITERATURE REVIEW

When I originally heard my grandson's narrative, "It's difficult to be me", my thoughts of ADHD were disrupted. I wanted to find out more through the narratives of mothers like myself, but it was important to dive into the ideology of ADHD. Most of the research literature available on ADHD is medical and quantitative. The literature focuses on the neuroscience of ADHD and medication. There are far fewer articles published that focus on the experiences of those mothering children with ADHD. There are two other overarching themes in the literature including mothers' experiences of mental health agencies and their experience of schools (CADDAC 2019; Leitch, et al., 2019; MHASEF Research Team, 2015). Hence, this literature review first addresses the master medical narrative of the child diagnosed with ADHD. The master narrative of Attention Deficit Hyperactive Disorder (ADHD) is biomedical, a common perspective among the biological sciences over the past 90+ years. The increasingly polarized views of ADHD are immersed in power and disciplinary politics.

The main arguments in this section address dominant voices emerging from mental health professionals addressing the etiology of ADHD. The second theme emerges from schools/government as their contribution to ADHD holds an important narrative towards education and government supports. The third voice addresses the lived experiences of mothering a child diagnosed with ADHD intertwined with the above narratives. The convergence of interests raised from the literature posits mothers as encountering various levels of oppression, stigmatization, and marginalization through various intersectionalities.

Medicalization and medication

The medical model is entwined with a long-standing tradition in quantitative methodology embracing positivist sciences infused by quantifiable data. In critically examining current literature, mixed views exist on the causation of ADHD outlining possible factors such as genetic neurodevelopment, DNA variants (Farone, 2019) and physical discrepancies (i.e. low birth weight). However, there is no one study to date that provides an objective cause of ADHD and its etiology (Chang et al., 2014), as objectivity in assessing ADHD is extremely difficult. The difficulty in the ADHD diagnosis is explained by Hugo et al. (2017), outlining variables such as learning disabilities with a query of ADHD can set the direction of the research and level of support in a completely different direction. Children who have learning disabilities will display ADHD behavior due to academic frustration many may hide under desks, run out of the classroom, and get ‘aggressive’ with others due to high levels of anxiety. The following studies emphasize early detection and diagnosis outlining medication as a strong step towards a child’s success in society (Halperin, Bedard & Curchack, 2012; Martinez-Raga et al., 2017; Sheri, Reichenbacher & Ghuman, 2013).

The emphasis on evidence-based practices leads towards medication to alleviate the symptoms from the child and help them to live a more productive life both at school, home, and society (Hamed, Kauer & Stevens, 2015). The use of medication may assist with attention/focus and minimize hyperactivity, a common thought among psychiatry and psychology. Further studies on ADHD address evidence-based supports which include neurofeedback, the use of an ADHD coach, Cognitive Behavioral Therapy and Behavior Therapy, all of which are costly (Page et al., 2016; Pelhum, Foster & Robb, 2007). The various positivist experts create the master narrative that early intervention is the key to a child’s success in society (Halperin et al., 2012). Academic

quantitative research studies raise fear of not medicating early, outlining future concerns in drug use, school drop-out, social difficulties, other comorbidities, difficulties in marriage, and unsuccessful employment (Chang et al., 2014; Halperin et al., 2012; Humphreys, Galan, Tottenham and Lee 2016; Sonuga-Brake et al., 2011; Villodos, Pfiffner, and McBurnett, 2012).

Though positivist research outlines biological behaviors, genetic factors, and neurobiological implications as important to an understanding of ADHD, it omits lived and diverse experiences of ADHD in society. The overreaching evidence in the research from Ford-Jones, (2015) on ADHD and its challenges explores the additional controversy of over-diagnosing and overuse of pharmaceutical treatments, which pose a serious challenge for parents who are informed they are jeopardizing their child's future in resisting evidence-based practices on treatment of ADHD (Marten, Cwik, Margraf & Schneider, 2017). There are many factors that make up the human brain we have yet to fully understand; each person needs to be understood for the gifts they possess. Unfortunately, too many children are diagnosed with ADHD and are directed to mental health agencies for further assessments/supports. According to Hinshaw, a psychologist; "Within a 10 to 12 minute evaluation, and especially given the increased recognition of ADHD these days, it's quite possible that ADHD is a convenient diagnosis for individuals with a variety of conditions," that could be depression, trauma or anxiety (Hinshaw & Scheffer, 2014, p.620).

Canada is currently dealing with a broken-down mental health system. The most up to date information is from 2014 which comes from a 30-year study (1983-2014) from the Ontario Child Health Study for ages 4-17, which outlines various discrepancies in the model of care and core measures across mental health services in Ontario (Boyle et al., 2019). Therefore, the Canadian government struggles with allocating appropriate policies, programs, and services if the research captures a fragmented system of inconsistencies. This is a system which includes a limited amount

of information recorded, no provisions across agencies, and failure to standardize assessments. Many of these services have long wait lists well over two years. This is despite Premier Doug Ford's promise to add \$1.9 billion to the federal government's support, raising them to \$3.8 billion overall for Mental Health services. It is estimated by Children's Mental Health Ontario that over 28,000 children and youth are on waitlists for mental health supports (CMHO, 2017). Unfortunately, this leaves many parents frustrated and unsure of the next steps in support. Parents are desperate to receive these supports due to various media explanations of ADHD, pressures from teachers and the stigma that lies with a child possessing ADHD symptoms, which in many cases leads to medicating (Mueller, Fuermaier, Koerts & Tucha, 2012).

Schools/government

Canadian teachers are encountering many children perceived to display ADHD behaviors in the classroom. It is stated that at least 5% of children struggle with ADHD in Canadian classrooms (Freedman, 2016). Research studies from Loe and Feldman (2007) reveal teachers become the extension of the medical profession as they are using a checklist to monitor the behavior of the child with a query of ADHD in the classroom. This is supported by Freedman (2016), who outlines teachers lack training and many rely on medical knowledge. Moreover, an importance is placed on a teacher's critical analysis of ADHD and visiting new approaches for teaching and learning, by making changes to classroom settings. Thus, embracing the strengths of the child diagnosed with ADHD, allowing for flexibility and cohesion in the classroom. Hence, diagnosis is very subjective to the teacher's perceptions of the behavior, but not the inner world of the child (Solomonsson, 2016). This is overly concerning as the medical model relies heavily on the teacher's checklist for outlining ADHD behaviors in the classroom. The optimal outcome

would be for parents, teachers, doctors, and other influential individuals in the child's life to share in the input (Bied, Biederman & Farone, 2017).

Medicalizing research indicates that negative behaviors in children, particularly those gendered as boys, become evident when they enter the school system (Barkley, 1997 in DePaul & Storer, 2003). The behaviors that boys display are usually 'hyperactive' if they are constantly in motion, in contrast to those gendered as girls who display 'inattentive aspects'. There is no data to date addressing teachers' educational experience in working with children with such disabilities to support their findings (Al-Moghamsi & Aljohani, 2018).

There are various levels of learning disabilities among children with a diagnosis of ADHD (i.e. Dyslexia, MID etc.) but training teachers in this area is awfully expensive, requiring specific educational models (i.e. Orton-Gillingham approach) (CADDAC, 2017). In addition, long-term educational support for many students struggling with ADHD is costly. Unfortunately, underfunded schools continue to struggle in obtaining proper equipment (i.e. iPad, laptops) which can assist a struggling student to access on-line tutorial supports for optimal supports. Moreover, school supports for children diagnosed with ADHD are inconsistent across Canadian provinces, despite the disability recognition from the Human Rights Commission. Additional literature by Meerman, Batstra, Grielens & Frances, (2017), reveal that ADHD is the "catch-all umbrella" for other concerning behavioral issues that children are displaying in the classroom that may not be ADHD. A research study from Mayes, Calham & Crowell (2000), outlines 70% of children with ADHD tested positive for a learning disability. This study supports a more recent study by DuPaul, Gormley & Laracy (2012), outlining that between 2001-2011 a total of 17 studies looked at comorbid (ADHD/LD), revealing difficulties in writing not just reading and math difficulties.

The main struggle is the Canadian government not officially recognizing ADHD as a learning risk; the diagnosis is not considered an LD. It is stated that 8%-10% of children with ADHD show a decline in their academics over a 4-year period and numbers are increasing (CADDAC, 2017). The difficulty emerges from the Ministry of Education outlining that ADHD symptoms do not impede learning. However, if a child has an LD then they will be able to obtain a category of “exceptionality,” which is outlined in the Early Identification, Assessment and Transition Planning (IPRC) and the Individual Educational Plan (IEP). Unfortunately, “exceptional learner category” does not open doors for children diagnosed with ADHD. The study by Kim, King & Jennings (2019) reveals socio-economic struggles in receiving the right support for a child with ADHD, outlined as “health inequality” in contrast to children in wealthier geographical areas.

The student’s education is put at risk because they are competing for resources in the classroom, and many succumb to the ‘wait to fail method’ (Reynolds & Shaywitzs, 2009). A child must be failing by two years otherwise no support will be provided due to not enough specialized teachers and adequate classroom size for special education. Unfortunately, schools are poorly funded and poorly trained teachers do not understand the psychology of the child with ADHD in the classroom, or/and best methods needed to teach. A large team of special educators, counselors, child and youth workers, tutors are all required to support children with ADHD in the school system.

Additional research findings outline “stigma” as a risk factor for those diagnosed with ADHD, i.e. public perceptions of ADHD behaviours, skepticism on the effects of medication. In addition, various health professionals' perceptions, knowledge of ADHD vary which may contribute to stigma outlined by Ellison, Bussing, Bell and Garvan (2010) as well as Mueller,

Fuermaier, Koerts and Tucha (2012). Moreover, research from Rennie et al., (2014) directs attention towards “opportunity pushing” in school systems where “Institutional inequality” exists. The stigma in school settings is towards inappropriately assessing children academically and behaviorally, because of perceived ADHD symptoms. Unfortunately, the misbehaviors of the child are not further explored to their original causation; a child’s environment may be oppressing the individual (i.e. bullied in school, difficulty at home, LD). Furthermore, Link and Phelan (2010) compliment the above articles by associating stigma around how a child is perceived to function academically, socially, and developmentally in school. Hence, medication intake has a correlation to poor academic standards in a process described as “negative ability-labeling,” further stigmatizing and oppressing the intellect of the individual (Mueller, Fuermaier, Koerts & Tucha, 2012). The following quotation speaks to this labeling;

A lack of effective interventions for ADHD children is evident across the board, with services for children with ADHD spanning the general medical, mental health and educational sectors of a community and including constitutional and environmental issues, it is not surprising that there are differences of opinion about the condition and its diagnosis and treatment (Wolraich, 2002 p.469).

In capitalist neo-liberalist ideology which is entrenched in the school system it is believed that discipline is key to learning. Schools demand restraint, goal directed actions, single mindedness of purpose, self-regulation, and delayed gratification. Every student should fit in, otherwise they are considered dysfunctional, lazy, and unproductive (CADDAC, 2017). Such a thought signals a total disregard for how a young persons’ mind experiences their world. It silences their voices. In addition, it fails to understand oppression as well as trauma, interpersonal difficulties, bullying, and other possible contributing factors (CADDAC 2017).

Mothers' voices

Faced with such controversy amongst teachers, health care providers and parents on treatment and diagnosis of ADHD, it is no wonder mothers are experiencing pressure to fit into the role of “good mother”. It is important to understand what contributes to mothers’ construction of identity, by exploring the struggles and stressors in their child’s ADHD behaviour by looking at outside influences impacting on mothering. Eaton, Ohan, Stritzke and Corrigan (2016), state the following on mothers’ feelings, societal expectations, and constructed views on mothering (p. 1635).

As a parent, all you want to do is protect and be there for your child” (Dee), “you have to do what’s right for your children” (Kate), and “they’re my kids, I’ll do what’s right for them” (Eve). “that’s the ideal isn’t it, that’s what’s been rammed down our throats since we were little, that idea of being a good person, and a good parent” (Jane), “like watching the Brady Bunch, those sorts of concepts of a good parent” (Eve), “it was expected that is what my life would be, I would have a job, then I’d get married, and be a good mother (Ava).

Large levels of stigma are associated with the diagnosis of ADHD not only for the child but for the mother. She encounters what is called “courtesy stigma” by association in raising a child with mental health issues. Mothers are aware that others hold “stigmatizing attitudes” such as public stigma, which is internalized. Mothers are aware of stereotypes (i.e. poor parent control) when children engage in public outbursts, yelling, screaming, hitting/biting in public. Hence, mothers internalize and construct their identity as the “bad mother” because she is seen as

incapable of appropriately disciplining (or managing) the child (Mikami, Chong, Saporito & Na, 2015). Furthermore, additional research from Algora et al., (2018), and Chronis-Tuscano, et al., (2013) outline high levels of stress among mothering a child with ADHD. The stress that mothers encounter is partly due to high work demands and additional demands to support their child's mental health needs. Mothers encounter additional pressures at work and personal life all which contribute to poor health, lower workforce participation, caregiver strain, and a need for exceptional care requirements. Mothers spend time coordinating education and care of their children and managing crisis situations. In and outside of the home, they become their own case managers and advocates. Moreover, disruptive parent child relationships, poor flexibility in their job, poor support, isolation, and rejection from extended family or friends may lead to depression, divorce, parenting stress, and family conflict. All these factors can leave a mother feeling emotionally overwhelmed and physically drained. Therefore, with all this mounting evidence and negative experiences mothers outline a road of frustration, regrets, fear, and sheer exhaustion in mothering a child with ADHD. Additional literature reveals a "lifetime of maternal stress" in parenting a child with ADHD as the disorder does not diminish in young adulthood, on the contrary it brings further struggles captured from elementary school--to high school and beyond (Babinski et al., 2019).

Research by O'Brien, Sauber, Menson & Chronis-Tuscano, (2016) echo the above findings, with an additional focus on supports for mothers' who are susceptible to depression. Additional studies explore the need for respite support for mothers due to social isolation, many who feel exhausted with the high demands in parenting their child. The literature on mothering children with ADHD outlines additional supports such as self-care in order to obtain a better

prognosis for her child (Rasmussen et al.,2018; Peters & Jackson, 2008). The focus of this research is to clarify that both mother and child should be supported equally not one over the other.

Some ‘research’ suggests a link between income level and ADHD. This is common and yet very problematic. For example, one study linked ADHD to television use among children (Beyers, ValKenburg & Piotrowski, 2018), and Choi, Shin, Cho and Park (2017) linked low socioeconomic homes to ‘susceptibility’ to ADHD due to poor health. Moreover, the study by Russell, Ford & Russell (2015) echoes the above study, indicating mothers who struggle socioeconomically to pay for necessities, and low parental involvement contribute to the diagnosis of ADHD. Despite being supposedly ‘scientific’, this medical model centered work is oppressive as is blaming and individualizing rather than politicizing. Thus, such research is another example of how mothers are portrayed in the media, supporting cultural ideologies.

In addition, mothers receive media advice, which is obtained through blogs, website-parenting-tips including various methods and treatments, usually a road towards medication. Mothers’ are advised on new and improved pharmaceutical treatments and biomarkers to confirm ADHD diagnosis (Gonon, Konsman, Cohen, Boraude, 2012). A large study from The Centres for Disease Control and Prevention (CDC) indicates children are not receiving both therapeutic and pharmaceutical combined supports. This study suggests mothers’ experience socioeconomic barriers to obtaining therapeutic supports, in contrast to accessible pharmaceutical treatments. It is estimated that 1.9 million women in Canada 18+ are experiencing poverty outlined by Angus Reid’s Institute- Canada’s Non-profit Foundation Committed to Independent Research, 2018. Many mothers succumb to medicating their children as it is the most economical efficient route to manage focus, attention, and hyperactivity. In addition, literature indicates that parents raising children with ADHD are also cajoled/guided into finding out if they have ADHD too, claiming it

is 'better parenting' if they know about their own mental health as well as their child's (CADDAC, 2019, CHADD, 2019).

If time and length permitted, I also would have added in more citations from the literature on mothering and specifically from mothering studies. As suggested by my second reader, this would have added to the literature reviewed for this MRP, but for now, I will just note that I will be delving into it for my post MRP re-search.

CHAPTER: 3 THEORETICAL FRAMEWORK

I have been intrigued by motherhood since I originally became a mother, however I have been challenged in the new role of “grandmother/mother” since I obtained custody of my grandson with a diagnosis of ADHD. My previous role as a young mother was distinct from this current “mother” role as my daughter did not have any mental health struggles. I believe the current role distinction lies in the oppression I have encountered raising a child with a diagnosis of ADHD, as my parenting is seen differently by different ideologies. Leaving the medical model behind, I want to question its versions of motherhood by embracing Critical Race Feminism (CRF), AOP as well as a ‘pinch’ of Foucault’s biopolitics. These theoretical approaches have assisted me towards a deeper understanding of mothering when your child has ADHD.

Beyond the medical model

The medical model has made motherhood into a ‘science’ and made it important for mothers to grasp scientific, quantitative, neurological information from “experts” to understand child development, and thus child rearing. Foucault (1975) might say this discourse of “scientific motherhood” puts the responsibility back on the mother to raise a productive, obedient, well behaved ‘normal’ member of society in a neoliberalist society (Henderson, Harman & Houser, 2016). Similarly, and as noted by Smith-Rosenberg & Rosenberg, 1976; Sheilds, 1975; Weisstein, 1993, there is all kinds of problematic writing on a mother’s role and “motherly instinct”. Throughout time ‘her’ identity is [produced] and [reproduced] in the media, government policies and institutions glued to strong cultural ideologies, marginalized, stigmatized, and oppressed (Chase, 2014).

These discursive constructs are now supported through neoliberalism and its focus on self-sufficiency, independence, and personal responsibility. Mothers are asked to do more with less or extraordinarily little support from government. The stronghold of neoliberalism has cut many public services that would normally support mothers encountering economic barriers. Moreover, many mothers are scrutinized, stigmatized by class, race, sexuality, and mental health. Despite all these struggles, ‘she’ is to smile, because a “good mother” is a happy mother who supports her child even if it means compromising her own mental health and physical health (Broussard, 2010; Munoz-Silva, Lago-Urbano, Sanchez-Garcia & Carmana-Marquez, 2017). The aim of my major research paper is not to dispute the validity of ADHD, but to examine mothering in this context through the theoretical frameworks of “CRFT”, Foucault’s bio-politics and, given the context of the inquiry, Anti-oppressive Practice (AOP).

Anti-oppression

When I think about oppression, I think about the four levels of unjust use of power; these levels include the ideological (the idea), institutional (policies, practices, laws), interpersonal (people interacting), and internalizing (what is going on within), and each one of these levels reinforces the other. Oppression moves silently; it is filtered through language, thoughts, and actions that empower and/or privilege the oppressor (Baines, 2017). We must be vigilant, as it works within us when we are in positions of privilege as I was. We are assigned multiple social identities some have more influence and power over others. Audre Lorde (1985) said it best, “So long as we are divided because of our particular identities we cannot join together in effective political action” (p. 6) The core identifiers of oppression are prejudice, which is wrapped in a feeling we have about a group of people, stereotypes driven by a belief filtering through us, and discrimination is the

behaviour which filters through our actions. These effects filter through oppressive groups by the unjust use of power over others such as children diagnosed with ADHD.

Anti-oppressive practice challenges the unequal power distribution and marginalization existing from an allocation of subordinate groups in society. It is important to bring awareness to such inequalities and illuminate its long-term effects on the individual's psyche. By recognizing the cycle of oppression filtering through each of us we can begin to disrupt social power structures that are vehicles of oppression. We must ask ourselves what world we want our children to live in.

The focus of critical social work practice is to move away from one way of "knowing". By working from an anti-oppressive model, using active critical questioning, and active listening through counter-narratives of mothers, we validate their experiences in raising a child diagnosed with ADHD (Ballentine, 2019). AOP seeks to validate experiences of oppression, struggles, frustration, fears, and micro/macro-aggressions in everyday encounters. The framework of AOP unmaskes colonialism in a neoliberal society infused by the ideological constructions of "motherhood."

Critical Race Feminism

Critical Race Theory is a term originally coined by Richard Delgado in the 1980s to address everyday micro-aggressions that take place through social issues in and out of constitutional law (i.e. educational inequality), ethnic studies, and women's studies. Critical Race Feminism seeks to illuminate the inequities that continue to specifically oppress racialized women globally (i.e. economically, socially, and politically), which are social justice problems; maintained and perpetuated by an elite system.

As a mother, grandmother, native woman, and AOP social worker, I can see myself through the lens of Critical Race Feminism (CRF). Through this lens, my journey emerged as an evolution of my own critical self-reflexivity. I understand the use of the theoretical, methodological, and pedagogical in research is seen as a tool kit to uncover racism, sexism, classism, as ultimately CRF focuses on a commitment to social justice and an exposure of white supremacy.

For my MRP, CRF helps me dismantle pathologizing views of mothering by critically looking at the interconnections and interactions between the individual mother's narrative and the social system they encounter. Many children who come from families living with low incomes and/or lone parent homes are surveilled by schools in contrast to their counterparts from two parent or higher income homes (Jensen, 2009). Many racialized, Indigenous or refugee mothers are singled out. Through critical race feminism, the focus becomes the racism, sexism, and classism such mothers face in their everyday lives, how they negotiate and navigate through institutional services (i.e. medical, health clinics, school) as they experience stigma associated with raising their child (Mikami, Chong, Saporito & Na, 2014).

Critical Race Feminist scholars have taken a stance questioning research language and analysis that perpetuates the “good mother” and “bad mother” binary (Rich, 1976). The “good mother” is the mother that follows “expert” knowledge on what is considered the correct way to raise a child diagnosed with ADHD. The “bad mother” is the mother that pushes back and takes a stance by questioning ‘master narratives’, binaries and embracing her own knowledge, despite barriers to essential resources such as assessments, therapy and even a lack of food (McIntyre et al., 2003).

Of all the CRF scholars, for this MRP I follow the work of Sherene Razack, a professor of sociology and equity studies. The focus of Sherene Razack's work is interrupting and exposing

the colonial paradigm and dismantling dominant discourses on race and gender (Razack, 2010). Razack challenges and disrupts the oppressive practices of colonialism, and her work casts light on the struggles of Indigenous women, immigrant women, refugee women and the many others impacted by colonials' notions of race and gender. Following Razack's lead, CRF is important to this MRP as it highlights the many dominant discourses that impact mothers raising children diagnosed with ADHD. Furthermore, mothers' voices are additionally supported by Foucault as I am using CRF infused by notions of power, the subject, and governmentality. The two theoretical frameworks reveal the labyrinth mothers encounter in navigating support systems.

A pinch of Foucauldian thought

As noted, I am also interested in tracing power and medicalization in mothers' experiences with schools and medical sites and am informed by Foucault's work on biopolitical power (Foucault, 1979). The work of Michel Foucault takes up power relations and dominant discourses on how children diagnosed with ADHD are "positioned" as "problematic" through theoretical, institutional, and cultural practices (Horton-Salway, 2018). Moreover, his work explores power relations, seeking to unmask oppressive practices and institutions. Foucault emphasizes how individuals are turned into "subjects" through day-to-day practices which are very subtle and unnoticeable. According to Foucault, "Power is never localized here or there... [Rather it] is employed and exercised through a netlike organization...[Individuals] are always in the position of simultaneously undergoing and exercising this power" (as cited in Shullman, 1997). It follows that mothers must maneuver through a net of negotiation around power/knowledge in order to best support their children. At the same time that this net may make them compliant, disciplined subjects, hoping to be perceived as 'good mothers', it may also construct them as bad or even,

resistant. Informed by Foucault in this way, this MRP is interested in how mothers take up or push back on these kinds of discursive pressures and meta narratives.

Similarly, there is a strong push towards medicalization of ADHD, an increase in ADHD diagnosing and high demand for pharmaceutical treatments (Martinez-Rage, et al., 2017). The medicalization of children is a way to “normalize” undesirable behaviour through “subjectification” (Heller, 1996). According to Foucault, the individual is not always conscious of subjectification; including when children take medication. Equally important to note is how parents may enforce the medication of/on the child, a notion Foucault called medical surveillance. Such surveillance exercises its power through not only the child’s school, but mental health clinics and the larger society. Many mothers are confronted with a decision to medicate or not, but many succumb to medicating their children because other therapeutic options are costly and unattainable due to socioeconomic factors.

In summary, the situation is complex, and its study needs a complex theoretical approach which I think is possible with CRF, AOP and Foucault.

CHAPTER 4: METHODOLOGY

This MRP formulates a dialogue that relies largely on qualitative, narrative inquiry (NI) methodology. The focus of qualitative research is to understand the lived experiences of individuals through their narratives by generating textual data; its focus is not on prediction and control (Creswell, 2013). Hence, qualitative literature seeks to move away from numerical data. Instead, qualitative narrative inquiry research solely focuses on the individual's interpretation of their world as they understand it. My qualitative project looks at the narrated experiences of mothering a child with ADHD. Using narrative inquiry (NI), the goal was to obtain the narratives of these experiences and what it meant to the mothers I interviewed. I have been intrigued by this methodology and compelled by the lack of research on mothering children with ADHD. Hence, by working from a qualitative NI methodology I sought to center mother's voices within these pages as their stories unfold.

The main question guiding this major research paper is what narratives get produced and reproduced by mothers raising a child with ADHD? How do these narratives play into the ways in which mothers form their identity, in both subjugating and subverting ways? My research questions were guided by an in-depth analysis informed by anti-oppressive, Critical Race Feminist Theory and Foucauldian concepts.

I used narrative theory to identify the impact of narrative construction, addressing the parental reflective functioning. Narrative theory is shared across many disciplines including social work. As social workers, we use narrative stories to obtain a better understanding of how our clients make sense of their lived experiences (Creswell, 2007). However, how do we begin to make meaning out of their stories? The individual's identity is shaped by their experience, making sense of their personal and social world, creating meaning through their culture, beliefs, understanding,

interpretations, and their historical context (Creswell, 2007). Hayden White (1986) outlines, through the narrative we can translate “the knowledge to the telling.”

I have incorporated a Foucauldian approach to narrative research as it explores power/knowledge relations. Foucault outlines the following “locate the space left empty by the author's disappearance, follow the distribution of gaps and breaches, and watch for the opening this disappearance uncovers” (Foucault, 1998, p. 209). Foucault’s emphasis is on the author who may leave empty spaces which can be an emerging theme in the narrative inquiry process. Therefore, it is implied that within the narrative emergence exists dominant and marginalized voices exploring counter-discourses that arise. In this process, I was especially looking for emergent dominant narratives’ vs counter narratives.

I embraced narrative inquiry as it is open to individualized stories that counter dominant paradigms. I worked collaboratively with three mothers as I wished to focus on the discourses that shape mothers’ experiences of raising a child with ADHD. Each mother has her own unique account, and each mother narrates her story differently according to the audience, the time and place, which will be open to different interpretations. This major research paper has interwoven accounts of my personal experiences as a grandmother raising a child diagnosed with ADHD and as a social work, a scholar. My passion and commitment in raising a child with ADHD propelled me to look deeper into NI as a scholar, an AOP social worker, and grandmother through this personal narrative lens; I understand there are many hidden oppressed and marginalized voices. I listened critically for the oppressed marginalized voices and common themes as I raised their voices within these pages. The use of narrative inquiry is about a journey we take as mothers who [reconstruct] and demythologise meanings of parenting and demystify the label of ADHD.

I understand there is also an exchange of knowledge that takes place between researcher and researched, in turn building a commonality in the relationship. Therefore, the participant is not seen as the subject but as a co-creator of their experience of the world and interpreted as personally meaningful. Equally important, the NI method will take various turns from one way of “knowing” to another, as there are multiple ways of knowing/studying. Moreover, the conversations surrounding this research unpacked the future possibilities of these lives. It also addressed how mothers view their child’s ADHD diagnosis because it plays a large role on the level of intervention their child receives.

Data collection method

I was excited to collect the data, but was also feeling overwhelmed and with how it would all come together. The data must be collected in a coherent whole, with actions, events and happenings captured, making sure the richness of each narrative is savoured in all its complexity. I collected audio data from each participant acquiring the beauty in each narrative. I needed to be open minded and open to curiosity in the process as it is difficult to tell what would evolve or emerge. The use of the qualitative NI approach is a method of research which embraces the use of words as data, in contrast, to using numbers to gather information. In using this qualitative methodology, it was important to use corroboration through every step of data collection, data analysis and data interpretation. Equally important was how to present, analyze and interpret interview data. I needed to ensure the mothers’ ‘voices’ were preserved by outlining the rich descriptions of each mother’s narrative in chunks from the interview transcript (Charmaz, 2014).

For narrative analysis, I gathered data from transcribed semi-structured participant interviews. The data gathered was divided into two categories, the first category answered my

primary question, the second identified emergent themes (i.e. ideas, questions) to expand my original MRP question. Using open-ended questions facilitated a dialogue and a fluid process of storying events, experiences, and understandings. It also identified key direct quotes, with related patterns combined into themes (Nowell, Norris, White & Moules, 2017).

In the analysis process, it is important that the findings support my literature review and the theoretical perspectives. However, equally important was to not let my own epistemological and ontological view cloud my analysis of the information and to centre the unfolding of the mothers' narratives (Creswell, 2007) including plotlines, social and cultural references. In addition, Josellson (2006), outlines that at every step of data/analysis the researcher is in the "interpretive stage." Equally important Riesmann (2008) outlines that gathering data/analysis is not to merely interpret and stand outside (i.e. neutral/objective) of the story but allowing a flow of the narrative. Chase (2003) encourages the researcher to write interpretive comments as side notes during analysis and data by providing reason and evidence to support the interpretations.

Ethics approval

The ethics approval process through the REB required a well-developed research methodology, outline of participants, recruitment process, method of data collection, analysis, and ethical considerations. The initial process required me to complete a Tri-Council Policy Statement: TCPS-2: Core-tutorial online. The REB process also requires the researcher to include benefits of the research, risks of the research, known and anticipated risk to the participants, safeguards for protection of participants (i.e. therapeutic references), an information letter and consent form. In addition, the faculty supervisor is listed as the project supervisor in the REB application process. The supervisor works in conjunction with the researcher and the REB for an optimal outcome in

obtaining REB approval. These are rigorous steps to ensure the protection of participants. Equally important for the REB is a clear outline of how safe you will keep any material used in the interview process, where will it be kept, who has access to it. These steps are intended to ensure the protection of human participants, rights, safety, and well-being. There is usually a six to eight-week period wait while the REB reviews your proposal which consists of your thesis outline, references, theoretical framework and methodology and procedures. As a new researcher I was excited to have received REB approval, but equally humble to the ethical process along the way.

A twist of fate caused the REB to reconfigure how interviews were going to take place as COVID-19 emerged, leaving faculty and students perplexed towards next steps. The main concerns arose around health and safety in conducting in-person interviews. I became anxious as I was really looking forward to meeting each mother. The REB directed us to conduct interviews over the phone, but I felt this was not a warm way to connect with mothers. I was provided with the option to complete my MRP using a different lens other than NI. I realized the enormous importance to completing my MRP was mainly directed by narrative inquiry as the experiences of mothers raising A child with ADHD has a co-existing narrative with my own. Hence, the personal meaning and the experience of mothers had to be told within these pages as narrative inquiry can only do—speak a personal truth.

CHAPTER 5. FINDINGS/ANALYSIS

In this chapter, I have gone deep into the narratives shared with me by three mothers parenting children with ADHD. If I could do this again, I would have asked them to create short bios that I could share here, but for now I will just say they all identify as mothers, parents of children with ADHD in the Greater Toronto Area. Working with my chosen theoretical and methodological lenses, I have tried to stay really close to their stories and to focus on key themes in them such as how the mothers understand their children's diagnosis, medication, education and finding their own voices.

Mothers' views of diagnosis

When it came to how they storied the diagnosis of ADHD for their children, two of the participants felt it was an internal intuition that something was different in parenting their child. Those two also had the experience of the school asking them to address a behavioural and learning concern. However, one participant outlined the great level of confusion she encountered due to the way the diagnosis of ADHD was presented to her.

'Marilyn' (a pseudonym) shared the following information around her confusion; "Having a kid with a disability is challenging. I never felt things were clearly explained to me." Marilyn was seeking a better understanding of her son's behaviour and academic struggles due to concerns outlined from educators at her son's school.

They left me kind of hanging with the information for some answers that I don't think we really got and because I was struggling with him at home. Because the way he was learning he could not pay attention to things and he was fidgeting, it was really frustrating. He didn't do homework and for me... him not finishing just accomplishing what he needed for that day. I realized something else was happening.

Marilyn expressed she first met with a psychologist who had been referred to her by her family doctor. The visit to the psychologist's office outlined a diagnosis of ADHD within 10 minutes, in contrast to a full psychoeducational assessment. Marilyn explained she was not provided with a full explanation towards the ADHD/LD diagnosis, feeling confused like she had done something wrong as a mother; "I was lost, the whole thing was overwhelming with trying to understand the whole thing in English."

Marilyn was very upset when providing this part of her narrative, her voice escalated during the explanation of her encounter with the psychologist. In addition, language barriers were an additional struggle. During my conversation with Marilyn, she expressed her shock and fear of what may be next for her son.

'Cher' (also a pseudonym) had the opposite experience when her son received the ADHD diagnosis.

In grade 5 the teacher indicated he often look like he was daydreaming...I did not equate that to a learning disability. I just thought it was that he was a typical boy learner that it may take him a while to learn.

Cher experienced a gradual process from initial questions around her son's learning struggles to a full comprehensive psychoeducational assessment over a two-day period. This process provided Cher with a more detailed outline of her son's ADHD/LD and its presentation.

Our experiences that when we were told my son had ADHD. He did not exhibit the common symptoms that people associate ADHD with, his was he has problem focussing. We did bring him to a private psychologist who provided two days of testing-ADHD diagnosis that present as a learning. He did not have the hyperactivity; he did not have the lack of focus it was more comprehensive. Executive functioning. His ADHD presents in a learning disability rather than being hyper.

Cher adds to her narrative by outlining how important it was for her to obtain a better understanding of the diagnoses.

It's funny because we thought that he had a reading disorder, so we brought him to a specialized reading coach, and she spent an hour with him. At the end she said he has no problems in reading, so that is not the issue. And that is when we got him tested.

'Robin's' (a pseudonym) experience of the ADHD diagnosis for her daughter was similar to Cher's. Robin outlines the various behaviours her daughter presented led her to think something was different in parenting.

Well I guess from when my daughter was about 2 1/2, I noticed that she was just a little bit different than the other kids. She was not terribly good at communicating- she was really in her head a lot. So, as she got older, I notice that she had a hard time paying attention. She was very distracted. A teacher mentioned to me in JK that she kind of did her own (thing) when he would call them to the circle, she would kind of like...she would not say anything, she would walk over like she was in her own world.

Robin had noticed a pattern in her daughter's behaviours both at home and at school. Hence, she wanted to know for herself what might be the underlying issue to her daughter's behaviour.

And immediately this teacher who is a little bit on the strict side said there is a big problem, so I said ok, and I went and got her tested-So, she was diagnosed with ADHD at 6, and... but there were some thoughts that there could be something... LD's along with that, so we decided to bite the bullet and get her assessed like a psychoeducational assessment. So, she was... she still had the diagnosis of ADHD and then she was also diagnosed with an LD and in writing and reading and possibly mathematics.

The various views and experiences in the diagnosis of ADHD came from how information was presented to each mother. In addition, the experience of diagnosis was tied into how mothers viewed the child's conduct both at home and school.

To medicate or not

All three narratives outlined the rejection of medication. Following diagnosis, medication was first introduced as a way to assist the child with the ADHD symptoms and hopefully provide optimal outcomes. Mothers' narratives shed light on the pressures to medicate their children before they were provided with other levels of supports (i.e., tutors, behavioural therapy). The risk of 'poor academic success', and a 'poor future' were common motivators to apply stimulant medication by mental health professionals.

Marilyn's narrative illustrated reluctance from a psychologist to consider treatment outside of medication. The psychologist clearly indicated that failure to medicate was considered a waste, and harmful to the child in the long run. All three mothers challenged this master medical narrative by looking into other ways of supporting their children.

Cher's narrative tells how she pushed back on stimulant medication right away as she felt supporting her son to reach his own potential (in his own way) was optimal for him.

I should also tell you our son is not currently on medication; it is the first thing of course the psychologist does recommend. Uhm, we felt that at this time it was not necessary. Even our pediatrician said that he will prescribe if we notice a decline in his schoolwork. My son is in grade 9 and he is thriving, it was a surprise to all of us.

Cher outlines in more detail why she feels stimulants are not something they wanted to try.

The biggest thing for me is side effects when taking the medication. I mean everyone is different. It could inhibit hunger, it could inhibit growth, right? For us it was not worth the risk, I mean you...we could have tried him on it. We could have fought him on it, and it could have meant that marks could have been instead of an 80 to a 90. But for us it is uhm... we waived the risk. If down the road he needs it for whatever reason, then hopefully it will be a decision he will be able to make.

Similar to Cher, Robin outlines the necessary steps she took in making sure she was making the best choice for her daughter around stimulants.

We did end up doing a blind trial, but I saw how [daughter] reacted. I can only assume it was the pill that had medicine, it was not the placebo. I did not like how it made her extremely emotional and I didn't like to see her like that. So, I did not continue with the trial and I thought but I think we are just going to wait for medication to go that route if we go that route.

Marilyn outlined her rejection of the stimulant medication due to her continued uncertainty of the ADHD diagnosis.

She [psychologist] was very unprofessional, wow you are very unprofessional and just because I'm answering a few questions you want to go and give him medication. She [psychologist] said well it's the only way...I don't see any other way. I said ok, I just left and went back to school saying that I wanted him to be tested.

The unprofessional conduct by the psychologist provided an extra level of confusion for Marilyn.

It was in front of the kid, what kind of professional was this. Kids remember this is not something that you forget. They might not understand fully what is being said but they hear it. She just told me that my son's life was a waste because we did not do anything sooner and she told me if we don't give medication right away, he is going to be like nothing. He is not going to accomplish anything he is going to be basically a failure.

All three narratives outline the mothers' resistance to stimulant medication as the main concern was side effects and uncertainty of its long-term success. Each parent in one way or another felt stimulant medication was not the answer for their child. In contrast, medication was seen as an essential approach by professionals in assisting the child to an optimal outcome.

The doorway to “education”

Mothers also shared their narratives of experiences with their child’s teachers and school supports. These narratives illustrate that the doorway to education is not open for all children.

Robin’s narrative outlines her frustration with the school system, particularly with homework and trying to obtain a better understanding of how to best help her daughter reach academic success.

I was getting really, really frustrated extremely frustrated before this COVID-19 happened I was just like I have told you. I did not say that to [teacher], but I was just thinking, I told you time and time again you know she needs these supports. I know that none of the IEP has been followed and it’s just frustrating. Now I’m in the process because I have done all those meetings the IEP where they have a list of all this stuff, they are supposed to do in the classroom well they don’t do it. I mean how are they supposed to deal with it. Well he had twenty kids in the classroom I can see how difficult it would be to try to accommodate her. But you know, just try, try anyways!

Robin outlines a set plan for next steps to modify the guidelines on her child’s Individual Education Plan (IEP) to make it workable.

I’m going to bring forth my own set of guidelines that I would like them to take a look at it and move forward; I want to be part of it the whole way, it was like pulling teeth. I had difficulty getting work at home. He was like well we don’t really do homework. Well I’m just saying give me work, well I can show you some web sites, like give me some work. I want some work I want to know what they are doing in class. Well know that I know what they are doing in class now she is really learning some things because I’m with her and we are together, and she is having that one on one with me. I can explain it in a way that she can understand because when he speaks in the classroom he speaks very quickly. He is one of these people that talks very quickly and someone like [daughter] cannot process that.

Marilyn outlines a deep concern with the school system around the lack of supports offered to her son in special education classes. Moreover, she speaks to confusion around how such supports are actually put in practice.

I believe it was very stressful because the teachers would say he is doing really well he is doing fine, then you go to the special education teacher and he is fine. Everything seems to be normal there is never a problem... of course there is a problem, but these people I don't know the way they work. It was a lot of frustration build there even when I thought it was a good idea to have him in the specialized program, but ..uhm, I don't think it really helped him. How can I help him how do you have time to do your work, and. uhm don't worry if you get a low mark? All those things I don't think help him you know it can help him a little bit, but they never push him to excel to do anything, I mean he was labeled right away. I think they should have a better way to help these kids. If you are helping a kid sending to a special class to get some assistance with whatever, then you are giving another subject to the rest of the class. This is big time that is your job you are the teacher you can tell the child I'm going to sit with you for a while, right? And we are going to put this together.

In addition, Marilyn explains how her son felt in the special education class. He told me at some point... "mommy I don't like going here we are the stupid of the class." Marilyn outlines the importance of teachers in making more supportive classrooms. In addition, she adds that although teachers recommend tutors, she felt that teachers investing extra time for the student is more helpful.

I felt a little hopeless because I did not see the structure or caring for the kids. You need to have someone caring for the kids. You need to sit with the kid, sacrifice a little or even sit with the kid once in a while. It would be so helpful from then telling the parent to go and pay for the tutor why are you there for. I would like to see more attention from the school a lot of room for improvement from the teachers.

In contrast, Cher expressed how she felt supported by her son's school, in particular his high school years. However, she outlined poor staffing levels in elementary school.

Sure, when he was in grade school for example in grade 7/8, he went to a new school. At school there is only one resource teacher that had to look out for everyone, so he actually didn't get a lot of support. I think his teachers may have helped, but uhm my son goes to a high school. My son now goes to St. X it's here in [GTA] it is one of the top three schools according to those EQAO or whatever. So, ah his school has an IB program there expectations of students there reputation is very high. I was very nervous in sending my son to a school like that. I thought you know all these kids are going to be used to getting 90 or 100 what is the support going to look like for my son who has a learning disability,

but let me tell you I can't have asked for better support for my son. Uhm... there are quite a few children with ADHD, but because his school has got such a high reputation. The amount of kids with ADHD or who need the support or who need IEP are lower not going to that school, so the resources are still thin, but they are there, they are available.

Robin shares her experience in obtaining supports for her daughter through a special program called the Empowerment Program (i.e. reading supports) for children with a learning disability such as dyslexia (decoding difficulties).

So, she still had the diagnosis of ADHD and then she was also diagnosed with an LD and in writing and reading and possibly mathematics. The learning disability was in reading and learning expression mainly dyslexia well I guess they don't say that in reports but so because of the empower. Because of the Orton-Gillingham she just improved so well and so quickly.

Robin further outlines how this essential support is not available to every child as it is only offered in affluent communities. Hence, children in lower socioeconomic areas will not receive these supports.

Oh, it takes money, I believe the area where they have a good home and school association; where they can raise a lot of money those are the schools that benefit. The schools that are in higher socioeconomic areas, right! Which is really unfortunate because I would say we are not kind of a part to experience, we are renters. We like living in an area that is quite nice and we like that they provide a lot of things at the school. Uhm but I wouldn't identify with that crowd or whatever. I wish it was not dependent upon that, but for so many kids in the city because I think that it is needed more like Thorncliffe park than in Leaside.

Robin indicates how expensive the program is because teachers need to be specially trained for the Empowerment Program.

Not because regular school, but because she was in a program called the Empowerment Program. It is not offered at every school; I was really surprised when I came to this school because they never had it at the first school, she was in. They never had anything like that. There is quite a process to get trained be special education teacher than you have to go to [X hospital] to trained for it. So, there are not many people even able to do the work. One

woman went on maternity leave just before COVID they were saying there is no one to replace her, so they were not going to do it.

Robin questions equitable access, why such an essential service is not available for every child with ADHD/LD.

The kids need the supports. Its ridiculous that not every school has this. It is absolutely ridiculous this program changed [daughter]ability and gave her more confidence within one year. She had gone from being at JK level to being at grade level-- in one year. It was remarkable so it's definitely something that I was very thankful to have found at that school.

All three mothers' stories outlined the difficulties in obtaining supports for children with the diagnosis of ADHD/LD in the classroom. Once identification took place the teacher's role was minimized as in the narratives outlined by Marilyn and Robin. Both mothers outlined a fragmented collaboration process where teachers and parents were not properly communicating. Furthermore, both mothers outlined a perceived lack of interest and understanding educators showed with the formulation and language of their child's Individual Education Plan (IEP). Moreover, concerns arise around equity in education around program availability only in certain neighbourhoods, schools and for certain learners.

I never thought I had a voice

There are various struggles a child encounters when they have a diagnosis of ADHD as well as learning disabilities and inequitable access to supports. All three narratives outlined how mothers raise their voices and reformulate their identities as advocates for their children.

Robin outlines her persistence with the school to support her daughter's needs in a reading program specializing in dyslexia. "I had to push for it. She is going into this [Empowerment program]. I learned that unless I speak up nothing will ever be done. I need to be really a big advocate for her." Furthermore, Robin outlines how she is supporting her daughter to have a voice for herself, to advocate for herself.

It's been really good to see a slice of her life through the schooling online (COVID-19 pandemic) and through the virtual meetings the class has. It has been quite interesting she really still reluctant to use her voice. She has had so many experiences where she may have been made fun off, she is very, very careful now. We are working on that with her, with the social worker-trying. I mean not at the moment; we were before the closures but we were working on her assertiveness because that is one thing that I think is so important specially her being a girl going into womanhood. This is one thing really that I really want for her is for her to be assertive.

This is what I need to get by there were many times where I was not assertive and I have regrets about that, so I don't want her to feel that way. I should have said something, but I didn't because you feel like you don't want to sound like you know a--nasty woman. So, it is really important that she learns assertiveness that is a big thing.

Robin further states how important it is for all mothers raising a child with ADHD to raise their voices.

I think it is important to give mothers a voice. The children are falling through the cracks, and they are. Especially the ones... and boys are also have the ADD factors but more often than not, it is the girls they are the day dreamers and they fly under the radar. The boys who are more on the hyperactive side they are the ones that get a lot of attention. It is so difficult to advocate for a girl with ADHD because it is not really apparent, they have somehow learned I need to hold it together. I don't know how she learned, I asked her once how do you keep it together at school? She said I don't want to get in trouble at school by the teacher, oh so you safe it for home. And you don't care if you get in trouble by me--no it's just that I'm so worried about getting in trouble by the teacher. There is something there, there is this innate knowledge that girls have, that they have to be good, they have to act appropriately, it's so interesting!

Cher outlines how important it was to raise her own voice as a mother parenting a child with the diagnosis of ADHD. She expressed the importance of parenting differently than she was parented and reconstructing certain cultural ideologies of mothering.

Oh, uhm, oh god, you know tiger mom, it's basically your whole child is based on their mark. So not who they are as a person but what they get in school to me that is a tiger mom. In my son's school there were two suicides in a matter of two weeks. Uh two boys both in grade 11 uh, both [culture x], yeah, once again we don't know the details but yeah uhm you know a lot of pressure. Tiger mom's put a lot of pressure on their children to do well in school uhm to get to the right universities; god forbid if they don't become a doctor or an accountant something they can brag about to their friends --then their kid is a looser [culture x] is really bad, yeah, so, I don't even know if... ADHD, if you can even bring that up.

Marilyn's narrative speaks about her frustrations with the current school system. Moreover, feeling like structure is not a priority in teaching students, just getting through. She outlines how she is accepting of the differences only for her son's success.

Everything is different in the education system back home, so structured step one, step two the way we were writing our information was so structured. All our notebooks had to be in covers right, mandatory with a particular color of paper. Everything had to be labeled every page had to be numbered and with red lines you can put your name, subject, date, and it was really like that. Those were the basic rules, you have titles in red. We were told everything has to be nice and neat, not because I don't care you just right it on the back of a piece of paper? Yeah it is very disorganized here, I just don't care--it really gets to me.

More than a mother

The various narratives outline an inner strength mothers acquired by taking on the extra roles of tutor, behavioural therapist, and advocate. Robin outlines how important it is to learn as much as possible about ADHD/LD in order to best support her daughter. She describes the

following steps she needed to take due to the high wait period for supports (over a year currently).

But what I have been doing is I have been taking a lot of webinars that [Children's mental health agency] offers, and that [X Hospital] & Mental Health offers about ADHD and Learning Disabilities. So, I have been doing one a week and just collecting as much information as I can. The one that CDI are \$15.00 each, but the one through [X Hospital] & Mental Health are free. Those have been really helpful just understanding how the ADHD and Learning Disabilities affect different aspects of her life like social, academic all these things. It has been really great just gathering as much information as much as I can. This is my only choice to watch as many webinars as I can and collect as much information as I can. I'm going to try to implement it until we are going to get in there.

Robin describes that there is another wait period on-top of the original wait for more specialized programs that her daughter qualifies for. Moreover, she outlines that the wait for boys is even longer.

It is a ridiculous wait for the girls and more for the boys I heard. It was about 18months on the dot that they called me and said they have a spot open in the summer for the program. I guess the social worker that I talked to every week the program called [Mental Health] for kids who have learning disabilities. I put her on the list for that [special program] I applied for that I guess maybe three or four months ago and then they got back to me and said she is approved for the program but there is another 18months wait. So, it is going to take a while before she gets into that one.

Cher outlines the necessity for a tutor to support her son. She explains how such supports require out of pocket expenses.

So, we have a special tutor to work with him once a week. He is in grade 9 English he just started this semester he was apprehensive because he is in the advance version. The tutor is \$75 dollars an hour.

Marilyn expresses the difficulty in paying out of pocket for tutoring. Hence, she looked at various websites for additional in-home supports; she became the tutor for her son.

I couldn't pay for tutors I wasn't working I was staying at home with the kids. Uh whatever help he got was from us at home. We were working with him searching on the internet never really extra help, no, no, we couldn't afford that. I mean they charge you like a lot of money for half an hour or an hour. They will say it's more meaningful for an hour because its more time for someone to come to my house for 30 minutes it was not doable for us at the moment.

Power and privilege: Reflections and further Foucauldian-informed analysis

As the narrative inquiry developed and I interviewed these three mothers, I was taken back to the various micro-aggressions I encountered as a parent raising a child with a diagnosis of ADHD/LD. The “meta-narratives” were all too familiar to me, as I had taken a familiar path many years back when my grandson was very young. I was transported back to that journey, traveling together with the mothers through their stories. As the interviews developed, I began to see the similarities to my own past encounters with an unsupportive system. This section of my analysis outlines the micro-practices mothers encounter when they vigorously advocate for their child to receive the necessary supports. Throughout the three narratives a consistent emergent theme appeared around systems of power, control, and privilege.

Oppression works through marginalization, exclusion, and classism for instance to perpetuate systems of structural inequity. All are in play when Robin outlines how a much-needed resource such as the “Empowerment Program” for children with learning disabilities is only offered in certain affluent communities, “Oh, it takes money I believe- the area where they have a good home and school association where they can raise a lot of money those are the schools that benefit the schools that are in higher socioeconomic areas, right.” Unfortunately, children from less affluent communities don't have these essential programs needed to support their learning. There exists a not so subtle practice of systemic and institutional oppression, meant to subjugate and exclude particular young people. The façade that education is public and available for all, that

a choice truly exists serves to keep those in power who wield it. It reinforces a system of whiteness and white privilege continuing to marginalize and disempower children from less affluent (and often racialized communities). There is a basic assumption that schools are there to support the academic success of the young person, but many schools are falling short in supporting an increasingly diverse population of learners.

Institutional oppression strips the young person of their dignity by making them feel unintelligent, that they are poor achievers, that they are lacking in effort and by placing emphasis on “misbehaviours” and “poor achievement” further subjugating them. Unfortunately, the individual is seen as the problem not the system that perpetuates educational inequality. The system benefits some while it deprives others due to their economic status. The school system is designed to exclude these young people caught in a rhetoric that blames the other. This is all done very subtly under its policies and practices. It involves years of complex and cumulative factors, for example the Individual Education Plan developed to support children with “exceptionalities,” which is a learning disabilities designation. The functional process of the IEP is described as the cornerstone of “quality education” by the Ministry of Education. However, the mothers’ stories reveal a different narrative around the functionality of the IEP. The confusion lies in the role parents play, poor communication between school and home, and how recommendations in the IEP are not necessarily followed or applied by teachers in the classroom. Hence, we are confronted with a fragmented system. Robin outlines her frustration with the IEP, not only poor communication between home and school when she says; “I know that none of the IEP has been followed and it’s just frustrating. Now I’m in the process because I have done all those meetings the IEP where they have a list of all this stuff, they are supposed to do in the classroom... well they don’t do it.” In addition, Robin adds that teachers are not even sure what is fully outlined in the

IEP, “So, then I thought ok one of the things I asked him was--what do you mean by this--, and he couldn’t tell me. He said oh, it’s just part of the form and like I’m ok, why is it there? You don’t even know what it means? So, I thought that was really interesting and very telling, so you know.”

Marilyn outlines her frustration with the IEP process, also poor communication between teacher and parent around homework, grading, subjects, and unclear direction. She expressed a lack of clarity, and disproportionate levels of support all under the fabrication that everything is fine and going well. We are further reminded of these struggles when Marilyn outlines, “I believe it was very stressful because the teachers would say he is doing really well. He is doing fine then you go to the special-ed teacher and he is fine. Everything seems to be normal; there is never a problem of course there is a problem but these people I don’t know the way they work. It was a lot of frustration built there even when I thought it was a good idea to have him in the specialized program but uhm I don’t think it really helped him.”

Both Marilyn and Robin outline a system that keeps parents in a vicious loop of uncertainty towards their child’s education. Moreover, these narratives outline the dominating power relations that exist between the teacher and parent. Despite both Marilyn and Robin seeking answers towards the best way to support their child, and their eagerness to be involved in the IEP process, they were both confronted with Eurocentric norms and the silencing of devalued voices of both their children’s and their own as mothers.

Another piece I want to come back to is how the narratives speak to the ‘gendering’ of ADHD and primary focus being on ‘hyperactive’ boys. Many girls are not diagnosed with ADHD as they have different symptoms and may internalize them or become very fearful of getting into trouble at school. Robin speaks to this in the following explanation, “I asked her once, how do you keep it together at school? She said I don’t want to get in trouble at school by the teacher, oh so

you save it for home. And you don't care if you get in trouble by me, no it's just that I'm so worried about getting in trouble by the teacher. There is something there, there is this innate knowledge that girls have that they have to be good, they have to act appropriately, it's so interesting." Symptoms of ADHD may differ between genders which can be detrimental in providing appropriate supports for child and family, particularly when there is a learning disability that may not come to the attention of teachers and parents until much later.

The narratives strongly speak to how a young person can fall through the cracks in a fragmented system which benefits some groups, while marginalizing other groups. This is a system that draws upon western colonialization of education which unfolds around issues of classism, gender, patriarchy, and white supremacy. All these inequalities begin to surface and are further illuminated by the mothers' narratives addressing the subtle ways in which power shapes everyday encounters within the education system by the cultural tools used and selective resources available. Thus, these everyday encounters become the ontological reality of both mothers and children caught in oppressive systems. We are reminded that such oppressive practices are not within the IEP only but through oppressive educational structures such as the Empowerment Program. A program offered only to a select few in affluent communities this process upholds power and control for privileged individuals. However, we also see how Robin critiques the dominant paradigm by challenging the formulation of the I.E.P, unveiling the world of privilege, through her question, and rejecting privileged cultural tools. We see this action in the following narrative, "I'm going to bring forth my own set of guidelines that I would like them to take a look at it and move forward I want to be part of it the whole way, it was like pulling teeth." Robin is expressing how she is taking charge of her daughters' I.E.P, by formulating new approaches to enhance daughters' learning.

In critical feminist theory we are reminded that patterns of oppression collide together revealing intersectionalities around ability, race, gender, and class. This is revealed through the pedagogical thinking exposing wider unyielding systemic structures and oppressive educational regimes (Annamma, Ferri & Connor, 2018). We clearly see evidence of these subtle practices through mothers' narratives as they reveal their struggles with the various systems, they encountered in order to obtain supports for their child. We are confronted with subtle systems at work, such as the IEP, Empowerment Program, costly psychoeducational assessments, highly expensive tutoring, and long-wait periods for behaviour modification supports. This level of inequality is exposed not only in schools through the IEP, but through teacher practices, power relations (i.e. parent & teacher), and the wider community enforced through policies where white interests are immersed within the political mainstream in the creation of its policies and practices in institutional systems.

The various encounters depicted through mothers' narratives reveal how dominant discourses are filtrated through everyday encounters with medical institutions which hold individuals in positions of power and control. The systems of power, social control and surveillance are acting through discourses within schools, psychologists, and psychiatrists who are situated as the "experts" and the "dominant professional group" upholding the biomedical truth of ADHD. The direction by doctor's to strongly suggest medication as the best option in treatment for ADHD is another emphasis on bio-power and control over the individual through medication. We see this example when Marilyn meets with the psychologist for the first time in a brief interview. The psychologist used the position of the "expert" and "knower" to strongly persuade medication as without it there is a grim road ahead for him. This is done in an attempt to "cure" him or at least get him to a place of "acceptability" and "normalization" to function as a 'normal

person' within western society. Here we see another example of the shift that takes place in upholding responsibility from society to the young person and parent. Mothers are positioned and blamed through micro-aggressions in everyday encounters such as Marilyn's experience when she met with the so-called "expert", the psychologists. Marilyn outlines how she was made to feel, that she had done something wrong for not seeking supports earlier (i.e. psychoeducational assessment) "she was blaming me for not doing anything".

Foucault (2003) reminds us that bio-politics is heavily entrenched in the practice of medicine and health, thus the implementation of medication for children with ADHD is one example of this and a disciplinary act to change the behaviour of the individual or modify it in some way. The young person is controlled within social, political, and cultural contexts. We are confronted with this when Cher expressed, "I should also tell you our son is not currently on medication it is the first thing of course the psychologist does recommend." Cher showed resistance to the emphasis placed on stimulant medication being the first option in treatment. In addition, Robin encountered the same situation but decided she would give the stimulant medication a try. Robin outlines, "we did end up doing a blind trial, but I saw how [daughter] reacted to it, I can only assume it was the pill that had medicine, it was not the placebo. I did not like how it made her extremely emotional and I didn't like to see her like that. So, I did not continue with the trial and I thought, but I think we are just going to wait for medication to go that route if we go that route." Similar findings in Marilyn's narrative outline her great displeasure with medication, " I said you know what you can't medicate any kid just because of some of your questions you have to evaluate him properly sit with him, watch him see what he is doing, medication is a last resort." This statement is supported by CADDAC and CHADD which point

to the dangers of not providing a full comprehensive assessment because it may overlook other difficulties such as a learning disability.

The various narratives outline a lack of comprehensive assessments and medication as the first direction in treatment for optimal outcomes. However, what is not revealed by the various professionals is how expensive treatments other than medication are. Mothers' narratives reveal this discrepancy; unfortunately, pushing parents without economic support (i.e. work insurance or a stable income) to succumb to the least expensive route. Cher outlines the out-of-pocket expense for tutoring, "The tutor is \$75 dollars an hour."

Robin outlines the large waitlist for supports from a mental health agency in Toronto, "the Mental Health Centre had 18 months wait period. It is a ridiculous wait for the girls and more for the boys I heard. It was about 18months on the dot that they called me and said they have a spot open in the summer for the program." Moreover, Robin outlines another wait for her daughter to obtain further supports on top of the original wait list; another 18+ months wait. Such large wait periods across the city are on the rise. According to the Mental Health Commission of Canada, 1.2 million children are struggling with mental health in a run-down, underfunded system (CMHO, 2018). The immediacy and push to remain on the waitlist despite such large wait periods is because therapeutic supports can be over \$150.00 per session when paying out-of-pocket. We are reminded by the mothers' narratives that to support your child without medication the parent is required to pay for tutors \$75 + per session and therapeutic supports (i.e. behavioural therapy) at \$150.00 per session. In addition, we are reminded of the high cost of a psycho-educational assessment that is over \$3,000.00 for additional diagnosis on top of ADHD. However, there is no cost to medication as it's covered by the OHIP card.

The ethical position we hold to children and families is one of support and understanding that mothers know best for their child. Unfortunately, discourses on medication and what is considered appropriate cultural behaviours where young individuals are subjected to stimulant medication, because the subject has no control over their behaviour. The diagnosis and behaviour that comes with ADHD is seen as “deviant” and not normal. This is done through continuous promotion of stimulant medication for children exhibiting ADHD/LD diagnoses under the notion that the child will function better in society if behaviours are corrected and normalized through stimulant medications.

There is a large shift from social, political, and cultural responsibility to providing appropriate supports for various individuals who may be struggling economically. The focus has moved away from looking at a lack of equal access to education, and programs for all who would benefit from it. The above discrepancies outline the large gaps in mental health supports, many who are further marginalized by the inability to pay for supports to override large wait periods.

Critical Race Feminist Theory reminds us of the various intersectionalities women are confronted with. Marilyn explains how difficult it was for her to understand the school system in Canada. She found the system a large struggle to maneuver through as an immigrant, as a woman who speaks another language. She explains the cultural clash in trying to understand the special education class and the various meetings with teachers and other school personnel. The findings reaffirm educational, medical, and social difficulties that play a hindrance towards raising children with ADHD. However, all three mothers emphasise the extra mile they are willing to go for their child’s overall success. The mothers address the various hats they have worn as teachers, tutors, and advocates as part of the parental role in providing the best support for their child. In addition, these mothers have [reconstructed] mothering, by looking within dismantling cultural ideologies,

challenging gender inequalities, and challenging the master narrative of ‘bad mothers.’ These mothers repositioned themselves within these pages by taking a strong stance for their children to be seen outside of the ADHD narrative; to be seen as a whole person. Each child should be seen for the wonderful qualities they possess, rather than restrained by medical ideologies, where the individual is only seen as a ‘bad child’. The children outlined in the mother’s narratives are described as possessing wonderful capabilities such as, Chef, IT computer Analyst and Mechanic through the various interests they each display outside the ADHD diagnosis. What is most important to note is they come with various capabilities/attributes they are not [the] diagnosis. Hence, their voices come through these pages to join their mothers indicating they are so much more than—the master narrative of ADHD.

CHAPTER 6: IMPLICATIONS

The journey I took to formulate my MRP was disrupted by deeply reflecting on my past and current work with mothers raising children with ADHD. This new awareness as a practitioner helped me look at deeper levels of self, and my world views.

I became curious during the interview process as mothers and I were co-creating and reconstructing a new narrative of ‘mothering’ children with a diagnosis of ADHD. I moved away from seeing the individual as a complete story, instead looking at the axiology formulation. I experienced a process of growth within me as the narratives developed. One mother’s narrative stood out the most because of her statement “I learned that unless I speak up nothing will ever be done.” “There were many times where I was not assertive, and I have regrets about that. I should have said something, but I didn’t because you feel like you don’t want to sound like you know--a nasty woman.” She [reconstructed] her vision of mothering by allowing her voice as a woman to come through, a mother gathering strength to advocate for her daughter. In addition, by assisting her daughter to raise her own voice. There was a process of realization and growth within her narrative, a powerful statement which pushed me to obtain a deeper understanding of women’s voice. When I analysed her narrative, I came across a new revelation; what it means to listen as a “woman.” I became more curious of the multiple realities of their lived experience. I began to see how traditional paradigms are reshaped as more women are teaching the next generation not to be silenced.

The silencing of our voices as girls, as women, as mothers suppresses our stories, we are our stories, but we are taught to self-silence our voice by cultural and white supremacy constructs. This is when I reached-- an Aha! moment in my research. I realized that many times I was also fearful of speaking up or even writing this MRP because of greater context. Until now I have

viewed/interpreted the world through the medical model. I remember saying to my MRP supervisor; “But I don’t want to upset anyone.” I had conflicting thoughts regarding the medical model and evidence-based practices. Was I ready to move away from one way of understanding? My supervisors’ statement was, “It can only be written in its truth.” I needed to understand the strength of my voice and how language is used to bring forth the voice of an AOP social worker by exploring a critical analysis towards social justice.

The voices of women are silenced in everyday encounters, and the “nasty woman” is punished by silencing her, interrupting her, by controlling how she views herself when speaking out. Women are seen as undeserving of their own voices--be nice, be polite, because ‘good girls are quiet girls’. Moreover, the good mother vs the bad mother, those who speak up for their children may be seen as an aggressive woman. Many mothers are silenced in everyday interactions with various individuals they encounter in trying to provide supports for their child. Hence, what does this say about the power of women and mothers and how we might be afraid to speak out. Most importantly, how we see ourselves in public spheres, (i.e. workforce, school, home), there is an illusionary freedom of voice.

I wondered how women and mothers are seen and perceived as clients in the therapeutic milieu; is the female therapist voice also a place of silence created by policies and procedures similar to what I experienced (i.e. meeting with the CEO). I know my voice was only accepted in certain circles, but not in others. I wonder how women silence each other unknowingly. Women are desensitized to its harm appearing as an unintentional approach to silencing another woman’s voice. It’s subtle and not even perceived as a problem that should be eradicated because with silencing others comes prestige, higher pay positions of power. Positions that pay well and help to support our families. But who are we actually supporting?

Curiosity propels me to wonder how many mother's voices in various settings are being silenced through everyday encounters. We have different ways of knowing, and we may override or disregard other salient ways of knowing another culture, another person, another way of being. The importance lies in the authentic connection we make with ourselves first. The importance of authenticity is with the client as all the therapy modalities do not equal up to working from this position. Equally important is not hiding behind the professional language and reconstructing our own voice. Recognizing the bias, we hold as practitioners by positioning ourselves in a level of accountability through self-reflexivity.

Dr. Charlynn Ruan (2017, p.110), a psychologist makes the following statement, "The most effective and insidious method of silencing women is through subtle methods, where the woman feels shame about herself as a person rather than identifying it as linked to discrimination against her gender." A cultural silencing of women was revealed in the narratives. I heard her voice; a position of resistance by stepping outside the boundary created for her as a woman—as a mother. She did so for the love of her child, she showed her daughter the importance of raising her voice—not to be afraid. When we are able to pass on this great gift of "agency" as women, as mother's we begin the change that is required for all voices to be heard. CRFT reminds us that voices of all women of colour within the various intersectionalities are silenced in subtle ways which keep women disconnected from each other.

As social workers we can be vehicles of discriminatory practices because it is not enough to say we practice AOP, or we embrace CRFT, or that we fight for social justice. The larger question is how we practice it, how does our clinical work embrace such frameworks. Outlining and embracing these particular frameworks requires a commitment to revisiting the position of

our own identity in society. As this quote makes clear the discussion is political where systems of oppression are able to remain alive because of how we do our work!

Our social world, with its rules, practices, and assignments of prestige and power, is not fixed; rather, we construct with it words, stories and silence. But we need not acquiesce in arrangements that are unfair and one-sided. By writing and speaking against them, we may hope to contribute to a better, fairer world (Delgado & Stefancic, 2013 p.180).

In order to contribute to a fairer world, resistance requires constant self-reflexivity how do we become the change if the setting we work within is silently changing women? Silence and powerlessness go hand-in-hand; whose voices get heard and whose do not.

CONCLUSION

The various hats I have worn in different agencies upheld one way of knowing which made me a vehicle of oppressive practices. The journey I have taken through this research path is one of growth, and personal transformation by placing an importance on AOP through authenticity. In addition, I have woven in the two-eyed seeing decolonizing methodology to my tapestry of knowledge formation (Absolon, 2019). Two-eyed seeing, which is about seeing both colonial (and medical) approaches as well as decolonizing approaches is now part of my ethical relationship between ‘knowers and learners’, sharing an equal relationship in the therapeutic process. This approach has encouraged me to bring in my authentic self in, embracing equality and respect in providing therapeutic support. Therefore, embracing two-eyed seeing is about co-creation, and through this approach I have gained a new approach to teaching and learning.

Through the findings, and analysis of this MRP we have heard mothers’ narratives on socioeconomic barriers; many are faced with few options in accessing therapeutic treatment such as behavioural therapy, CBT, or dyadic work. Mothers encounter a long waiting list for therapeutic supports in mental health agencies. Some clients have waited over 2 years for therapeutic supports, and many are left to their own devices. Accessing therapeutic services is a distant option, in contrast to immediate affordable options [medication] that are covered through the child’s OHIP card (Ontario Ministry of Health, 2019). The lack of access to therapeutic treatments is due to economic barriers and out of pocket expenses of \$150.00 per session which competes with putting food on the table or paying rent. I saw this through the narratives which outlined mother’s advocacy skills to support the needs of their child, via the Empowerment Program, extra tutors, time spent finding different affordable supports.

Students are engaged in a failing school system and failing mental health system, where access to services are mainly through out of pocket expenses. Many families struggling to pay out of pocket expenses such as assessments, tutors and special school programs are not granted access, due to poorly funded schools in certain communities. In addition, long wait times for community supports leave families to fend for themselves. The dominant narratives “position” children with ADHD as living with a behavioural deficit, which is supposedly the individuals’ fault. However, the mother’s narratives in this MRP outline an unsupportive fragmented system with resources only for those in affluent communities.

In this MRP the voices of mothers and their children are heard and held in a level of acknowledgement, their voices outline key gaps within the system. As I reflect back on the stories, I’m confronted with a powerful message-that they have often been excluded. Do their experiences not matter? Moreover, would the voices of the participants not enhance knowledge about and research on ADHD? Is research only conducted in clinical settings, omitting the perspectives and experiences of the individuals out in community? Is listening not a large part of understanding the individual? How else are we to understand others, and our world? I strongly believe it is unethical to not include the personal and the community in supposedly clinical concerns.

Research on ADHD often overlooks gender, as girls are underrepresented and often misdiagnosed and untreated. It also overlooks older ‘children’, such as high school students. The lack of school base effectiveness in concrete academic supports for children struggling academically omits the involvement of the individual in their own education.

The stories in this MRP clearly outline a “failure cycle” not only in the educational system, but in government supports. Children and their mothers deserve more a focus on diagnosis and academic performance but acknowledgement of and support for all of an individuals’ capabilities.

As a social work practitioner, all of these issues and concerns are important to me. Looking to the future, we must speak fearlessly, truthfully, and critically question and challenge the various structural institutions by exposing where power and knowledge operates —silencing voices!

APPENDICES

Appendix A-Interview Guide

Sample Interview questions:

1. Please tell me why you wanted to participate in this research.
2. There are a lot of different views of ADHD. How do you understand ADHD?
3. What has it been like to mother/parent your child with ADHD? What kinds of experiences have you had? Tell me the story of how/when/if you chose to medicate your child with ADHD.
4. How would you like things to be different/otherwise as a parent of a child with ADHD?

Appendix B- Recruitment Transcript

DOES YOUR CHILD HAVE ADHD?

ARE YOU A CUSTODIAL MOTHER OVER THE AGE OF
18? DO YOU LIVE IN THE GREATER TORONTO AREA?

Mothers are invited to participate in a research study
entitled, MOTHERING WHEN YOUR CHILD HAS ADHD

Participation includes a 1-2-hour phone interview at a time
of your choice between April and June 2020

Share your experiences of parenting, supports, schools and
systems. Email icastill@ryerson.ca for more information and/or to
arrange an interview.

Approved by Ryerson's Research Ethic Board

Appendix C- Referrals for Participants

List of Support Agencies

1. Toronto Distress Centre 416-408-4357 or text # 45645

2. Gerstein Centre 416-929-5200 (crisis line)
3. Canadian Mental Health Association <http://toronto.cmha.ca/mental-health/find-help/are-you-in-crisis>.

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.

TITLE OF THE STUDY; Mothering when your child has ADHD

INVESTIGATORS: This research study is being conducted by Iris Castillo, an MSW student in the School of Social Work and supervised by Dr. Jennifer Poole, Associate Professor and Co-Graduate Program Director of the MSW Program at Ryerson University.

The study is unfunded.

If you have any questions or concerns about the research, please feel free to contact the researcher Iris Castillo at icastill@ryerson.ca or Dr. Jennifer Poole at jpoole@ryerson.ca.

PURPOSE OF THE STUDY

My name is Iris Castillo, and I am a graduate student at the School of Social Work at Ryerson University. I am recruiting up to 5 participants for my master's research project called "Mothering when your child has ADHD". I am seeking potential participants to participate in a 1-2-hour phone interview at the time of their choice.

You are eligible to participate if:

- You are an adult custodial parent (over 18) and identify as a "mother"
- You have one or more children with a diagnosis of ADHD
- You live in the Greater Toronto area

I seek to center the diverse experiences of mothers parenting children with ADHD including their experiences with support agencies, schools, and the overall system. As a graduate student, this research is being carried out in partial completion of my MSW degree requirement and results will contribute to a major research paper (MRP).

WHAT YOU WILL BE ASKED TO DO: If you volunteer to participate in this study, you will be asked to do the following things:

- Participate in a 1-2-hour phone interview. This interview will be conducted at a time of your choosing and will involve responding to certain questions (see below). Interviews will be digitally recorded by me, the researcher, and then transcribed.

-Review your interview transcript: Once completed, I will set up a private google document for you to review your transcript. You will have up to three weeks to review it should you wish to. After that, I will work with the transcripts as is.

You will have access to the findings/final document through the Ryerson digital repository.
[Ryerson Library Digital Repository | Ryerson University Library](#)

Sample Interview questions:

1. Please tell me why you wanted to participate in this research.
2. There are a lot of different views of ADHD. How do you understand ADHD?
3. What has it been like to mother/parent your child with ADHD? What kinds of experiences have you had? Tell me the story of how/when/if you chose to medicate your child with ADHD.
4. How would you like things to be different/otherwise as a parent of a child with ADHD?

POTENTIAL BENEFITS

Potential benefits to participants include the opportunity to discuss their experiences and make recommendations for change in support for mothers with ADHD.

I cannot guarantee, however, that you will receive any benefits from participating in this study.

WHAT ARE THE POTENTIAL RISKS TO YOU AS A PARTICIPANT

There may be a risk of discomfort and/or distress due to the nature of the interview questions. You may reflect on unpleasant memories while responding. If you begin to feel uncomfortable, you may skip answering a question or stop participation, either temporarily or permanently. If you need to talk after the interview, I will refer you to support agencies that provide free and accessible support.

CONFIDENTIALITY

During the research process and beyond, your identity will remain confidential and no identifying information will be included in the dissemination of the results.

In certain circumstances, there may be limits to the protection of participant confidentiality. Researchers may be required to disclose confidential information regarding their participants to the appropriate authorities when required by law or if there is a special duty to report. For example, researchers are required by law to report to the proper authorities any suspicions of child neglect

or abuse that they may come across during the duration of their research. In addition, as a social work researcher, I am required to breach confidentiality in the event that I find out that their participants pose an imminent harm to themselves or others.

Only I will have access to the recording of your interview, and that will be destroyed immediately after I have finished transcribing it. You have the right to review/edit your interview transcripts. I will make these available to you at which time you will have up to three weeks to review them.

Research data, including interview transcripts, will be stored securely in a password protected file only until the results have been published and then data will be deleted. Should you wish to have a copy of the findings/final MRP, I can share these via a secure, password protected document. As well, you may want to access the final MRP via Ryerson's digital repository: [Ryerson Library Digital Repository | Ryerson University Library](#)

By agreeing to participate in this research, you are not giving up or waiving any legal right in the event that you are harmed during the research.

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. If you choose to stop participating, you may also choose to not have your data included in the study.

Your choice of whether or not to participate will not influence your future relations with Ryerson University or the investigators Iris Castillo and Jennifer Poole involved in the research.

QUESTIONS ABOUT THE STUDY: If you have any questions about the research now, please ask. If you have questions later about the research, you may contact:

Iris Castillo, MSW Student and Primary Investigator, School of Social Work:
icastill@ryerson.ca

Jennifer Poole, Associate Professor (and research supervisor), School of Social Work:
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 WHEN YOUR CHILD HAS ADHD

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

REFERENCES

Ahmed, R., Borst, J. M., Yong, C. W., & Aslani, P. (2014). Do parents of children with attention deficit/hyperactivity disorder (ADHD) receive adequate information about the disorder and its treatments? A qualitative investigation. *Patient Preference and Adherence*, 8, 661-670.

Bennett, J. (2007). (dis)ordering motherhood: Mothering a child with attention Deficit/Hyperactivity disorder. *Body & Society*, 13(4), 97-110.

Bowden, G. (2014). Disorders of inattention and hyperactivity: The production of responsible subjects. *History of the Human Sciences*, 27(1), 88-107.

Center for ADHD Awareness Canada (CADDAC), www.caddac.ca

Centers for Disease Control and Prevention (CDC), www.cdc.gov/rdc.

Clarke, J., Mosleh, D., & Janketic, N. (2016). Discourses about children's mental health and developmental disorders in north American women's magazines 1990–2012. *Child & Family Social Work*, 21(4), 391-400.

Coletti, D. J., Pappadopulos, E., Katsiotas, N. J., Berest, A., Jensen, P. S., & Kafantaris, V. (2012). Parent perspectives on the decision to initiate medication treatment of Attention Deficit/Hyperactivity disorder. *Journal of Child and Adolescent Psychopharmacology*, 22(3), 226- 237.

Comstock, E. J. (2011). The end of drugging children: Toward the genealogy of the ADHD subject. *Journal of the History of the Behavioral Sciences*, 47(1), 44-69.

Corcoran, J., Schildt, B., Hochbrueckner, R., & Abell, J. (2017). Parents of children with attention Deficit/Hyperactivity disorder: A meta-synthesis, part II. *Child and Adolescent Social Work Journal*, 34(4), 337-348.

Corkum, P., Corkum, P., Bessey, M., Bessey, M., McGonnell, M., McGonnell, M., . . . Dorbeck, A. (2015). Barriers to evidence-based treatment for children with attention-deficit/hyperactivity disorder. *ADHD Attention Deficit and Hyperactivity Disorders*, 7(1), 49-74.

Cortese, S., Holtmann, M., Banaschewski, T., Buitelaar, J., Coghill, D., Danckaerts, M., . . . European ADHD Guidelines Group. (2013). Practitioner review: Current best practice in the management of adverse events during treatment with ADHD medications in children and adolescents. *Journal of Child Psychology and Psychiatry*, 54(3), 227-246.

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry & research design: Choosing among five approaches* (Fourth ed.)

Curatolo, P., D'Agati, E., & Moavero, R. (2010). The neurobiological basis of ADHD. *Italian Journal of Pediatrics*, 36(1), 79-79.

Currie, J., Stabile, M., & Jones, L. (2014). Do stimulant medications improve educational and behavioral outcomes for children with ADHD? *Journal of Health Economics*, 37, 58-69.

DosReis, S., Barksdale, C. L., Sherman, A., Maloney, K., & Charach, A. (2010). Stigmatizing experiences of parents of children with a new diagnosis of ADHD. *Psychiatric Services*, 61(8), 811-816.

Edmunds, A., & Martsch-Litt, S. (2008). Adhd assessment and diagnosis in Canada: An inconsistent but fixable process. *Exceptionality Education Canada*, 18(2-3), 3.

Edwards, C., & Howlett, E. (2013). Putting knowledge to trial: 'ADHD parents' and the evaluation of alternative therapeutic regimes. *Social Science & Medicine*, 81, 34-41.

Erevelles, N., & Minear, A. (2010). Unspeakable offenses: Untangling race and disability in discourses of intersectionality. *Journal of Literary & Cultural Disability Studies*, 4(2), 127-145.

Erlandsson, S., Lundin, L., Punzi, E., Avdelningen (2016). A discursive analysis concerning information on "ADHD" presented to parents by the national institute of mental health (USA). *International Journal of Qualitative Studies on Health and Well-being*, 11(1), 30938-12.

Evans, S. W., & Young storm, E. (2006). Evidence-based assessment of attention-Deficit/Hyperactivity disorder. *Journal of the American Academy of Child & Adolescent Psychiatry*, 45(9), 1132-1137.

Fakis, A., Hilliam, R., Townend, M., Stoneley, H., & Robinson, G. (2014). Mothers' and grandmothers' perceptions relating to causality, treatment, and support for families of a child

with a diagnosis of attention deficit hyperactivity disorder: Applying enosis, an alternative mixed methods approach. *International Journal of Multiple Research Approaches*, 8(2), 148-165.

Filipe, A. M., & Singh, I. (2016). Raising generation Rx: Mothering kids with invisible disabilities in an age of inequality. by Linda M. Blum. New York: New York university press, 2015. pp. *The American Journal of Sociology*, 122(3), 985-987.

Filipe, Â. M. (2011). Through the looking-glass: A critical review of sociology and medicine towards the diagnosis of ADHD1. *Configurators*, (8), 73-86.

Firmin, M. W., & Phillips, A. (2009). A qualitative study of families and children possessing diagnoses of ADHD. *Journal of Family Issues*, 30(9), 1155-1174.

Flood, M., Hayden, J. C., Gavin, B., & McNicholas, F. (2019). A qualitative study exploring the decision of parents to use medication in attention-deficit hyperactivity disorder. *Research in Social and Administrative Pharmacy*, 15(9), 1095-1101.

Francis, A. A. (2012). The dynamics of family trouble: Middle-class parents whose children have problems. *Journal of Contemporary Ethnography*, 41(4), 371-401.

Freedman, J. E. (2016). An analysis of the discourses on attention deficit hyperactivity disorder (ADHD) in US special education textbooks, with implications for inclusive education. *International Journal of Inclusive Education*, 20(1), 32-51.

Gallo, E. F., Dr, & Posner, J., MD. (2016). Moving towards causality in attention-deficit hyperactivity disorder: Overview of neural and genetic mechanisms. *Lancet Psychiatry*, the, 3(6), 555-567.

Garro, L. C., & Yarris, K. E. (2009). "A massive long way": Interconnecting histories, a "special child," ADHD, and everyday family life. *Culture, Medicine and Psychiatry*, 33(4), 559-607.

Gesser-Edelsburg, A., & Hamade Boukai, R. (2019). Does the education system serve as a persuasion agent for recommending ADHD diagnosis and medication uptake? A qualitative case study to identify and characterize the persuasion strategies of Israeli teachers and school counselors. *BMC Psychiatry*, 19(1), 153-12.

Gharibi, H., & Gholizadeh, Z. (2011). Phenomenology of mothers' experiences in living with children with AD/HD disorder. *Procedia - Social and Behavioral Sciences*, 30, 1630-1634.

Ghosh, M., Fisher, C., Preen, D. B., & Holman, C. D. J. (2016). "it has to be fixed": A qualitative inquiry into perceived ADHD behaviour among affected individuals and parents in western Australia. *BMC Health Services Research*, 16(141), 141.

Gonon, F., Konsman, J., Cohen, D., & Boraud, T. (2012;2011;). Why most biomedical findings echoed by newspapers turn out to be false: The case of attention deficit hyperactivity disorder. *PloS One*, 7(9), e4475.

Gray Brunton, C., McVittie, C., Ellison, M., & Willock, J. (2014). Negotiating parental accountability in the face of uncertainty for attention-deficit hyperactivity disorder. *Qualitative Health Research*, 24(2), 242-253.

Harazni, L., & Alkaissi, A. (2016). The experience of mothers and teachers of attention Deficit/Hyperactivity disorder children, and their management practices for the behaviors of the child a descriptive phenomenological study. *Journal of Education and Practice*, 7(6), 1.

Henderson, A., Henderson, A., Harmon, S., Harmon, S., Newman, H., & Newman, H. (2016). The price mothers pay, even when they are not buying it: Mental health consequences of idealized motherhood. *Sex Roles*, 74(11), 512-526.

Horton-Salway, M., Davies, A., & SpringerLink (Online service). (2018). *The discourse of ADHD: Perspectives on attention deficit hyperactivity disorder*. Cham: Springer International Publishing.

Jackson, D., & Mannix, J. (2004). Giving voice to the burden of blame: A feminist study of mothers' experiences of mother blaming. *International Journal of Nursing Practice*, 10(4), 150-158.

Kirmayer, L. J. (2012). Cultural competence and evidence-based practice in mental health: Epistemic communities and the politics of pluralism. *Social Science & Medicine*, 75(2), 249-256.

Kingston, A. K. (2007). *Mothering special needs: A different maternal journey*. Jessica Kingsley Publishers.

Laugesen, B., & Groenkjaer, M. (2015). Parenting experiences of living with a child with attention deficit hyperactivity disorder: A systematic review of qualitative evidence. *JBIM Database of Systematic Reviews and Implementation Reports*, 13(11), 169-234

Leitch, S., Sciberras, E., Post, B., Gerner, B., Rinehart, N., Nicholson, J. M., & Evans, S. (2019). Experience of stress in parents of children with ADHD: A qualitative study. *International Journal of Qualitative Studies on Health and Well-being*, 14(1), 1690091.

Lindsay, G. M., & Schwind, J. K. (2016). Narrative inquiry: Experience matters. *Canadian Journal of Nursing Research*, 48(1), 14-20.

Lin, M., Huang, X., & Hung, B. (2009). The experiences of primary caregivers raising school-aged children with attention-deficit hyperactivity disorder. *Journal of Clinical Nursing*, 18(12), 1693-1702.

Loe, I. M., MD, & Feldman, Heidi M., MD, PhD. (2007). Academic and educational outcomes of children with ADHD. *Ambulatory Pediatrics*, 7(1), 82-90.

MHASEF Research Team. *Mental Health and Addictions System Performance in Ontario: A Baseline Scorecard*. Toronto, ON: Institute for Clinical Evaluative Sciences; 2018.

Mikami, A. Y., Chong, G. K., Saporito, J. M., & Na, J. J. (2015). Implications of parental affiliate stigma in families of children with ADHD. *Journal of Clinical Child & Adolescent Psychology*, 44(4), 595-603.

Mukolo, A., Ph.D, Heflinger, C. A., Ph.D, & Wallston, K. A., Ph.D. (2010). The stigma of childhood mental disorders: A conceptual framework. *Journal of the American Academy of Child & Adolescent Psychiatry*, 49(2), 92-103.

Muñoz-Silva, A., Lago-Urbano, R., Sanchez-Garcia, M., & Carmona-Márquez, J. (2017). Child/Adolescent's ADHD and parenting stress: The mediating role of family impact and conduct problems. *Frontiers in Psychology*, 8, 2252.

Pajo, B., & Cohen, D. (2013). Time spent with children and working parents' willingness to medicate ADHD-like behaviors. *SAGE Open*, 3(4), 215824421351213.

Pajo, B., Pajo, B., Cohen, D., & Cohen, D. (2013). The problem with ADHD: Researchers' constructions and parents' accounts. *International Journal of Early Childhood*, 45(1), 11-33.

Perez Algorta, G., Kragh, C. A., Arnold, L. E., Molina, B. S. G., Hinshaw, S. P., Swanson, J. M., . . . Jensen, P. S. (2018). Maternal ADHD symptoms, personality, and parenting stress: Differences between mothers of children with ADHD and mothers of comparison children. *Journal of Attention Disorders*, 22(13), 1266-1277.

Peters, K., & Jackson, D. (2009). Mothers' experiences of parenting a child with attention deficit hyperactivity disorder. *Journal of Advanced Nursing*, 65(1), 62-71.

Reynolds, C. R., & Shaywitz, S. E. (2009). Response to intervention: Ready or not? or, from wait-to-fail to watch-them-fail. *School Psychology Quarterly*, 24(2), 130-145.

Samiei, M., Daneshmand, R., Keramatfar, R., Khooshabi, K., Amiri, N., Farhadi, Y., . . . Samadi, R. (2015). Attention deficit hyperactivity disorder (ADHD) and stress: A mutual relationship between children and mothers. *Basic and Clinical Neuroscience*, 6(2), 113-121.

Schatz, N. K., Fabiano, G. A., Cunningham, C. E., DosReis, S., Waschbusch, D. A., Jerome, S., . . . Morris, K. L. (2015). Systematic review of patients' and parents' preferences for ADHD treatment options and processes of care. *The Patient -Patient-Centered Outcomes Research*, 8(6), 483-497.

Sellmaier, C., Leo, M. C., Brennan, E. M., Kendall, J., & Houck, G. M. (2016). Finding fit between work and family responsibilities when caring for children with ADHD diagnoses. *Journal of Child and Family Studies*, 25(12), 3684-3693.

Smagorinsky, P. (2014). Who's normal here? an atypical's perspective on mental health and educational inclusion. *The English Journal*, 103(5), 15-23

Smith, A., Kochan, *Factors, and symptoms contributing to parent stress in raising an ADHD child*. Chestnut Hill College, ProQuest Dissertations Publishing, 2011. 3518283.

Smith, M. (2017). Hyperactive around the world? the history of ADHD in global perspective. *Social History of Medicine: The Journal of the Society for the Social History of Medicine*, 30(4), 767-787.

Te Meerman, S., Batstra, L., Grietens, H., & Frances, A. (2017). ADHD: A critical update for educational professionals. *International Journal of Qualitative Studies on Health and Well-being: Thematic Cluster on ADHD*, 12(1), 1298267-7.

Thapar, A., Prof, Cooper, M., MRCPsych, & Rutter, M., Prof. (2016;2017;). Neurodevelopmental disorders. *Lancet Psychiatry*, the, 4(4), 339-346.

Vasko, E. T. (2017). "mad mothers, bad mothers": Resisting stigma and embracing grace as disease. *Journal of the Society of Christian Ethics*, 37(1), 141-159.

Wallace, N. (2005). The perceptions of mothers of sons with ADHD. *Australian and New Zealand Journal of Family Therapy*, 26(4), 193-9.

Wiener, J., Malone, M., Varma, A., Markel, C., Biondic, D., Tannock, R., & Humphries, T. (2012). Children's perceptions of their ADHD symptoms: Positive illusions, attributions, and stigma. *Canadian Journal of School Psychology*, 27(3), 217.

Wilder, J., Koro-Ljungberg, M., & Bussing, R. (2009). ADHD, motherhood, and intersectionality: An exploratory study. *Race, Gender & Class*, 16(3/4), 59-81.

