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Motherblame-Stigma and Institutional Gaslighting: Obscuring Failures in Child Disability Care Infrastructures

Mothers of children with mental illness are on the frontlines of two global crises. The rates and severity of children's mental illness have been rapidly growing, increasing the need for services and community supports. At the same time, four decades of privatization and austerity have resulted in what Emma Dowling calls "the care crisis," including a state of disarray in the children's mental health service sector. The intersection of the children's mental health crisis with the care crisis makes it impossible for many children to access hospital beds for mental health emergencies and community-based disability services necessary to keep them alive and in their own homes. Mothers overwhelmingly bear the economic and social burdens of filling in disability service gaps. Furthermore, the very agencies charged to serve children with disabilities depend on the exploited and appropriated unpaid labour of their mothers. This article introduces the concept of "motherblame-stigma," a social prejudice in the form of social disgrace, blame, and distrust of mothers related to a stigmatized characteristic of their child. After tracing the history of motherblame-stigma for children's mental illness, I apply an epistemic oppression framing to illustrate how motherblame-stigma functions to prevent mothers from correcting distorted public narratives about child disability service infrastructures (a contributory injustice) and to sow self-doubt within mothers about their own experiences and capabilities (gaslighting). I provide examples of institutional gaslighting in state policy, law, public statements, and narratives to blame mothers for failing to seek and navigate services that do not exist.

Introduction

According to the World Health Organization (WHO), 14 per cent of the world's children and youth aged ten to nineteen live with a mental health condition, most of which are "unrecognized and untreated" (WHO, "Mental

Health" 1). Although this crisis is not new, it was exacerbated by the COVID-19 pandemic, which saw a 24 per cent increase in mental-health emergency room visits for children aged five to eleven and a 31 per cent increase for children aged twelve to seventeen (Leeb et al. 1677). The pandemic also brought attention to what Emma Dowling calls "the care crisis." This is the state of disarray in various care service sectors because of privatization and austerity (3). As the Care Collective points out, this crisis predates COVID-19 by forty years (3).

Only 51 per cent of the WHO's 194 member states had mental health policies consistent with human rights instruments ("WHO Report"). Even in high-income nations, most youth are not receiving needed treatment (Barican et al. 36). This is particularly true in the United States (US), which, according to the Commonwealth Fund, has some of the worst mental health outcomes among industrialized countries, in part due to its relatively low workforce capacity to meet mental health needs (Tikkanen et al. 1). The US has only one child psychiatrist for every 620 children with mental illness, and only half of these children receive any mental health treatment within one year (Williams et al. 37). Not "a single state in the country has an adequate supply of child psychiatrists, and 43 states are considered to have a severe shortage" (Tyler et al. 1). Although the need for child and adolescent psychiatric hospital beds has been increasing over the last three decades, the number of such beds has been decreasing under privatized managed care (APA 85). The situation is particularly dire for youth with mental illness who require direct support services to live in their communities. For the last two decades, there has been a significant shortage of direct support professionals (DSP) in the US (Bipartisan Policy Center 4). Providers leaving states or closing shop contribute to this shortage because they cannot get accurate reimbursements from privatized Medicaid programs (Ramm 1). Getting data on this crucial workforce is difficult because the US government does not currently include DSP on its jobs list.

The lack of community-based services deprives many children of basic human needs. Those most affected often end up institutionalized or part of the juvenile justice system, far from home, cutting them off from their families and communities. This is also an economic crisis because a significant part of the workforce must leave to engage in unpaid family care labour to fill these gaps. According to estimates by the US Bipartisan Policy Center, about thirty-eight million caregivers in 2021 were unpaid, and the estimated economic value of their care reached approximately $600 billion (5).

This economic burden does not affect people equally. Whether it is childcare, eldercare, or care for people with disabilities, the burden overwhelmingly falls on the world's women, who make up 70 per cent of the global health workforce (Boniol et al. 1) and do three times more unpaid care work than men (UN

Women 2). The UN Census Bureau's Current Population Study shows that mothers are four times as likely as fathers to miss work due to childcare and mothers account for 95 per cent of stay-at-home parents in the US—that is, adults remaining out of the workforce specifically to take care of family members (Haines). Similar gender disparities exist among caregivers of persons with mental illness. For instance, a survey of unpaid caregivers of adult persons with schizophrenia in the US revealed that 82 per cent of caregivers were women, 90 per cent of those being mothers of patients (Sharma et al. 11). It is noteworthy that data are not publicly available on the unpaid care labour for minor children with mental illness (or disabilities in general)—specialized care made invisible by subsuming it under the "parenting" rubric.

Structures are not in place to adequately meet the needs of children with mental illness. For instance, several recent federal class-action lawsuits against US states have been filed for failing to provide federally mandated and medically necessary mental health services for children with disability (*CA v. Garcia* in Iowa; *DD v. Lyon* in Michigan; *MH v. Noggle* in Georgia). However, mothers are regularly gaslit into thinking deficits in their child's services result from their failures at service navigation, and if they just worked hard enough (as good mothers do), their children would be fine. This gaslighting often comes from the very agencies mandated to provide such care.

Over the past decade, "gaslighting" has expanded from a primarily psychological concept about interpersonal abuse to include epistemic injustices that occur in the context of structural power (Abramson; Bailey; Davis and Ernst; McKinnon; Pohlhaus; Ruiz; Shane et al.; Sweet). According to Miranda Fricker, who coined the term, an epistemic injustice is a "wrong done to someone specifically in their capacity as a knower" (*Epistemic Injustice* 1). Fricker distinguishes between two types of epistemic injustice. Testimonial injustices occur when a speaker experiences a deflated level of credibility due to a prejudice in the hearer. Hermeneutical injustices are gaps in shared interpretative resources that lead to misunderstanding, misrepresentation, and, in extreme cases, complete erasure of lived experiences that fall within those gaps. Discrimination causes both—in the case of testimonial injustices, the hearer is not believed due to prejudice. Hermeneutical injustice arises out of "hermeneutic marginalization in relation to some area of social experience. This puts them at an unfair disadvantage in comprehending and/or getting others to comprehend an experience of that kind (a somewhat indirect discrimination)" ("Evolving Concepts" 53). It is important to Fricker's account that these forms of discrimination are nondeliberate and very common, although as she points out, this does not entail non-culpability ("Evolving Concepts" 55). Mothers of children with mental illness regularly experience testimonial injustices when seeking healthcare for their children. For instance, a doctor may assume that a mother is exaggerating or distorting the needs and behaviours of her child with disabling tics and OCD related to Tourette's syndrome. Hermeneutical injustices occur when people lack the language and understanding to distinguish between manipulative tantrums and sensory meltdowns. For instance, a dysregulated child in a grocery store is often viewed through the lens of bad parenting by onlookers. This not only shames the mother and child but obscures the fact that the child's sensory needs are not being met in the public space, something that might be remedied by universal design.

Such testimonial and hermeneutical injustices mutually reinforce a third type of epistemic injustice introduced by Kristie Dotson. Contributory injustice blocks knowers from contributing to or changing the knowledge system itself ("A Cautionary Tale" 38). When this happens, knowers experience epistemic oppression: the unwarranted exclusion of certain knowers from knowledge-production practices ("Conceptualizing" 116). Dotson's epistemic oppression framework is structural, focussing on the knowledge system itself. Fricker focusses on the intentions and behaviours of individuals during interpersonal transactions (Anderson 165). An individualist approach often leads to "bad apple" thinking—such as "well that doctor ignored you, but that was one bad doctor" or "the people in that store were rude, but that is not everyone." Such statements miss the mark. These are not random events, but regular experiences resulting from ideologies and prejudices embedded in the knowledge system.

Mothers often experience contributory injustice when they try to share their specialized knowledge with professionals who make decisions about their child's education and healthcare. Mothers have specialized knowledge through proximity to and caregiving for their children. Not only do they, as primary caregivers, spend more time with their children than professionals, but they also interact with them in a wider variety of settings. Mothers want to collaborate with professionals to ensure educational and medical plans meet their children's specific needs but regularly feel dismissed (Ryan and Quinlan, 205). Likewise, they have specialized knowledge acquired through proximity to and interactions with the service infrastructures they navigate on their children's behalf. This knowledge is valuable for evaluating and improving those infrastructures. But as the final section will argue, mothers are often systemically gaslit about their experiences with these infrastructures, resulting in maintaining the status quo.

The central feature of any form of gaslighting is that it causes its target to question the validity of their perceptions of reality, experiences, and understanding. Nora Berenstain defines structural gaslighting as "any conceptual work that functions to obscure the nonaccidental connections between structures of oppression and the patterns of harm that they produce and license" ("White Feminist Gaslighting" 734). Structural gaslighting includes shared dominant narratives and controlling images that obscure the ways structures of oppression operate to cause harms. They are effective by hiding in plain sight. What I call "motherblame-stigma" does the conceptual work that obscures the lack of adequate care infrastructure. I define the concept as a social prejudice in the form of social disgrace, blame, and distrust of mothers related to a stigmatized characteristic of their child. This article focusses on motherblame-stigma about a child's mental illness.

Motherblame-stigma obscures the lack of adequate care infrastructure in two important ways: Through gaslighting, mothers come to doubt their experiences navigating services, and as a social prejudice, it causes testimonial injustices when mothers do try to communicate their experiences of service navigation. It blocks uptake of those experiences and the recognition of the mother as a knower, causing contributory injustice.

Motherblame-Stigma

Motherblame is a ubiquitous phenomenon that is not unique to mental illness. It is widely felt and discussed concerning everything from decisions to work while mothering to whether to breastfeed (Eyer; Ladd-Taylor and Umansky; Reimer and Sahagian). A salient feature of motherblame is that there is no way out of it—any choice the mother makes brings disapprobation and social critique. For example, she experiences social disapprobation if she does breastfeed, breastfeeds "too long," or if she does not breastfeed at all (Eyer 63; Umansky). What is unique about the motherblame surrounding a child with mental illness is its gravity, scope, and history. The blame is often about making bad maternal decisions and being a bad mother altogether. In the first half of the twentieth century, childhood mental illness was attributed to early childhood relationships, specifically with the mother. These accounts emerged from the child guidance movement, which between the 1920s and 1940s performed the first psychological and intelligence testing on a mass population of children with emotional and behavioural problems (Smuts 207–25; Richardson 87–107). Influenced by Freud's psychoanalysis, these clinicians worked directly with the mothers, not the children themselves, and started to focus on mothering as the cause of the child's problems. The sociologist Ernest Groves went so far as to declare "that even typical mothering was pathological and in need of scientific improvement" (qtd. in Waltz 353). Experts from the movement, such as the paediatrician and psychoanalyst DW Winnicott and the psychologist Bruno Bettelheim used the media of the day (e.g., books, magazines, radio, and speaking tours) to "change the behavior of mothers to prevent social disorder, crime, and disability. Only with professional guidance and scientific practice, they argued, could mothers save their children, and by extension, society: (Waltz 353).

During this period, many influential theorists identified mothers as the cause of various mental and developmental conditions, perhaps most famously Bettelheim's "refrigerator mother" whose cold personality he claimed caused autism. According to these Freudian accounts, troubling behaviour in children is essentially caused by mothers, "whose personality, sexuality, and unconscious emotions made their nurture or very being harmful" (Blum 204).

In the second half of the twentieth century, new paradigms emerged, but rather than eliminating motherblame, they changed its form. For instance, in the 1970s, "Many radical behaviorists saw infants as a "blank slate" onto which behavior was imprinted through infant-parent interactions. Lovaas's applied behavioral analysis (ABA) therapy presented methods for teaching absolute obedience to adults' demands and behavioral conformity as 'treatment' for autism" (Waltz 355). This treatment involved up to forty hours of repetitive drills to be carried out by the mother under professional supervision. Being a good mother required constant engagement in this "therapeutic parenting" (Waltz 355).

In "Mother-Blame in the Prozac Nation: Raising Kids with Invisible Disabilities," Linda Blum discusses another narrative arising in the second half of the twentieth century: neurological causes and pharmaceutical solutions for the child's behaviours. But as she outlines, this new paradigm also morphed motherblame: "In the era of brain-blame, few mothers are blamed directly for their child's troubles, yet many experience stigma as secondary, contributing, or proximate causes if they fail to act concertedly" (205). In both cases, fitness as a mother is redefined as "intensified action." Mothers who do not engage in this intensified action are labelled bad mothers.

Since Blum wrote about the shift from blaming the mother's being to blaming the mother's lack of intensified action, there has been rising focus on adverse childhood experiences (ACEs). ACEs are determinants of physical and mental health problems—both later in life and in childhood itself. This recent shift in the causal account of childhood mental illness has its form of motherblame, one that effectively combines motherblame elements from biogenic and psychogenic theories.

The phrase "adverse childhood experiences" was coined in the seminal 1998 study by Vincent J. Felitti and his research team: "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Deaths in Adults." The study consists of a survey of adults who completed standardized medical evaluation, asking if they had experienced seven categories of ACEs: "psychological, physical, or sexual abuse; violence against the mother; or living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned" (245). The study summarizes its conclusion as follows: "We found a strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults" (250). Soon other studies followed, showing connections between ACEs and mental health outcomes, not only in adulthood but also childhood, arguing such traumas rewire the young brain (National Scientific Council on the Developing Child; Shonkhoff et al.).

The ACEs approach is often framed as stigma reducing, for the child changes the question from "what is wrong with the child?" to "what happened to the child?" In other words, disability is no longer represented as a deficit of the child's essential biology. However, it might be more accurate to see the ACEs approach as stigma shifting, since the narrow understanding of trauma in the original ACEs categories in effect reduces "what happened to the child" to "what is wrong with the family" and, often more particularly, "what is wrong with the mother."[1] As we have seen, being a caregiver is highly gendered in practice and social imagination. Historically, being a good mother has required protecting the child from harm. Even if the mother is not the perpetrator of abuse, she is expected to be the protector from such abuse (Ladd-Taylor and Umansky 3; Roberts 196–202). Even if she is not the family member who is imprisoned, mentally ill, or suicidal, she is expected to make better choices to protect children from such hardships. In other words, the ACEs research has had the effect of making the caregiver the ultimate and proximate cause of the child's mental illness—and regardless of the gender identity of the primary caregiver, that blame is gendered—for it is a continuation of motherblame. The caregiver is blamed for the child's neurological impairment as well as for failing to meet the demands of intensified concerted effort to secure the services needed to remedy it—a continuation of motherblame from the early twentieth century.

Motherblame is stigmatizing. When the condition the mother is blamed for causing carries a stigma, it adheres to her as a courtesy stigma. In 1963, Erving Goffman introduced the term "courtesy stigma" to refer to stigma individuals face because of their proximity to stigmatized individuals. They do not themselves have the stigmatized characteristic, such as mental illness, but experience stigma due to their proximity to the person with that characteristic. Goffman notes that courtesy stigma spreads out in waves of diminishing intensity, causing people to avoid the person with mental illness and those who share in their courtesy stigma (30).

When courtesy stigma combines with motherblame, it presents a difficult amalgam of social disgrace, blame, and distrust of mothers. This is because the proximity to the stigmatized characteristic is understood in terms of causality, either through heritability, parenting, or both. Motherblame-stigma affects the way the mother is perceived socially, resulting in regular experiences of prejudice and deflated credibility, often leading to social isolation. For these reasons, many mothers attempt to hide their family situation from public view.

Motherblame and mental health stigma are deeply woven into our society. They serve as useful tools for obscuring how neoliberalism is gutting community-based services for children. As we will see in the next sections, mothers not only become scapegoats for state failures to provide child disability services, but the state presents itself as helping such mothers with navigation services for those missing services.

Motherblame-Stigma and Epistemic Gaslighting

Motherblame-stigma functions to prevent mothers from correcting distorted public narratives about child disability service infrastructures (a contributory injustice) and to sow self-doubt within mothers about their own experiences and capabilities (gaslighting). These epistemic oppressions are structural and systemic, greatly infringing on caregivers' agency as knowers.

Sally Haslanger makes a helpful distinction between systemic and structural injustices:

> **Structural injustice** occurs when the practices that create the structure—the network of positions and relations—(a) distort our understanding of what is valuable, or (b) organize us in ways that are unjust/harmful/wrong, e.g., by distributing resources unjustly or violating the principles of democratic equality.
>
> **Systemic injustice** occurs when an unjust structure is maintained in a complex system that is self-reinforcing, adaptive, and creates subjects whose identity is shaped to conform to it. (22)

Motherblame-stigma fuels structural injustices that distort the fact that needed services are not accessible and organize systems to exploit unpaid and invisible care labour. In this section, the case study of Iowa illustrates motherblame-stigma unjustly distributing blame for why children are not getting needed services—it blames parental service navigation failure for what is the result of decades of cutting programs and the privatization of the state's Medicaid program. Motherblame-stigma does the conceptual work that Alison Bailey calls structural gaslighting:

> It happens when knowers attribute epistemic harm to imagined individual character flaws and poor choices in an effort to conceal how the mechanisms of power function to asymmetrically distribute harms in ways that fortify the social structures and practices that enable the violence to continue. Complex systems of domination require structural gaslighting, among other things, to keep their infrastructures in good working order. (667)

Below I examine how the state of Iowa engaged in institutional gaslighting through public speech, law, and policies to imply that children were not receiving needed mental health supports due to parental failure to seek services for their children (rather than the state's failure to provide federally mandated services). I will show how motherblame-stigma is systematic. It is maintained by a complex system of mutually reinforcing levels of epistemic gaslighting, affecting not only what uptake caregivers' experiences receive from others, but their own subjectivity. It operates on institutional, interpersonal, and internalized levels.

The phrase "institutional gaslighting" refers to gaslighting within or by organizations. Current literature refers to cases in which a person with institutional authority gaslights either other individuals within that organization through interpersonal interactions or individuals outside of that organization through public statements by the organization (Aguilar; Johnson; Keiler; Matthew). Both cases focus on disingenuous speech acts. For example, when an attempt to protect the reputation of an organization is described as an institutional investigation (Kennedy-Cuomo; Urban Dictionary). I want to draw attention to how institutions also gaslight through policies, legal codes, practices, and control over narratives.

Iowa's Mental Health Redesign provides a case study. In 2012, the Iowa Acts Chapter 1120 (Senate File 2315) directed the Iowa Department of Human Services (DHS) to redesign the health and disability system "where a set of core mental health services are locally delivered, regionally administered, and meet state-wide standards of care" (Iowa Department of Human Services).

On March 12, 2014, I attended a Family & Youth Focus Group. Ask Resources, a nonprofit child disability advocacy organization, contracted with Iowa to carry out a series of these focus groups around the state to describe the rollout of the system redesign and its impact on children with disabilities. Parents in attendance, overwhelmingly mothers, were excited because Iowa did not have a children's mental health system, and advertising for the event, as well as news coverage interviewing spokespeople for the state, said that the redesign included services for children. However, I learned at that meeting that while core mental health services were being added for adults, the redesign only offered children two things: a paediatric integrated health home (PIH) and a children's disability workgroup, neither of them mental health services. Even after mothers stated this through press conferences and statehouse rallies (Jensen), state's spokespersons continued to represent the PIH and committee as services. For example, from a *Des Moines Register* article published on December 3, 2014:

> Amy Lorentzen McCoy, a spokeswoman for the Iowa Department of Human Services, said earlier this week that the state has been adding some services for children with mental illness. Those include

> Integrated Health Homes, which are designed to coordinate assistance for physical and mental health issues at the same time. McCoy said in an email to the Register that nearly half of the 18,577 Iowans using that new service are children. McCoy also noted that a "children's disability work group" was set up under the state mental health redesign. (Leys)

This is an example of institutional gaslighting because it concealed the failure to add core child services with the implication that children were not accessing services because mothers were not adequately navigating systems—a form of motherblame.

Another illustration of institutional gaslighting is the frequent use of child in need of assistance (CINA) legislation to obtain needed mental health care for children with high needs. A *Des Moines Register* article describes how this happened to the Woodley family (Rood). They adopted Sam, a child with significant mental illness from the foster care system. After several years, Sam's condition worsened, and he started to engage in behaviour that was dangerous to his siblings. The Woodleys tried to get Sam help, but no appropriate community services existed, nor could he access a bed in a residential facility. Things became quite bad, and the only way they were able to protect their other children was to put Sam in an emergency youth shelter—a heartbreaking choice because the shelter did not meet Sam's mental health needs and took him away from his family. The parents were told by their caseworker that the only way they could get Sam into a treatment program was if they filed for CINA case.

CINA is the part of Iowa Juvenile Justice Code (§232) that removes a child from their home because of abuse and neglect and relinquishes parental custody. Parents of children with mental illness unable to access the services their child needs are often encouraged by caseworkers to file a CINA case, claiming that once children are wards of the state, they will be eligible for the very few services that do exist. The relevant part of the law defines a child in need of assistance as one: "Who is in need of treatment to cure or alleviate serious mental illness or disorder, or emotional damage as evidenced by severe anxiety, depression, withdrawal, or untoward aggressive behavior toward self or others and whose parent, guardian, or custodian is unwilling to provide such treatment" (232.96A.6). However, the Woodleys were not unwilling to provide treatment. They were unable to because treatment was not accessible in the state. After filing a CINA, Sam was shortly placed in a residential facility, but it soon closed, and the state could not find another placement. DHS put him back in the foster care system. So, Sam was removed from a loving family and is still unable to access services. Sam's parents lost Sam by trying to save him and had to do it by legally stating they were unfit parents.

Institutional gaslighting also occurs through entrenched organizational practices. For instance, managed care oganizations (MCO) and PIH teams require extensive meetings and phone calls with the mothers to obtain services. These meetings are represented as "care coordination," but because the needed services are often not available, the only interventions are often the meeting itself, which require additional unpaid labour of the mother, who has to document and report personal details about the child and family and any supports mothers could cobble together (through their service navigation or unpaid caregiving labour). In other words, the meetings amount to state surveillance of the family and a bureaucratic appropriation of the mothers' labour. The state or a MCO will now document that child as having certain services and supports even though they played no part in acquiring them. This is an example of institutional gaslighting through policy.

Certain institutions are uniquely positioned to disseminate and reinforce gaslighting narratives. The motherblame narratives associated with Freudian psychology, brain blame, and ACEs are examples. These paradigms were taught and spread by professional schools, certification training, public outreach, and institutional cultures within child-serving institutions. I have learned as a mental health advocate that motherblame-stigma is felt most strongly within institutions meant to serve children with mental illness. I have always been saddened about how many professionals come to me in confidence to share their family's story and say they could never let their coworkers or employers know for fear of the stigma hurting their career. As one mother working within the DHS once told me, how would the state let her help children once they saw her as a "bad mother" herself? These harmful gaslighting narratives are reinforced at the interpersonal and internalized levels.

An often-discussed form of interpersonal gaslighting is medical gaslighting —"when health-care professionals downplay or blow-off symptoms" (Sebring 2; see also Bailey; Barnes; Berenstain, "Stem Cell"; Ruiz). Parents sometimes experience this when reporting their child's signs and symptoms. However, when interpersonal gaslighting is used to maintain the illusion that there is an adequate children's mental health system, it is different from medical gaslighting, which is about the patient's medical condition. In these cases, parents are constantly referred out from doctors, therapists, and educators to services that are simply unavailable, and these referrers often do not believe the parent when they report back their experience of chasing circles in attempts to find the supposed services.

When motherblame-stigma is internalized, it affects the mother's internal dialogue and decision-making, sometimes resulting in self-gaslighting. It is common for mothers to attempt to follow up on a doctor's referral only to find the service no longer exists, is not accepting new patients, or is not what the referrer presented it to be. Self-gaslighting makes the mother think the problem is her failure to work hard enough. Her life becomes dominated by the search for elusive services. In the meantime, she is blamed for both her child's mental health condition and the inability to acquire appropriate care for that condition.

Motherblame-stigma places mothers of children with mental illness in a double bind: The intense actions required to be a fit mother (seeking out needed services for her child) reveal her to be an unfit mother (because her child has mental illness). As a result, self-gaslighting can take two forms. The first goes like this: "I am a good mother, so I must have imagined those symptoms. My kid is really fine and does not need services." Ironically, this form of self-gaslighting is recognized by mental health systems and agencies, which attempt to get such parents to recognize the symptoms and seek out services through stigma-reducing campaigns. Although such parents do exist, the prevalence of stigma-reduction campaigns can give the public the impression that the reason children in general are not receiving services is parental attempts to avoid stigma (not the lack of an adequate care infrastructure). What gets obscured is the countless parents already engaged in an intensive search for services for their child.

The other form of internalized self-gaslighting takes this form: "My child's mental health is suffering, he needs services, and we have not yet acquired those services because I am bad at navigating the system. I am a bad mother. I just need to work harder. I need to be a better mother." This form individualizes a structural problem as the failure of a particular mother—the very goal of institutional gaslighting. This makes mothers vulnerable to the exploitation of unpaid labour discussed above.

Conclusion

Parents of children with mental illness experience systemic gaslighting. Motherblame-stigma manifests on all levels (i.e., internal, interpersonal, and institutional) to undermine a mother's direct perceptions of her child's lack of access to a full continuum of community-based mental health care and supports. This gaslighting causes society to blame parental failure of service navigation as the cause for the child's lack of care rather than the lack of infrastructure itself. The parent internalizes this and engages in concerted action to cobble together care for the child in an ad hoc fashion. This labour gets appropriated and exploited by the systems responsible for, but failing to, provide the infrastructure in the first place. Institutions perpetuate this gaslighting through public relations campaigns, legal codes, policies, and their power to control narratives among professionals, whose training they certify.

Endnotes

1. There is an emerging movement to expand ACEs to include harms beyond the home, such as expanding the concept of adversity to include witnessing violence in the community, experiencing bullying, and living in foster care (Cronholm et al.). I applaud this movement for its structural lens.

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