Bearing Witness to Neurodivergent Indigenous People with Attention-Deficit Hyperactivity Disorder: Stories of Belonging, Strength, and Resilience

by

Caitlin Alder

B.A., Carleton University, 2012

B.S.W., Nicola Valley Institute of Technology, 2020

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We acknowledge and respect the Lək̓ʷəŋən (Songhees and Xʷsepsəm/Esquimalt) Peoples on whose territory the university stands, and the Lək̓ʷəŋən and W̱SÁNEĆ Peoples whose historical relationships with the land continue to this day.

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Abstract

This research bears witness to neurodivergent Indigenous storytellers with Attention-Deficit Hyperactivity Disorder (ADHD), demonstrating the significance of how these intersectional identities have been influential in their development of a sense of belonging. Through the experiences of the researcher, who identifies as neurodivergent and Anishinaabe, and nine (9) other neurodivergent Indigenous people living in Canada, this research serves to contextualize the importance of belonging as a fundamental human need. The purpose of this research is to contribute to the growing conversations on the importance of belonging—particularly, how the development of a positive sense of belonging serves as an important indicator of social, mental, and physical wellbeing; and how negative experiences create a sense of unbelonging, contributing to poorer wellbeing and long-term outcomes. This work observes how belonging is used as a tool of oppression, arguing that conceptions of "normal" or "typical" are intentionally used as a method of "othering" to establish metrics of who belongs and who does not through colonial, white supremacist, and ableist ideologies—which are then supported by Eurocentric methods of research and data analyses that favour the medical model of disability. To challenge these notions, this research embraces frameworks that use the medicine wheel to guide the process of bearing witness to Indigenous storytellers and challenge misconceptions and stereotypes associated with both Indigeneity and neurodivergence that negatively impact belonging—as well as demonstrating how a positive sense of belonging requires a balance between our physical, mental, emotional, and spiritual selves.

Key terms: *neurodiversity, neurodivergent, intersectionality, Indigenous, ADHD, Attention-Deficit Hyperactivity Disorder, identity, belonging, othering.*

Definitions

Neurodiverse/neurodiversity

A biological truism that refers to the limitless variability of human nervous systems on the planet, in which no two can ever be exactly alike due to the influence of environmental factors. Coined by autistic sociologist, Judy Singer, to create a category within the intersectional analysis of social and political issues (Singer, n.d., para. 18).

Neurodivergent/neurodivergence

Speaks to individuals who have a mind that significantly diverges from what is defined by dominant society as "typical" or "normal" (Feinstein, 2017, p. 9). [1]

Attention-Deficit Hyperactivity Disorder

Attention-Deficit Hyperactivity Disorder is described by the American Psychiatric Association as one of the most common mental disorders affecting children. Symptoms of ADHD are described as behaviour that may include inattention, hyperactivity, or impulsivity (American Psychiatric Association, 2024, para. 1).

Disability [as defined by the medical model theory]

An observable mental or physical loss or impairment which is measurable, and which may be permanent or temporary (Withers, 2012, p. 31).

[1] *Neurodivergent* is sometimes mistakenly used synonymously under Singer's term *neurodiverse*, however the term was established by Kassiane Asasumasu (formerly Silbey) a biracial, neurodivergent activist around 2000. Originating source for Asasumasu's definition of neurodivergent/neurodivergence is difficult to find as they primarily published content through their blog/social media, but they have been credited and referenced within academic content as the creator of these terms.

Disability [as defined under radical disability theory]

A social construction used as an oppressive tool to penalize and stigmatize those who deviate from the arbitrary norm (Withers, 2012, p. 99).

Identity

Referring to traits or attributes that identifies linkage (belonging) to social categories, as well as one's personal view of their own characteristics or self-attributes that are not necessarily observably expressed in terms of social category (Fearon, 1999, p. 2).

Belonging

A subjective feeling of connection with social groups and physical places that is shaped by experiences within those spaces (Allen et al., 2021, p. 87).

Intersectionality

Intersectionality is a framework of understanding and acknowledging how different social identities overlap and intersect leading to different experiences of discrimination and privilege. First coined in 1989 by American legal scholar and civil rights advocate, Kimberlé Crenshaw to discuss the intersection of race and sex in the context of exclusion and underrepresentation of the unique experiences of Black women in the context of feminist and anti-racist movements (Crenshaw, 1989, p. 140).

Othering

A process in which a dominating group imposes an identity or perception on a subordinate group with the intent to alienate or divide differing groups (Modood & Thompson, 2022, p. 782).

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Dedications

To the honour and memory of four Indigenous women walking in the spirit world, whom I hold close in this work.

Mary Elders (nee Crow), survivor of Cecilia Jeffrey Indian Residential School in Kenora, Ontario. Mother to five beautiful Indigenous women. I am eternally proud to be her granddaughter. Without her strength, resilience, and resistance, I would not be here to do this work. I am truly grateful to have her spirit walk alongside me on this journey of personal self-discovery and speaking truth to power.

Roberta "Buttons" Jean Elders, Mary's eldest daughter, whom I did not get the chance to know personally. Roberta became one of Canada's MMIWG in 2001, her case remains unsolved 23 years later. Her story sent me on a path that led to my work with the National Inquiry into Missing and Murdered Indigenous Women and Girls in 2017 where I was entrusted to help gather and protect over 600+ testimonies from families of MMIWG and am so grateful to have been witness to these voices and have them feel heard for the first time.

Connie Alanna Loon Elders, Mary's youngest daughter, brought into their home as a foster placement when she was a baby, and was later adopted by Mary and Robert Elders. Although she was my aunt, our ages were so close that we really grew up as sisters. Connie was neurodivergent and was taken from us far too young from a preventable illness due to lack of proper support and inadequate healthcare.

Skye Crassweller, Dene belonging to Teelit Gwich'in Band. I began my MSW at a time where I had been very recently diagnosed with ADHD and was in the first months of a new role working for the Representative for Children and Youth where I was introduced to Skye. Skye tragically passed away in 2017 and in 2020, I was part of the investigations team at RCY supporting the

completion of the public report, *Skye's Legacy: A Focus on Belonging* following the investigation into the death. I owe a great deal to Skye and hold such gratitude for being entrusted to carry her story into the world and my intention is to uphold her legacy with the honour and respect that she deserves.

I also wish to dedicate this work to my mother, Jacqueline. A warrior woman who taught me how to be fiercely independent, to rise above and build others up with me.

To my husband, Matthew. Somehow, the most neurotypical person I have ever met, yet we fit together so comfortably. You taught me that I did not have to always be fiercely independent and that I can ask for help when I need it. Thank you for supporting me in every endeavor I have dared to pursue, for being the best father to our son, and for cooking dinner every night. Without you, we'd be living off chicken nuggets forever.

Finally, to my son, Nolan. You led to the discovery of a side of myself that I was completely unaware of. My diagnosis of ADHD changed our world, helping me become a better mother and person. You are growing up to be an amazing, kind, and brave individual that I am immensely proud of. You are the break in the cycle, and I will forever protect you with my entire heart and soul.

Acknowledgements

I wish to acknowledge that the five years spent working towards completing my thesis could not have been done without the support of my instructors, Dr. Gwendolyn Gosek and Dr. Billie Allan. In October 2020, facing the loss of my aunt Connie, they supported me to ensure that I would be able to successfully complete my classes. Then, only one year later, our world was shattered once again when my stepfather was diagnosed with terminal cancer. Going through that process slowed down my progress on my thesis work and it felt like I would never reach the finish line. Many times, I contemplated changing my focus, completing the MSW-I program via practicum instead, but every time that crossed my mind it never felt right.

Over the past few years, we have seen the world regress in ways we never thought imaginable. Certain people have turned towards removing spaces of belonging for people that we worked tremendously hard to create. Now more than ever, I see this work as necessary to bring into the world and speak to the importance of belonging, inclusion, and making space for voices to be uplifted and heard.

During the last phase of this work, I have had the privilege and pleasure of speaking with and collaborating with many wonderful neurodivergent Indigenous people that I am tremendously grateful to for sharing their gifts and stories with me. Each person has brought a different lens to the meaning of belonging and it is important to understand that this work is not mine alone. Gii chi miigwetch to everyone who spent time with me and those who reached out who I did not get the chance to speak with. This work belongs to all of us.

Lastly, I want to acknowledge any neurodivergent readers who have struggled and faced barriers to achieving goals and dreams. Some of you may have been overtly discouraged by

others around you, while some may be internally struggling with oneself—and for many it could be an experience of both. Know that you are not alone and where there are barriers to achieving what you want and many things fall outside of your control, they are not an outcome of personal failure. I could not have gotten here alone. I have not risen above the adversity I have faced by pulling myself up by my bootstraps. While this work demonstrates that I have achieved something to its completion, know that there were many days I felt defeat. I spent days in my bed that I wished I could have spent working toward my goals. My community, my family, and my friends are the ones who pulled me through this. There are strengths and abilities within all of us that need to be fostered by a community of belonging that encourages us and supports us, and only together can we push against the systems built to disperse and divide us. Dream out loud, help build up others that are willing to help build you up, resist those who aim to bring you down, and never forget that you belong here.

Chapter 1: Introduction

"It's hard to be yourself and feel belonging in a

culture that is hostile toward your existence" (Bacon, 2020, xi).

This thesis presents a search for knowledge about identity and belonging in the context of the intersecting identities of being Indigenous and neurodivergent. Specifically, I examine the diverse experiences of Indigenous people with Attention-Deficit Hyperactivity Disorder (ADHD) and how these intersections of being impact the development of a sense of belonging. With the intention of building a narrative of neurodivergent Indigenous people with ADHD that is strengths-based, I focus less on the pathology of ADHD and more on the innate qualities of ADHD as part of a person's identity. Without denying that ADHD is a disability that comes with barriers and difficulties, there is room in the conversation to also speak to the greatness that lies within neurodivergent people; and to demonstrate that the greatness that lies within is not *despite* being neurodivergent, but *because* of being neurodivergent. I lead this introduction with a quote by Lindo Bacon (2020) because it speaks loudly about the effort it takes to simply exist as an Indigenous person, a disabled person, or any other marginalized identity that has been pushed toward erasure. The feeling of belonging requires the existence of spaces where we are explicitly and unconditionally allowed to exist in our bodies and identities. We may find these spaces within our families, with peers and/or in our communities and culture (Allen, 2021, p. 27). While it may seem like an exaggeration, belonging is a basic human need equivalent to that of breathing or eating. Without belonging, we could not survive.

1.1 About the Researcher

My research comes from a deeply personal place that is centred in my own intersectional identities of being Indigenous and neurodivergent. They are both very significant identities that I am proud of, but they are also both identities that I could not embrace until adulthood. To properly express my intentions for this work, I must introduce myself and my positionality in this work utilizing an Indigenous method of contextualizing knowledge (Anderson, 2016, p. 1). Many other Indigenous researchers like Shawn Wilson (2008), Margaret Kovach (2010), Leanne Simpson (2017), Renee Linklater (2014) and Kathleen Absolon (2022), also speak of the importance of locating themselves as part of the process of engaging with their communities. It is a process of introducing who we are, where we come from, and what connections and intentions we have with this work. Linklater (2014), writes, "First, we write our own stories and share our position in the world before we write about the world" (p. 11). This requires us to be very aware of who we are and how we have come to this place in the world, doing the work that we do. I could not and would not do this work as a non-Indigenous, neurotypical researcher; there is enough of that in the world with researchers speaking on behalf of people rather than creating space for the people themselves to share what is significant to know about them.

So here is what is significant to know about me. I was born in Treaty 3 Territory in Northwestern Ontario to my mother who is of Anishinaabe and English descent; and my father who is mixed European, primarily from Finland and Scotland. My maternal grandmother belonged to Naotkamegwanning (Whitefish Bay) First Nation but was born in Naongashiing First Nation (Big Island). My maternal grandfather was from Onigaming (Sabaskong) First Nation on

his mother's side and his father was an English WWI veteran. My grandmother was a residential school survivor and attended Cecilia Jeffrey Indian Residential School in Kenora, Ontario, the town where I grew up, from the age of 5 to 16 years. Our family was largely disconnected from our First Nations community because of my grandparent's choice to reside outside of the reserve (more on this later). My grandmother's time spent in residential school made her community a foreign, and truthfully, unwelcoming place to her and unfortunately, I had very little connection to my Indigenous identity growing up and I was not raised with cultural traditions, teachings, or my traditional language.

In 2008, I started my Bachelor of Arts at Carleton University in Ottawa, Ontario majoring in Human Rights, which ended up being a pathway not to my career, but to myself. I had not, at that time, come to terms with myself and who I was as an Indigenous person; however, I was attending university as a student sponsored by my Nation. Part of me felt like I did not deserve this opportunity to have my education paid for by a community that I only belonged to by the definitions of the *Indian Act.* I had a card with my photo on it that declared me a member of Naotkamegwanning, but I had no genuine connection to my land or the people who lived there. I was also conflicted by claiming my Indigenous identity because I do not necessarily *look* Indigenous due to my fair complexion and light hair I inherited from my father.

In the spring of 2009, between completing my first year and beginning my second year I lost my grandfather. Following his passing, as I prepared to go back to school, I reflected on the courses I took in my first year. I thought about how I wished there had been more discussion and learning on Indigenous issues in Canada, but the program was focused on a global human rights scope. Something drew me to enroll in Indigenous studies. A feeling, I think could best be

explained as what Maori writer, Owen Eastwood (2021) described as a yearning to know more after the death of his father, his only link to his Maori heritage and culture. The loss of his father, he said, was a severance from a heritage he was born into. A chain broken and a sense of dislocation from a place he had never been but knew he belonged. As the years passed, a yearning to know more fed Eastwood's determination to repair this broken chain (Eastwood, 2021, p. 14).

After some time spent learning in a classroom, I knew connection to my culture and identity needed to happen on a deeper level and sought out urban Indigenous organizations in the community. In my third year of my undergraduate degree, I was hired at the local Friendship Centre as a summer student, which would become the first Indigenous space where I would feel welcomed and feel like I belonged. That experience opened me up to thinking about how I would continue to be present in the Indigenous community and knew that on some level I wanted to be a helper. This led me to pursue a college diploma in social work, and I continued to work at the Friendship Centre on and off for three years, first in various student roles, and eventually managing programs with Indigenous children in the city.

In 2014, one year after completing my social work program, I was hired by an Indigenous child welfare agency in British Columbia and made a big leap forward into where my connection to self would become more significant. Certainly, it was one of the hardest jobs I have ever had in my life. I spent the next three years working with Indigenous children and families, experiencing many ups and downs. I built close relationships with some of the families I worked with, cheering for their successes in their pursuit of healing and wellness for their children. What drove me to leave frontline social work was not the difficulty of working with

children and their families through years of addiction, trauma, and violence. It was the impact of the losing battles where I was equipped with only bandages to support families going through tremendous strife and adversity. There was a helplessness to it where I felt that no matter what my intentions or how hard I worked with a family, it would never be enough. I realized that change needed to happen at a higher level, and I would need to go back to school.

I was never a high performing student in elementary or secondary school, not even in my undergrad. I was a well-liked student, and teachers never found any real reason to be concerned about my learning. However, I struggled with organization, completing assignments, tests, and had to repeat a couple of classes in high school. When I got to university, I felt like I had to learn how to learn. I worked extremely hard to get my degrees, but often still only received average, so-so grades. I never questioned it, I just figured that for some people academics came easy to them, and I just was not one of those people. Unsurprisingly, when I applied for a Master of Social Work (MSW) for the first time, my application was rejected as only a small number of students were accepted without a Bachelor of Social Work (BSW). So, I set out on a different path and decided to pursue the two years needed to obtain my BSW, transferring credits from my first undergraduate degree.

Going back to school at 28 was much different from the first time I went to university, ten years prior. Although not yet diagnosed with ADHD, I felt invigorated in the classroom. I had a purpose and a goal, I had field experience, and I had a very positive connection with most of my instructors who were very encouraging in my work and effort. After my first semester, for the first time in my life I saw straight As and made the Dean's List.

One thing that is significant to mention is that one month before I started the BSW program, I found out I was pregnant. I completed that school year with my newborn son only days old, as I wrote my very last paper for one of my courses. Still oblivious to my neurodivergence, I started to think to myself that maybe it was not that academics were difficult for me. Rather, I just did not have a vested interest or set goal when I pursued my first degree, and we are all supposed to flounder a bit when we first enter adulthood. Obviously, I could not have achieved all this on my own, and I am grateful for the tremendous support I received from my husband and my parents who did so much for us during our son's first year of life. I was also very well supported by my teachers and school administrators as they accommodated me for some of my physical needs during pregnancy, something I had never had before. When it came time to reapply for the MSW program, I was not only accepted but was awarded an entrance scholarship to the very program that had rejected me years before.

While there were some pretty clear signs of my neurodivergence when going through the BSW program, it was motherhood that ended up leading me to uncover this other hidden piece of myself. Following the birth of my son, my sense of stability and ability to function in ways I did prior to becoming a parent unraveled. I experienced extreme post-partum anxiety and panic attacks while trying to care for my newborn baby. When my son was four months old, I was referred to see a post-partum psychiatrist, who asked me for the first time in my life if I had ever been assessed for ADHD. It took me another year of connecting the pieces that would drive me to pursue a confirmed diagnosis from a specialist. In the summer of 2020, between my BSW ending and the start of my MSW, I was formally diagnosed with Attention-Deficit Hyperactivity Disorder (ADHD).

My Indigenous and neurodivergent identities are pieces of me that I was unable to connect with until I was an adult, which has affected me both positively and negatively. Positively speaking, I am at a stage in my life where I feel like I am living closer to my truest self than I ever have. I know what I want to do with the knowledge I have learned working with Indigenous communities across the country. I know how my brain works and responds to my environment; I know what is going to affect my nervous system and how to approach things with a priority for ensuring that I care for myself in the process. I also know that I do not have to muscle through things with twice as much effort as my peers to achieve my goals; medication for my ADHD has helped this tremendously. This knowledge about myself, my identity and understanding of where I belong allows me, as a parent, to share what was missing in my childhood with my son and hope that this helps him be the truest version of himself sooner than I was able to.

On the other hand, there is a lingering grief that I cannot help but feel for the younger version of myself. Numerous "what ifs" cross my mind, wondering, what if I grew up with the support of my culture and community around me? What if I had been diagnosed with ADHD when I was a child and had support and accommodations to help me when I struggled with school and my peers? Would I still be who I am now? Where would I belong?

1.2 What is Belonging?

Belonging is a subjective feeling of connection with social groups and physical places that is shaped by experiences within those spaces (Allen et al., 2021, p. 87). However, belonging arguably goes deeper than just connection to physical people or places and requires defining in multiple dimensions. To make meaning of belonging more holistically, I considered the

dimensions of balance between the physical, mental, spiritual, and emotional parts of our being. I consider a feeling of **physical belonging** as a connection to physical spaces we inhabit throughout our lifespan where we can be our whole selves, accepted, and cared for by others. However, one cannot experience physical belonging in itself without considering the balances of emotional belonging, spiritual belonging, or mental belonging. A feeling of **emotional belonging** may include the meaningful relationships one has that strengthen physical spaces of belonging. For example, a home is meant to be a comfortable space of belonging that may be strengthened by the connections of those we live with. In a home where there are strained relationships (e.g., feuding roommates, separating spouses, etc.), keeping a sense of emotional belonging can be challenging (if not impossible) and would arguably affect one's sense of physical belonging in a space.

Mental belonging is a sense of self, connection to identity and the feeling that we truly belong in our bodies and in our spaces. When struggling with mental health it can be very difficult to feel a sense of belonging within one's body and mind, which can affect personal relationships and connections to others emotionally. Lastly, **spiritual belonging** I consider what we hold as most important to us in terms of connections to land, culture, values, and beliefs that shape and define our identities and influence our actions or choices. May (2011) posits that identity is a sense of self that is constructed in a relational process in our interactions with other people as well as in relation to more abstract notions of collectively held social norms, values, and customs (p. 368). When a person is occupying a physical space shared with other people who may hold contradictory values or beliefs, a sense of physical, emotional, and mental belonging can be significantly compromised.

Dr. Martin Brokenleg, from the Rosebud Sioux tribe, has shared Indigenous perspectives on belonging as pivotal to healthy social-emotional development for children and youth for decades. In 1990, Brokenleg and his colleagues Brendtro and Van Bockern presented their Circle of Courage framework (figure 1), represented visually using an interpretation of a medicine wheel to connect Indigenous perceptions of developmental needs critical to positive child and youth development. The four developmental needs including, **generosity, belonging, mastery, and independence,** are rooted in knowledge from traditional tribal kinship systems in which partnership and cooperation are central to the community culture (Brokenleg, 1998, p. 130). Brokenleg notes similarities of the circle of courage model to that of Stanley Coopersmith's (1967) positive self-esteem framework which asserts that children require feelings of significance, competence, power, and virtue to develop a positive sense of self and identity.

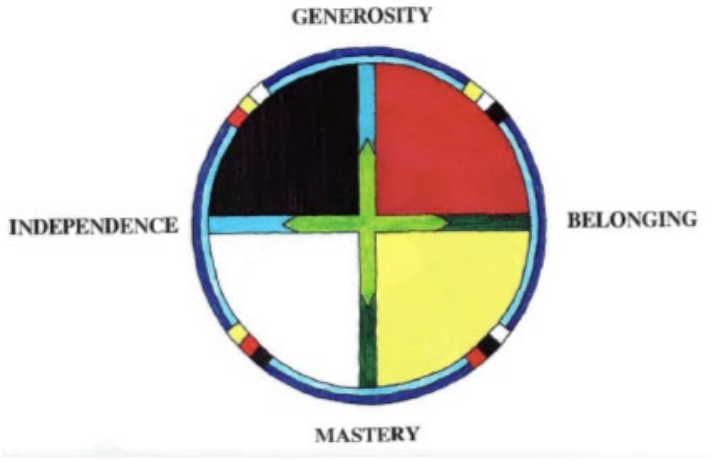

Figure 1 Circle of Courage Framework (1990)

Aligned with Coopersmith's idea of significance, Brokenleg (1998) says, "belonging is the organizing principle in partnership cultures. Significance is assured by belonging, whereas in dominator cultures one gains significance by standing out from others, as seen in the hyper-

individualism of U.S. society today" (p. 131). Belonging in a culture of partnership and cooperation is something that can be understood relatively simply because partnership requires mutual understanding and a general alignment of shared values. In the still Eurocentric-dominated individualistic systems that operate within contemporary society, however, the measurability of belonging is much more complex and nuanced.

The Government of Canada has acknowledged the importance of belonging and the connection of Indigenous peoples to their cultures and have attempted to gain measurable statistics about a general sense of belonging through the 2022 Canada Indigenous Peoples Survey (CIPS) (2022). Selected findings from the 2022 CIPS pertaining to First Nations children living off reserve, Métis children, and Inuit children and their families indicates an understanding that those with access to cultural activities experience a more positive sense of belonging. Participation in ceremonies, traditional craft work, learning traditional ways of living and being relevant to their specific cultures strengthens cultural identity, fosters a positive self-identity and is a positive social determinant of health and wellbeing (Arriagada & Racine, 2022, p. 11).

Engagement with Indigenous peoples for the 2022 CIPS included six questions pertaining to a sense of belonging and the Statistics Canada website indicates an existing report that discusses findings in the differences of three sense of belonging indicators based upon CIPS responses. However, attempts to access that information indicates that the links leading to the report are invalid and a request for access to these documents has been requested through a contact form on the Statistics Canada website. At the time of revising this work in 2026, this

information remains inaccessible. With that information inaccessible, the only information that can be analyzed at this time are the questions posed within the CIPS:

2022 Canada Indigenous Peoples Survey Sense of Belonging (SB) SB_R05 The following questions ask about your sense of belonging to your geographical surroundings.	
SB_Q05 How would you describe your sense of belonging to your local community? Here, your local community refers to the immediate surroundings where you currently live your everyday life.	1: Very strong 2: Somewhat strong 3: Somewhat weak 4: Very weak 5: No opinion
SB_Q10 How would you describe your sense of belonging to Canada?	1: Very strong 2: Somewhat strong 3: Somewhat weak 4: Very weak 5: No opinion
SB_Q15 During the past five years, has your sense of belonging to Canada become stronger, become weaker, or stayed the same?	1: Become stronger 2: Become weaker 3: Stayed the same
SB_R20 The following questions are about your Indigenous identity.	
SB_Q20 How would you describe your sense of belonging to people with the same Indigenous background as you?	1: Very strong 2: Somewhat strong 3: Somewhat weak 4: Very weak 5: No opinion
SB_Q25 During the past five years, has your sense of belonging to people with the same Indigenous background as you become stronger, become weaker, or stayed the same?	1: Become stronger 2: Become weaker 3: Stayed the same
SB_Q30 How do you feel about your Indigenous identity?	1: Very good 2: Good 3: Not very good 4: Not good at all 5: No opinion

Table 1 Statistics Canada, 2022 Canada Indigenous Peoples Survey Questions- Sense of Belonging (SB)

The CIPS is a national survey on the social and economic conditions of First Nations people living off-reserve, Métis, and Inuit, aged one year and older, with the 2022 CIPS being the sixth cycle of the survey (Statistics Canada, 2024, para. 5). A sample of 74,000 respondents of the 2021 Census who reported Indigenous identity or ancestry were selected to voluntarily participate in the 2022 CIPS. Statistics Canada reports that the survey was designed to be thematic and is based on previous cycles of the CIPS which were developed in collaboration with national Indigenous organizations (Statistics Canada, 2024, para. 15). While acknowledging that the questions pertaining to belonging are a good start at understanding the importance of connection to Indigenous heritage, culture, and community, there are many limitations to the CIPS that simply would not provide a very robust understanding about how the experiences of these respondents have impacted and influenced their sense of belonging.

A primary concern is that the CIPS questions only ask about a very surface level feeling of belonging to one's Indigenous identity, the community they reside, and the nation in general. It is uncertain the extent of analysis that goes into intersectional influences of belonging given that analytical reports that speak to the findings of the CIPS were inaccessible on the Statistics Canada website. From the information available, the 2022 CIPS indicates that 29,942 Indigenous respondents completed the survey (Statistics Canada, 2024, para. 42), a response rate of about 40%. However, 2021 Census data report the population of First Nations, Inuit, and Métis people in Canada to be approximately 1.8 million (Statistics Canada, 2023, para. 2), indicating that respondents of the CIPS only represent 0.016% of that population. Furthermore, census data for First Nations people who live on reserve is not robustly collected and CIPS data

specifically excluded First Nations living on-reserve and so experiences of belonging pertaining to those living directly in their Indigenous communities, at least for reserve-based First Nations, are unaccounted for.

Statistics Canada reports that the 2022 CIPS was the first time an electronic questionnaire was implemented, in which those selected to participate were required to access the questionnaire online with a secure access code. While there were options for accessibility in which a person could complete an interview with a proxy person to complete the survey, this method of data collection may have posed numerous barriers to the 60% of invited participants who did not respond to the survey. Accessing the survey would require a certain level of technological acuity, reliable internet connection on an appropriate device, and require the time and energy to devote to the survey which was of significant length. The data also is not meaningfully accessible to the broader public in ways that could make impact on a broader understanding of the importance of belonging. Accessing reports that were developed from the CIPS data analysis was extremely difficult to navigate on the Statistics Canada website, with a large number of broken links and pathways to information that were blocked.

Overall, the CIPS cannot even scratch the surface of understanding belonging from the perspectives of Indigenous peoples in Canada given that the survey itself only provides rating scales for respondents to enumerate the value they attribute to their sense of belonging, with no qualitative understanding about what that rating means to the respondent. There may have been meaningful findings reported in some of the analytical reports developed from the data gathered—and there could be great potential for really analyzing these factors of belonging and the importance to Indigenous people in Canada. However, I unfortunately see a lot of this work

as it currently appears, as performative at best. I as a researcher, looking into the importance of belonging, cannot make meaning out of reports that may exist but are not accessible. It is also arguable that lack of access to this information demonstrates a lack of care that the Government of Canada has in demonstrating their reconciliatory efforts. It does not matter what data they collect and what kind of analysis has come out of it, if what they have to show for it is nothing but broken links and dead ends.

Searching for ways to look specifically at belonging on a deeper level with meaningful understanding, I came upon Allen et al.'s (2021) framework for understanding, assessing, and fostering belonging (Figure 2),

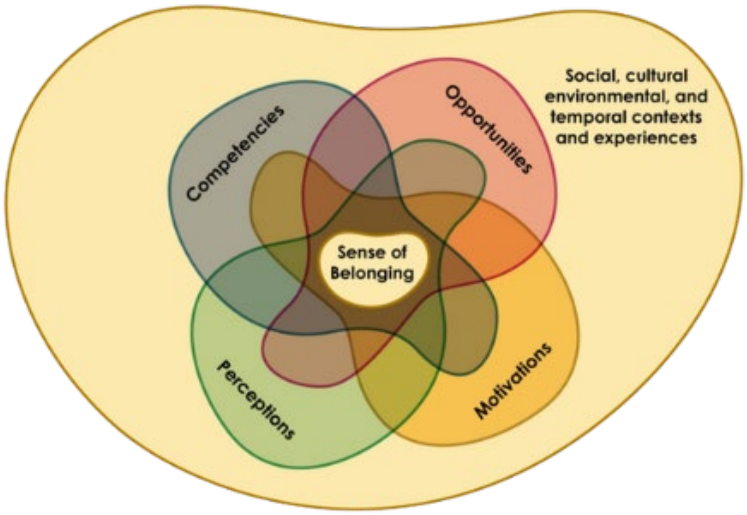

Figure 2 Integrated Framework for Understanding, Assessing, and Fostering Belonging

which demonstrates a measure of belonging by considering four interconnected, dynamic components that ebb and flow within our social, cultural, environmental, and temporal contexts and experiences (p. 6). Although it is not an Indigenous-specific framework, it attempts to look at experiences of belonging more holistically and intersectionally

understanding that there are distinct nuances to individuals that create a picture of belonging unique to each person.

The first component, **competencies**, are described as an individual's skills and abilities that enable them to "relate to others, identify with their cultural background, develop a sense of identity, and connect to place and country" (p. 6). For a "normal" or "typical" person, they are likely equipped with social skills and competencies that align well with most spaces of belonging and the social acceptance they receive will likely lead to extended opportunities to belong in other spaces. Experiencing ease in which a person feels belonging, their motivations to connect with others would likely come with a positive perception of belonging in most circumstances. Somebody who has experienced negative circumstances that have limited their sense of belonging, however, may become demotivated from connecting with others, limiting opportunities of belonging in current and future spaces.

Opportunities to belong are the availability of groups, people, places, times or spaces that enable belonging to occur (p. 6), something that we may not think about often enough and perhaps go so far as to take for granted. As Allen et al. (2021) state "the need for opportunities became poignantly evident during the COVID-19 pandemic, as social distancing was enforced in countries around the world and many human interactions became virtual in nature" (p. 7). The year 2020 saw the world come to a stop when the threat of illness spread across the globe in the form of a virus previously unknown to people. In 2022, the World Health Organization (WHO) estimated that during the first year of the COVID-19 pandemic the global prevalence of anxiety and depression increased by approximately 25% (para. 5). I lived in Vancouver at the time when the COVID-19 pandemic first emerged, striking fear among many. I was just

returning to work after my maternity leave, where my son had just had a very uneventful first year of life, until the point where I had to cancel his first birthday party in April 2020. Going back to work was supposed to mean my return to an office environment as I moved my family to Vancouver Island for a job opportunity. I became one of the many, whose homes became makeshift office spaces and got used to a new normal spent using web-based productivity applications like Zoom or Teams. Unsurprisingly, this sudden unprecedented change made it challenging to separate one's work life from their home life, leading to impacts on mental wellbeing for many.

Another important consideration about the opportunity to belong is that some opportunities emerge from the experience of unbelonging. People who have experienced disenfranchisement, discrimination, and other forms of trauma may seek out alternative spaces of belonging or go so far as to create their own space of belonging to bring similar disenfranchised people together. Sometimes these groups are supportive, healthy spaces of belonging like support groups and community organizations that have a specific cause. However, some people gravitate to spaces of belonging in unsafe or risky circumstances because their vulnerability creates opportunity to be drawn into such situations. For example, many Indigenous youths who have experienced the foster care system are at higher risk of involvement in gang related violence, drug trafficking, and more (Dunbar, 2017, p.11). A 2017 report released by the Government of Canada states that:

> The path from child welfare to gang involvement is intensified through the displacement of Aboriginal children that can lead to vulnerability, abuse and harm, trust and attachment problems as well as an array of mental health issues. Gang members themselves state that

> their peers who have been raised in care make good targets for recruitment because gangs promise to act as family substitutes. (Dunbar, 2017, p. 11)

A prominent example of the importance of belonging and the impact on Indigenous children and youth who have been affected by the foster care system in Canada, is the story of Skye Crassweller. Skye is actually one of the driving forces behind this research as I got to know her on a deeply personal level, although sadly I never met her in person.

Skye was a beautiful young Dene person from Teelit Gwich'in Band and was born and raised on Vancouver Island. Tragically, Skye passed away in 2017, and I would actually not meet her until 2020 while working as an investigator for the Representative for Children and Youth where I was part of the team that tried to very carefully weave together her story meaningfully, resulting in the release of *Skye's Legacy: A Focus on Belonging* in 2021. Skye's story is what opened my eyes to the importance of belonging, as we examined the ways in which the child welfare system failed her:

> The cumulative result [of the investigation] was that Skye wasn't able to realize the sense of belonging that all humans need and seek. The focus on legal belonging (adoption) came at the expense of all the other elements of belonging for Skye, including connection to family, culture, community, and physical place, and resulted in her searching for identity and meaningful connections throughout her short life, which ended with her tragic overdose death on her 17th birthday in August 2017. (Representative for Children and Youth, 2021, p. 4)

Bearing witness to Skye's lack of opportunity to find a lasting positive sense of belonging led me to reflect upon the many Indigenous children and youth I worked with as a child protection

social worker in the early years of my career. I also reflected on my own experiences and those of my family, realizing that all of our experiences of adversity and trauma could be linked back to (un)belonging in some way or another.

The third component, **motivation** is the need or desire to connect with others (p. 7). Human motivation to belong is something that is inherent and instinctually deep within us. We are born with the need and desire to connect with others and those needs start in our first place of belonging, the womb. Many people understand and accept that attachment and bond in infancy is important and disruptions to those attachments can be detrimental to development. Additionally, and as previously discussed, we know that children and youth who experience disruptions to their sense of belonging, such as experiencing foster care and separation from family, can contribute to a higher risk of poor outcomes in the future. What is not talked about enough is that when the disruption to a positive sense of belonging is so significant during infancy and early childhood that it causes permanent brain damage. Allen (2021) says that "the most compelling evidence of our need to belong from birth can be found in the consequences of the absence of belonging" (p. 21-22) referring to case studies of young children who experienced extreme child abuse, neglect, and abandonment resulting in severe developmental delays, emotional and behavioural issues, and mental health disorders.

While humans have an instinctual motivation to desire belonging, significant and severe neglect eventually diminishes motivation. Probably the most studied and taught case in psychology classes is the experience of a young girl known as Genie, born in 1957, who experienced extreme trauma from abuse and neglect from infancy up until the age of 13. Sparing the details of her abuse, what is more important to understand is that the

consequences of what she experienced left her severely cognitively and physically disabled. Allen (2021) says that “Genie developed several physiological problems and developmental delays such as the inability to chew, swallow, walk or focus her eyes” (p. 22), requiring intense fulltime caregiving and therapeutic interventions once she was safely out of the custody of her abusers. Genie may very well have been born without any cognitive impairments and might not have grown up to be neurodivergent. However, the extreme neglect and abuse she experienced left her with a brain that is vastly divergent from what is considered neurotypical and a body that was unable to develop critical gross and fine motor skills, unable to ever care for herself independently.

The last component, **perceptions**, are one’s subjective feelings about belonging related to their experiences (p.7). Perceptions of belonging is an important component to consider both in the context of neurodivergent as well as Indigenous individuals because there are so many experiences tied to feeling like being on the outside looking in at spaces of belonging. Perception is subjective to how one makes meaning for themselves, and depending on experience, it may influence how trying to belong becomes a performative effort. When motivation and opportunity to belong is present but there is something preventing acceptance into that space our instinctual need for belonging will try to discern what is missing; what do those who belong in the space have that those on the outside do not? To gain acceptance, a person may try to adapt themselves through observations of those who are within that space and attempt to replicate the competencies of those within the space to fit in. It becomes a performance of wearing a mask that may contradict who we are naturally, with the attempt to suppress what appears to be undesirable and replace it with what a person perceives as

acceptable within a space. While those efforts may work at first, unless that space of belonging adapts to accommodate that person and their own competencies, it is more than likely to be unsustainable in the long term. Moreover, the longer one attempts to demonstrate competencies that they may never actually have, the higher likelihood for detrimental effect on one's sense of belonging over time.

Jonathan Mooney, author of *Normal Sucks: How to Live, Learn, and Thrive Outside the Lines* (2019), is a motivational speaker and writer who talks openly about his experiences of unbelonging in childhood due to his multiple learning disabilities, including ADHD and dyslexia. Mooney is very intentional that he does not ascribe to wearing a mask to fit the environment. His motivational speeches, often delivered to young people in elementary and secondary school, are intended to teach them that being different is okay and disability is not a dirty word. In one of his anecdotes, Mooney (2017) speaks about his experience witnessing a school deal with a student with challenging behaviours by subjecting him to a literal wooden box in the corner of the classroom, which the teacher appeared very nonchalant about. expressed that he was further taken aback when it came time to deliver his speech to the class, a group of children in special education. The teacher introduced him, saying "Jonathan used to be like you. He had learning and behaviour problems but overcame his dyslexia through hard work" (p. 173). Mooney's perception of that moment was that his presence was not intended inspire kids to have pride in themselves, but rather that the school saw him as an example of a disabled person being celebrated for his "ability to approximate a 'specific expectation of normalcy'" (p. 173). This is unfortunately all too common in many approaches to behavioural intervention in neurodivergent children. Children are taught to replace undesirable behaviour with what is

more neurotypically acceptable; ultimately sending the message that belonging hinges on their ability to, as Mooney put it, approximate a specific expectation of normalcy.

1.3 Attention-Deficit Hyperactivity Disorder: Misconceptions and Overgeneralizations

To understand how being neurodivergent, specifically having Attention-Deficit Hyperactivity Disorder (ADHD), impacts and influences one's sense of belonging, it is important to understand what ADHD is not. While ADHD is commonly well known throughout the world, it is not necessarily well understood by the general population and there are many overgeneralizations as to what ADHD really is. As such, negative stereotypes can begin to define a neurodivergent person very early in life and directly impact one's sense of belonging as they know it. I want to be clear that in my research findings and discussion, there is an intentional deviation from focusing on the medical pathology of ADHD as this work does not look at how ADHD presents in Indigenous people. This intention does not serve to invalidate the use of the medical model in its entirety. The medical model carries importance in assessing disability and determining approaches to supporting a person from the perspective of a treating physician/medical professional. However, the significance placed upon the medical model in many western societies wields the perspective as paramount and is often recognized as the only valid perspective regarding the needs of disabled people. The following section provides a basic understanding on a clinical level of what ADHD is and how it is diagnosed using the criteria outlined by the Diagnostic and Statistical Manual (5th edition) (DSM-V). Understanding these criteria is important to broadly consider the social implications of the medical model of disability, including the barriers that result from its influence; the perpetuation of stigma against disabled people; and what is misunderstood about ADHD.

As described by the American Psychiatric Association (2024), ADHD is one of the most common mental disorders affecting children, with symptoms described in terms of behaviour such as inattention, hyperactivity, or impulsivity. It is often first identified in school-aged children when behaviour begins to cause problems in the classroom or with schoolwork (American Psychiatric Association, 2024, para. 1). However, there are different types and presentations of ADHD, including hyperactive-impulsive subtype, predominantly inattentive subtype, and combined inattentive and hyperactive subtype (Lukie, 2010, p. 2). With this in mind, it is often the hyperactive behaviours that are primarily identified, resulting in earlier diagnosis.

Diagnostic and Statistical Manual-V Diagnostic Criteria for Attention-Deficit Hyperactivity Disorder **Disorder Class: Neurodevelopmental Disorders**
A. A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterized by (1- Inattention) and/or (2- Hyperactivity)
1. Inattention: Six or more of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities (for older adolescents and adults at least five symptoms are required) **a. Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities.** **b. Often has difficulty sustaining attention in tasks or play activities.** **c. Often does not seem to listen when spoken to directly.** **d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace.**

e. **Often has difficulty organizing tasks and activities.** f. **Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort.** g. **Often loses things necessary for tasks or activities (e.g., books, tools, wallets, keys, etc.)** h. **Is often easily distracted by extraneous stimuli (for older adolescents and adults may include unrelated thoughts)** i. **Is often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments)**
2. **Hyperactivity and Impulsivity: Six or more of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities (for older adolescents and adults, at least five symptoms are required)** a. **Often fidgets with or taps hands or feet or squirms in seat.** b. **Often leaves seat in situations when remaining seated is expected** c. **Often runs about or climbs in situations where it is inappropriate (in adolescents or adults, may be limited to feeling restless)** d. **Often unable to play or take part in leisure activities quietly.** e. **Often "on the go" acting as if "driven by a motor" (e.g., is unable to be or uncomfortable being still for extended time)** f. **Often talks excessively.** g. **Often blurts out an answer before a question has been completed.** h. **Often has trouble waiting their turn.** i. **Often interrupts or intrudes on others.**
B. **Several inattentive or hyperactive-impulsive symptoms were present before age 12 years.**

C. Several inattentive or hyperactive-impulsive symptoms are present in two or more settings.
D. There is clear evidence that symptoms interfere with, or reduce the quality of social, school, or work functioning.
E. The symptoms do not occur exclusively during the course of another psychological disorder (e.g., schizophrenia) and are not better explained by another mental disorder.

Table 2 DSM-V Diagnostic Criteria for Attention-Deficit Hyperactivity Disorder (Center for Behavioural Health Statistics and Quality, 2016, p. 17-18)

While the American Psychiatric Association's (2024) definition indicates that it is a disorder that affects children, it is not strictly a childhood disorder that one grows out of. Diagnostic criteria as outlined in the fifth edition of the Diagnostic and Statistical Manual (DSM-V) (figure 4 above), outlines the presentation of certain "symptoms" of inattention and hyperactivity/impulsivity. For adult diagnosis, at least five of the symptoms must be identifiable and have persisted for more than six months and directly impacts social and/or academic/occupational activities negatively. Furthermore, diagnosis requires several of these inattentive or hyperactive/impulsive symptoms were present before the age of 12 and are not better explained by another mental disorder (Center for Behavioural Health Statistics and Quality, 2016, p. 17-18). With no other pathways for diagnosis and official recognition of ADHD, there are many issues with the current diagnostic criteria relying upon the DSM-V that create barriers for adults seeking assessment and diagnosis.

A pervasive barrier for adults seeking a valid diagnosis is that many physicians are inadequately educated on ADHD, especially in adults (Mueller et al., 2012). Mueller et al. (2012) found in their study on the stigmatization of ADHD that adults with ADHD were more likely than

children with ADHD to be associated with misperceptions, confusion, and an increased number of people (including professionals) lacking adequate knowledge about ADHD (p. 108). A contributor to this stigma that is particularly hard to overcome is that the primary approach to treating ADHD symptoms is through pharmacological stimulants. Stimulant medications, particularly those in the amphetamine-based family are heavily controlled substances due to the risk of potential side-effects such as, insomnia, weight loss, anxiety, irritability, and depression; as well as concerns of dependency and misuse (Davis-Berman & Pestello, 2010, p. 483). Davis-Berman and Pestello assert that "prescriptions for stimulants are increasingly being written, not only for adolescents, but also for both younger children and adults. These medications have been approved for use in children as young as toddlers" (p. 482). However, it should be acknowledged that any medication always comes with a risk for side effects, and many of the side-effects of stimulant medications listed by Davis-Berman and Pestello are also commonly experienced by unmedicated people with ADHD.

Furthermore, there is also a higher vulnerability for addiction and self-medicating coping mechanisms for people with undiagnosed/unmedicated ADHD, which it might be acknowledged that medically prescribed treatment and management can mitigate reliance on other self-medicating coping mechanisms. Katzman et al. (2017) assert that "individuals with ADHD are twice as likely to experience substance abuse or dependency" (p. 3). However, addictive or problematic behaviours could also manifest in other ways such as gambling, shopping and over-consumption, or disordered eating and nutritional habits.

The stigma that is associated with ADHD and the pharmacological treatments available also intersects with racial and cultural biases that indicate that non-white people with

undiagnosed/untreated ADHD are less likely to receive diagnosis and subsequent support for ADHD than their white peers. Adams et al. (2024) published a study looking at 4 million commercially insured youths in the United States with at least one year of coverage between 2014 and 2019. Through coding identifications utilized in the insurance records, the researchers isolated youths with documented ADHD diagnoses and analyzed rates in which psychosocial and pharmaceutical treatments were claimed compared to race-ethnicity distinctions among the cohort (p. 521). The findings of the study, highlight that of those youths identified as having documented ADHD diagnoses, over 60% were identified as white followed by 14.7% Hispanic, 9% Black, and 5.2% Asian. Furthermore, of those identified, those within the white cohort were slightly more likely to receive psychosocial or pharmaceutical treatment compared to the non-white cohorts (p. 523). The authors acknowledge that this cannot be reflective of the general population of the United States as this only looks at a small cohort of insured youths. A further limitation they acknowledge is the data available is only subject to the coding used to identify insurable services. With no access to diagnostic notes or other information pertaining to treatment plans, the researchers can only demonstrate quantitative discrepancies among the cohorts but cannot assert racial-ethnic biases amongst the medical practitioners per se (p.526).

Indigenous youths were not identified in the Adams et al. (2024) study but given pervasive racial stereotypes and evidence of Indigenous-specific racism in the health care sector (in the Canadian context), it would not be unfounded to hypothesize that Indigeneity could be a factor of bias in the underdiagnosis and treatment of ADHD. *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care* (2020), an investigative report led by Honourable Dr. Mary-Ellen Turpel-Lafond states that they received,

“numerous complaints about Indigenous children and families not receiving proper respect or access to health-related services such as assessment and therapeutic services in the K-12 education system, including psycho-educational testing, speech language therapy or occupational therapy” (p. 9).

Beyond bias alone, diagnosis of ADHD in adulthood does become more complex and challenging because of the broad subjectivity of the diagnostic criteria (Muller et al., 2012, p. 108), as well as comorbid conditions that share similarities with or mask symptoms of ADHD (Kandeger et al., 2025, p. 549). In a literature review examining the impact of late diagnosis of ADHD in women, Attoe and Climie (2023) found that women were more often diagnosed and treated for a comorbid condition before recognized as having ADHD. The authors found that some literature indicated that almost 14% of girls with ADHD were prescribed antidepressants before receiving treatment for ADHD symptoms, compared to only 5% in boys (p. 647). While it is important to ensure that other mental health disorders are ruled out (as per DSM-V criteria E), and it might be easier to prescribe treatments for depression and anxiety than it is to prescribe ADHD medication, screening for ADHD concurrently is not often considered for adults (particularly, but not exclusively women) seeking medical help for their emotional overwhelm and symptoms of burnout, treatment for the former must often fail first. This approach, however, is problematic given that effect of untreated ADHD can be a significant contributor to symptoms of anxiety and depression. According to Katzman et al. (2017):

> The National Comorbidity Survey reported that adults with ADHD are three times more likely to develop major depressive disorder, six times more likely to develop dysthymia[2], and more than four times more likely to have any mood disorder (p. 3).

Another problematic issue about the DSM-V diagnostic criteria, is section "B" requiring several of the symptoms to have presented prior to the age of 12. Assessments in adulthood will require a person to deeply reflect and try to remember experiences that may be associated with experiences of trauma. This can be a significant risk to a person's physical and mental wellbeing if they are not equipped with the mechanisms for coping with the emotional impact that recollection may have. Research demonstrates that children with ADHD have a higher likelihood of experiencing trauma compared to their neurotypical peers. A common symptom or condition that often occurs in people with experiences of trauma is dissociation. Described by Kandeger et al. (2025), dissociation is a disruption or discontinuity of one or more mental functions such as memory, identity, consciousness, emotional regulation, and perception of the environment or body (p. 549). In considering the importance of belonging, particularly the idea of belonging to self and being comfortable in one's body, dissociation could be considered the antithesis of this. It is a response to trauma that is almost protective in a way, disconnecting a person from themselves internally, inhibiting pain receptors, affecting the ability to form memories around the event and the brain's ability to respond to neurotransmitters (p. 549). Kandeger et al. (2025) offer some compelling discussion about the links between dissociative tendencies stemming from experiences of childhood trauma and the persistence of ADHD symptoms into adulthood (p. 557).

[22] Persistent depressive disorder.

The idea that dissociation could be connected to the persistence of ADHD symptoms into adulthood because it is disrupting critical neurological pathways makes sense because neurologically, ADHD is linked to the neurotransmitter, dopamine. Neurotransmitters are different chemical messengers that send signals throughout the brain to support different bodily functions. Dopamine, specifically, is a chemical in the brain connected to the feeling of satisfaction or reward and is part of the ability to self-regulate and complete executive functioning tasks including, inhibiting actions, shifting and transitioning from place or focus, planning and organizing, and use of working memory (Lukie, 2010, p. 3).

More simply put, dopamine is the chemical that is released to give the sense of self-satisfaction, pleasure, and a job well done. For a neurotypical person, dopamine is released regularly and enables executive functioning to occur without much forethought or intervention. For a person with ADHD, the dopamine chemical pathway is disrupted and dysregulated. The brain recognizes the need for dopamine but cannot find sustainable sources, resulting in a lack of motivation to engage tasks that produce little-to-no dopamine and seeking out stimuli that releases dopamine more quickly and in larger quantities. Acknowledging and understanding dissociation as an inhibitor of the dopamine pathway, it makes sense that a disconnection from the body and mind could result in seeking more instant gratification, including some methods that can be harmful through long-term reliance.

Mainstream media is a key culprit in the oversimplified stereotypes representing ADHD, whereby the posterchild of ADHD is an uncontrollable young boy who acts upon impulse and becomes a “troublemaker” or “class clown” type (Bart Simpson, being the most obvious example). This representation has upheld the misconception that ADHD is not only a childhood

disorder, but a *male* disorder. Today, we know for certain that females (and trans/non-binary individuals assigned female at birth) also experience ADHD, but research failed to include female children until the 1990s (Kopp, 2018, para. 1). Males are more likely to be identified and diagnosed with ADHD when they demonstrate observable hyperactive/impulsive traits, because it simply draws more attention (Hjorne & Evaldsson, 2015, p. 627). Furthermore, gendered norms also impact the identification of ADHD in young girls because they are more likely to receive negative messages related to their unrecognized ADHD behaviours as hyperactivity is more "socially acceptable" for boys (Craddock, 2024, p. 1451).

Missed and ignored as young girls, neurodivergent women (and 2-Spirited/non-binary people assigned female at birth) then become dismissed as adults often being diagnosed with anxiety, depression, and other mental health disorders (Craddock, 2024). Craddock (2024) states that, "women's late diagnoses of autism and ADHD are a pressing public health issue with implications for healthcare, research, public awareness, and the (gendered) lived experiences of both conditions" (p. 1443). The gendered norms and expectations women are raised to comply with reflect a wholly untenable situation for neurodivergent women where they are in a constant state of (unknowingly) masking their symptoms of ADHD (Craddock, 2024, p. 2151). Eventually they reach a point in their lives where the mask of neurotypicality can no longer be sustained. Rather than questioning the problems with wearing the mask, women are conditioned to internalize this burnout as "what is wrong with me?". Some have begun to refer to the generation of Millennial women who have been late diagnosed in their 20s, 30s, even 40s as "lost girls". Girls who were overlooked because they maybe did well in school and raised no behavioural concerns. Maybe they were described as chatty or as having

their heads in the clouds. Carla Ciccone, author of *Nowhere Girl: Life as a Member of ADHD's Lost Generation* (2025) was diagnosed with ADHD at 39 years old. She says that "there's a generational reckoning underway, with girls who are now women finding out there's nothing 'wrong with' us, our brains just operate a little differently, and we have the scars to prove it" (p. 17).

Again, the medical model of disability and the DSM-V are not inherently bad. They serve a valid medical purpose in supporting people to identify clinical needs and access relevant resources to aid in improving individual wellbeing and outcomes. The issue is the over-medicalization of disabilities and differences that perpetuate notions that these approaches to wellbeing are superior and focus on curing or treating individuals in ways that aim to align them with what is perceived as "normal" and "acceptable". According to Clare (2017):

> The list of body-mind differences, illnesses, and so-called defects that the medical-industrial complex wants to eradicate goes on and on. This kind of elimination benefits some of us in significant ways—saving our lives or increasing our comfort. At the same time, it also commits damage, routinely turning body-minds into medical objects and creating lies about *normal* and *natural* (p. 26).

Consider how Allen et al.'s (2021) framework for understanding, assessing, and fostering belonging may contextualize how a person's sense of belonging could be detrimentally impacted as an unsupported, undiagnosed child with ADHD. Behavioural challenges get labelled as problematic and that alone sets them apart from their peers. Their competencies are different, and they may be inclined or compelled to develop or perform competencies in spaces of belonging that are inherently difficult for them. If difficulties are allowed to persist and the

child continues to be unsupported, their opportunities for belonging may diminish and motivations to belong may change. As continuous experiences of circumstances of unbelonging occur, a child with undiagnosed ADHD may develop perceptions that lead to negative self-thought and as mentioned before, manifest in ways that could lead to (mis)diagnoses of mental illnesses and development of other concurrent disorders (Attoe & Climie, 2023, p. 647). While the medical model acknowledges these experiences have linkage to poorer mental health and other adverse outcomes, it does not consider the context of other intersections of being that impact and influence a person's sense of belonging in relation to the environment they are disabled by.

1.5 The Politics of Belonging and How Normal is Coded in White Supremacist and Ableist Ideology

Normal may seem like an unassuming term that implies neutrality or sameness, but in reality, through the politics of belonging it is term that creates a metric of who belongs and who does not (Christensen, 2009, p. 24-25). The issue that stands with designating metrics of normalcy is that it cannot exist in any tangible measurable range because there is no absolute sameness. Mooney (2019) states that,

> The normalizing society uses the statistical abstraction of normal as its organizing principle. Schools, factories, cities, towns, and even families are designed and built, not for the reality of differences, but on the dream that we could, and should, all somehow, someday be the same. (p. 58)

Mooney (2019) asserts that this idealization of "normal" is a statistical fiction, created by flawed, self-interested, racist, ablest, homophobic, and sexist humans (p. 40). The fallacy of

normal has created a small box, sold to us as something we all should strive to fit into and that is the ultimate place of belonging. However, the box does not adjust to help us fit, and if we do not fit within the box, then where do we belong?

"Normal", as it is defined in many contemporary societies historically colonized by European settlers, has been arbitrarily defined through Eurocentric ideology that implies difference or divergence is an opposition to normalcy (Norris, 2014, p. 63). This reflects a kind of standardization that is ultimately rooted in white supremacy and ableism. A "normal" person has a space to belong in mainstream society because they fit a social construct where their physical appearance, abilities, and social behaviour align with societal expectations within their community (Mooney, 2019). This creates the dichotomy that abnormal is then pathologically wrong, creating a false rationale to stigmatize, shun, or sanction those that do not align with "normal" (Milton, 2012, p. 885). Fitting within the social construct of normal is also heavily influenced and enabled by socioeconomic privilege. Where normalcy is a baseline standard, deviation from any number of normal/typical attributes can separate an individual from their peers or community and give someone the sense that they do not belong if these differences are not welcomed or included within these larger spaces.

Another way to perceive the opposition to normal is the designation that disability or deviation from normal is a defect, implicating faultiness. Clare (2017) states that defectiveness is used as a designation to imply that there are bodies that are undesirable, worthless, disposable, or in need of cure and says that "the ableist invention of defectiveness functions as an indisputable justification not only for cure but also for many systems of oppression" (p. 23). In fact, medical diagnoses and pathologizing a human's "defectiveness" has been used as a

weapon to justify violence, and oppression is repeatedly evident throughout history. For example, physician Dr. Samuel Cartwright published in 1851, his medical opinion that Black, enslaved people had defects within their blood combined with a deficiency of cerebral matter in the cranium. Thus, these defects implied that Black, enslaved people were biologically incapable of caring for themselves to justify racial inferiority and continued slave-ownership (Clare, 2017, p. 4), which would not be abolished in the United States until 1865.

Arguably, all crimes against humanity stem from some kind of ideological basis that attempts to justify that certain people do not deserve to belong in the world. The example of Dr. Cartwright's example of scientific racism is only just one of countless ways belonging becomes weaponized, creating designations of abnormality based on superiority complexes (prevalently) of whiteness being the prime ideal. Race-based theories of disease have been used similarly to justify "Indian policies" based on medical portrayals of Indigenous people as "essentially pathetic, pathological, and powerless" (Kelm, 1998, p. xvii). Bissel et al. (2020) posit that belonging is one of the most powerful ways to understand the social, political and ethical stakes of our sociological futures (p. 2), where the dominant social culture ultimately has the authority to define the standards of who does and does not belong based on their perceptions of normal. Applying definitions of belonging to align with a collective national identity, legal and political status, and notions of citizenship is, in some ways, done in the spirit of unity and towards advancing a collective sense of belonging (Tsalapatanis, 2019, p. 14). In the politics of belonging, these identifications are intended to foster empowerment, pride, and connection; but the other side of the coin is that "otherness" is created and often weaponized against individuals in the pursuit of dominance, power, and control. Rowe (2005) posits this as "the

politics of relation" where we may (or should) belong in a certain space but could be denied by others or contested through misidentifications creating a division between where we see ourselves belonging in contrast to where others do. When such division occurs, the oppressor has an opportunity to seize limiting spaces of belonging as a weaponized tool of oppression against certain targeted identities.

Manipulating spaces of belonging may not be overtly obvious. Often, division of others begins through invoking shame against the "inferior" group. Bacon (2020) writes, "from an evolutionary perspective, our survival once depended on close cooperation with members of our group. Violating certain codes of behavior made everyone less safe" (p.133). Shame is an emotion directly linked to our instinctual desire to covet belonging. It is meant to be functionally protective, motivating people to preserve community values and needs as well as personal safety. However, it is also very manipulable and can be used as a form of social control, not only to encourage conformity, but to also punish non-conformity (p. 134). Under the guise of upholding community values, a power-seeker may impose restrictions defining parameters of belonging to reduce safe spaces of belonging for those who do not align with the oppressor. For example, people who live in poverty experience a great deal of shame imposed upon them through divisive propaganda that feeds public opinion to ascribe to the notion that:

> People experience poverty because of their own failures; that people are poor because they are lazy, irresponsible, averse to work, criminally inclined, or simply stupid. This explanation locates the causes of poverty in the individual and ignores the surrounding social structures. (Bacon, 2020, p. 144)

Propaganda and indoctrination are common tools for promoting an oppressor's ideal metrics, shifting the perceptions of belonging to fit their agenda and communicating to targeted so-called "inferior" identities to either change their motivations to belong and align with their competencies or leave. In the context of poverty, many people are told to get a better job, get a better education, jump through hoop after hoop and then you will belong among us. However, the person with the hoop is often holding it well above the heads of those trying to get through it; and the hoop gets further away as you add intersections of marginalized identities such as, disability, race, gender identity, and more.

A much starker and more blatant example of weaponizing belonging were the campaigns promoted to the public leading up to and during World War II against disabled people. As the Nazi party rose to power, government initiatives promoted the elimination of disabled people as well as eugenicist practices to reduce births of children to disabled people. In 1933 *the Law for the Prevention of Offspring with Hereditary Diseases* was passed, legalizing the forced sterilization of any individual identified as "hereditarily ill", in which they were required to be registered with the government and identified as such (Wald, 2022, para. 2). As Hitler's power and domination grew, this movement evolved into the promotion of euthanasia and the elimination of the "hereditarily ill", with several propaganda films screened to millions of German citizens to demonstrate their view that disabled people were a public health threat. However, the designation of "hereditarily ill" expanded to include "asocial behaviour including prostitution, vagrancy, community inclinations, and poor temperament as diagnostic symptoms of incurable disability" (Wald, 2022, para. 7).

At the time this was occurring in Nazi Germany, similar practices were in use against disabled people and Indigenous people in Canada in which many people were legally subjected to forced sterilization. Alberta's *Eugenics Act* was passed in 1928 and later followed by British Columbia's *Sexual Sterilization Act* in 1933. In British Columbia, a Superintendent of an institution (including prisons, mental hospitals, and Industrial Schools) had the authority to recommend the sexual sterilization by surgical means of "inmates" whom they believe, "would likely to beget or bear children who by reason of inheritance would have a tendency to serious mental disease or mental deficiency" (Province of British Columbia, 1933, s.4(1)). This law would appear to apply to Indigenous children in residential schools, as they would fall under the umbrella of "Industrial Schools", as well as Indigenous people who were being treated in Indian Hospitals. Geddes (2017) states that the eugenicist practices employed in the United States and Canada were even admired and adopted by Nazi Germany during the Holocaust (p. 113). Furthermore, he states that "it has been estimated that, although First Nations, Métis and Inuit people represented only 2.3 percent of the population in Canada in the 1930s, 25 per cent of those sterilized in Alberta were Indigenous people" (p. 113); although he assumes this statistic is likely higher as many hospital records of the time period were lost, altered or destroyed. While British Columbia's *Sexual Sterilization Act* was repealed in 1973, and while many likely could not fathom that forced sterilization could still be happening today, the reality is that there are Indigenous people across Canada still reporting that they were unlawfully sterilized without their explicit informed consent. In fact, language contained within the *Indian Act* still contains language that disabled Métis scholar, Dr. Rheanna Robinson (2024) points to as "settler ableist logic". Section 50 (1) of the Act denotes authority and control in relation to

the property of “mentally incompetent Indians”. Robinson connects this language to how forced sterilization could still arguably be found justifiable under settler ableist logic and practice (p. 12).

According to a 2022 interview and news article featured on CBC’s *The Current*, author and activist Morningstar Mercredi shared her story of being surgically sterilized without her consent at the age of 14 while undergoing a caesarean section in her seventh month of pregnancy. Mercredi only found out decades later when she was considering having more children (Canadian Broadcasting Corporation, 2022, para. 5). Mercredi said, “I’ve spent a lifetime processing this. There is no closure. This is not something I will ever recover from…” (Canadian Broadcasting Corporation, 2022, para. 26). She said further that it was not until she was in her fifties that she started experiencing symptoms of post-traumatic stress when more people began to speak out about their own experiences with forced sterilization. Responding to the many stories that have come out publicly like Mercredi’s, in 2022, Honourable Senator Yvonne Boyer introduced Bill S-250, *An Act to Amend the Criminal Code* with amendments to section 268 respecting acts of aggravated assault that would legally recognize that “the sterilization of persons without their consent is a legacy of systemic discrimination, colonization and racism, that disproportionately, but not exclusively, affects Indigenous and racialized persons” (Senate of Canada, 2024, para. 1) While this bill has passed its Third Reading, it has not yet reached the House of Commons at the time of writing this in 2025.

While Canada has made efforts to prioritize reconciliatory actions in the spirit of honouring Indigenous sovereignty, self-determination, and land rights, there is still a long way to go. It must not be forgotten that the acts of genocide against Indigenous people in North

America are not past tense. What started with the Doctrine of Discovery[3] in the 15th Century is still echoed in Canadian systems to this day, according to the Canadian Museum of Human Rights (2024), which says, "the racist assumption of superiority and dominance embodied in the Doctrine of Discovery underpins many aspects of Canada's colonial history, including the *Indian Act*, the reserve system, the Indian Residential school tragedy, and the Sixties Scoop" (para. 6). While many may deny that this ideology still rings true today and claim that the past is the past, we need only to point out one thing: *The Indian Act* (1876) is the only legislation in a modern developed country that governs a specific people based on their race and defines who may belong to this group and who may not; who may receive treaty benefits; and what rights the Canadian Government has over those who "belong" under this legislation.

1.6 Conclusion

This chapter serves as a mere snapshot into the foundation of why this research is important, and why centring belonging matters. Once you see it and understand it, you cannot unsee it. However, change does not happen because we will it to happen. Change happens when people bear witness to the context of why change needs to happen. So, to iterate the importance of belonging, I chose to present the preceding literature to contextualize my own experiences and experiences of people who share the intersectional identities of being Indigenous and neurodivergent and to provide a foundation for understanding the ways in which neurodivergence and Indigeneity have been influential elements in perceptions of belonging. By grounding the research in this way, I hope that readers will resonate more

[3] The Doctrine of Discovery is a declaration, justifying settlers' claim Indigenous "non-Christian" lands under the belief that European peoples, culture, and religion were superior to all others (Canadian Museum for Human Rights, 2024, para. 2).

strongly and bear witness to the meaning behind these stories. Witnessing is not just listening or hearing. Witnessing is taking in what you have learned, making sure that knowledge is not lost by actively carrying it not only with good intentions but also good actions.

Chapter 2: Resisting Who I am Not, a Literature Review

2.1 Introduction

Early stages of this literature review initially focused on locating literature that examined findings of connections between unbelonging and trauma in neurodivergent and Indigenous people. However, with personal introspection I knew that for myself as a neurodivergent Indigenous person I acknowledge that I have experienced trauma and I have experienced unbelonging as a result of trauma; but I know that is not my entire being. As Absolon (2022) said:

> Indigenous re-search is often guided by the knowledge found within. Aboriginal epistemology (the ways of knowing our reality) honours our inner being as the place where Spirit lives, our dreams reside and our heart beats. Indigenous peoples have processes in place to tap into this inner space to make the unknown—known. (p.12)

I began to very intentionally analyze whatever literature I could find in search of any strengths-based approaches and storied narratives from lived experiences. As anticipated, there was such a striking absence of any visible intentions of bringing strengths to light in both Indigenous and neurodivergent research topics. Where visibility and representation are lacking, deficit and trauma can appear to be the only narrative to tell. So, my focus in research shifted, not to ignore or disregard trauma as a valid piece of the narrative but rather, balancing it to better represent what it was: a mere piece of a much bigger picture. Absolon (2022) said, that her, methodological research process involves making the invisible—visible (p. 12); to find out what is invisible is to find the gaps in the narrative that need to be filled.

For the purposes of locating peer reviewed research for this literature review, I utilized academic databases through the University of Victoria Library to pull resources from multiple publishers and utilized key terms in multiple combinations and phrases to yield the best results possible. Key terms and phrases included, *Indigenous people with ADHD; neurodivergent and Indigenous; identity and belonging; neurodivergent Indigenous identities; ADHD and belonging;* and *strengths-based approaches in ADHD research,* in numerous combinations of search terms to attempt to capture of the broadest range of literature possible across academic databases. My search terms aimed to identify research on the intersections between neurodivergent identities and Indigeneity as well as neurodivergent identities and belonging. Problematically, the result of this preliminary research demonstrated that these terms hardly intersect each other.

Even the process of obtaining literature on ADHD and how it pertains to Indigenous people in the Canadian context showed how little focus there has been on the topic of Indigenous experiences with ADHD alone. Any research available that intersectionally focuses on ADHD and Indigenous children comes mostly from an Australian context. Di Pietro and Illes (2014) published an article entitled, *Disparities in Canadian Indigenous Health Research on Neurodevelopmental Disorders,* however, ADHD was not included in this research, and I found no research focused on Indigenous adults with ADHD.

The following literature review begins with a brief examination of Indigenous worldviews on disability; as this is Indigenous-based research, centring the importance of understanding disability from a North American Indigenous context is critical to helping to root the work in Indigenous worldviews. I then move to discussing the (limited) existing research on

ADHD and Indigenous children in Canada. I also examine the predominance of deficit-based research with the intention of demonstrating the limitations and issues that could lead to harming neurodivergent communities by ignoring relevant intersecting points of other overlapping identities such as race, class, culture, sex, gender, and more. This serves to lead into discussing how strengths-based qualitative research is necessary and beneficial for a greater understanding of neurodivergence and the intersectional experiences of neurodivergent Indigenous people with ADHD. I conclude with a brief reflection on how the literature has informed my research and helped to clarify its contribution to the growing conversations and discourse on the fundamental importance of belonging.

2.2 Indigenous Worldviews on Disability

This research project is not focused on the prevalence of ADHD in Indigenous people or being neurodivergent in other ways. However, in a way, there is some validity in assuming a prevalence of neurodivergence in Indigenous people in the context of the way diagnostic criteria in the DSM-V is defined in alignment with Eurocentric, white supremacist and ableist ideology. In fact, some Indigenous scholars theorize that neurologically, colonialism has deeply affected us intergenerationally in ways that we need to deliberately and mindfully engage in practices of neurodecolonization as an act of resistance and healing as Indigenous peoples (Yellow Bird, 2012). Yellow Bird (2012) describes neurodecolonization as understanding how brain functioning is shaped by the stresses of colonialism that can be resisted and disrupted through mindfulness practices and actions that aim to weaken the effects colonialism and create opportunities to promote relevant traditional Indigenous practices in present day settings (p. 64-65). The practice of mindfulness Yellow Bird proposes is not for everybody, and

mindfulness alone may not help mitigate fully the disabling impact of ADHD has on an individual. However, it could help process the way colonial environments, systems, and structures perpetuate and maintain disabling barriers and help a person increase their capacity for dealing with those disabling barriers.

Waziyatawin (2012) speaks to two crucial components of decolonization, the first being recovering traditional knowledge and ways of being, understanding and processing the ways colonization has affected us. The second component is challenging colonizer systems and institutions that serve to maintain the colonial relationship (p. 35). For the purpose of this work, I look to the ways we can and should reclaim Indigenous worldviews on disability from a community perspective to deconstruct and resist the colonial ideologies and models of disability that Robinson (2024) asserts have a significant omission of Indigenous voices, experiences, and values, and that an Indigenous disability paradigm respects the unique gifts those may have through lived experiences (p. 8).

Many Indigenous worldviews hold importance in acknowledging the connectedness of all things and that we have a collective responsibility to navigate our lives with respect to all things we are in relationship with, inclusive of those with differing needs of any kind. This acknowledgement of connectedness is an acknowledgement of understanding that all things connected have a place of belonging. This is expressed in conceptions of wâhkôtowin, the nêhiyaw (Plains Cree) word for kinship and is understood as centring relationality and reciprocity in respect to those we are connected to (Bruno et al., 2025, p. 2638). This conception of kinship is similarly reflected by the Nisga'a peoples as integral to their culture and ways of being as well (Robinson, 2024, p. 20).

Disability, Robinson (2024) writes, is not easily translated into the Nisga'a language because it has many different bodily representations that do not reduce the person to such a narrow singular word. Conceptually, speaking about disability the words used in the Nisga'a language instead reflect the way they as a community are expected to respond to those in need of support:

> …The word haxhaaxgwit prompts us [in our language and culture] to refer to the social and safety network that exists within our culture[and refers to peoples that the community support because they may be experiencing distress]. We have a real difficult time trying to translate our language into the English language. Sometimes we can't find the words to adequately describe the translation and adequately show the meaning within our language. Very important traditional terms that further formulate the reaction to disabilities, and they are kwhlix̲oosa'anskw, meaning "respect" and k̲'e'em-goot, which means "compassion". (Robinson, 2024, p. 19-20)

In effect, identifying disability is not put on the individual, rather it is identified to the community that one of their kin needs support and they must respond with respect and compassion.

Lovern (2008; 2017) posits that Indigenous perspectives do not focus necessarily on the difference of the individual, but rather where that person lands in the balance of the community. Disability is seen as only one element of that person's existence, and they are recognized as valued members of their community. Eurocentric colonizer ideology has impacted these worldviews, and some say they have seen a shift towards a lesser respect for disabled people in First Nations communities (Wright et al., 2005, p. 41). If we were to take a

step back from placing so much importance on trying to fit an individualistic impossible standard of normal (Mooney, 2019), disability would be less of an all-encompassing identity. Lovern (2008; 2017) asserts that there is room in the conversation to include the elements that make up the person's whole being, their strengths, and what they bring into the community. Ineese-Nash (2020) frames disability as an intentionally colonial construct, noting that concepts of disability do not often directly translate into many traditional Indigenous languages, saying "when describing a child, there is not often a discussion about what the child is lacking, or what they cannot do" (p. 30). Lovern and Locust (2013) describe tribal beliefs that spirits choose which body it will inhabit and that the spirit has chosen a disabled body by choice, saying:

> Many tribes do not see the spirit as "entrapped in a disabled body" or "having the misfortune to be disabled". On the contrary, tribal members tend to view the situation as that of a spirit, which was wise enough and strong enough to inhabit a disabled body. The physical body might have been disabled but the spirit was not (Lovern and Locust, 2013, p. 98).

This belief in spirit is important in understanding how disability can be viewed as a gift or a blessing and again demonstrates the understanding that all beings have a place of belonging regardless of the body they exist within. In December 2005, *A Window into Seeing the World Differently, National Symposium on Aboriginal Special Education* was held, in which four Indigenous elders shared their views on disability and exceptionality at the. They expressed that children come into the world with special gifts and that it is the responsibility of the child's parents, teachers, and other significant people in their lives to not focus on the child's weaknesses but rather help them find their strength and discover how they can use their

strength to help their community (Phillips, 2010, p. 68). Other Indigenous-led research shares similar sentiments. A participant from a 2005 research report on supporting disabled Indigenous children and youth in foster care said, "as I've understood it, any child that was born into a First Nations family, you just always accept them no matter what, how they come at you. That's just their way and they'll develop into their own person" (Wright et al., 2005, p. 40).

These are just a few Indigenous perspectives of disability in the context of Indigenous peoples within Canada that provide an understanding of how important identity and belonging are. These Indigenous perspectives also clarify that in community we have a collective responsibility to validate and hold space for a person to belong in community by embracing their strengths and abilities, and likewise, to recognize that barriers are created and placed upon them by society via ableist privilege and expectations.

2.2 ADHD Research and Indigenous Children in Canada

Baydala et al. (2006) is the only Canadian research study found on Indigenous children and ADHD. This study evaluated 86 Indigenous children from two communities in Northern Alberta. The researchers utilized parent and teacher questionnaires to identify the learning styles of the children who were between grades 1 and 5 and assessed how many of the children might align with DSM diagnostic criteria for ADHD. Among the children evaluated, approximately 22% scored within a range that could indicate a possible ADHD diagnosis, which was higher than the researchers had anticipated.

The authors do not conclude this to indicate a higher prevalence of ADHD in Indigenous children, but rather they caution the use of screening questionnaires alone in evaluating Indigenous children because they do not accurately take into consideration Indigenous cultural

practices, customs, or behaviours that could falsely influence the assessment (Baydala et al., 2006, p. 646). Although the researchers acknowledge the shortcomings of the screening questionnaires, they do not go further to suggest other approaches that may be more appropriate. This study did not indicate if any of the researchers were Indigenous.

In contrast to Baydala et al. (2006), Meyer (2005) presents findings from a research study in South Africa looking at the prevalence of ADHD in children from several Indigenous groups in the region. Similar to Baydala et al. (2006), the information was obtained through a screening questionnaire, however, it was adapted to be administered in each Indigenous language. The overall study consisted of 6032 children between the ages of 6 and 15. Ofthese, 528 children met possible screening criteria for ADHD and were invited to participate in further assessments (p. 104). Results of the study indicated similarities between the children with ADHD in South Africa compared to children with ADHD in Western countries but press the importance of considering factors of diverse culture and child rearing practices that would affect and influence a child's cognitive development (p. 105). Meyer (2005) posits that systematic research is greatly needed to identify and develop neuropsychological instruments that also align with a child's specific cultural background for assessing ADHD symptomology (p. 106).

The main issue I contend with in research studies speaking to issues of Indigenous wellness, disability, or disease is that much of this research, despite being focused on Indigenous people and experiences, is still presented from a non-Indigenous perspective. It is irrelevant how much the authors acknowledge the need for cultural considerations in approaching ADHD diagnosis and supportive interventions when they fail to include Indigenous

researchers at the helm themselves. Christensen (2019) asserts that research on Indigenous peoples from the perspective of a settler or non-Indigenous person imposes standards of settler normativity and that people at the intersections of both Indigenous and disabled identities are reduced to a "double disadvantage" (p. 32). By making Indigenous knowledge and approaches secondary, the disability discourse will continue to run up against a predominantly deficit-based dichotomy of disability/ability and bad/good (Lovern, 2017, p. 311).

2.4 Predominance of Deficit-Based Research

Research and literature on ADHD and other neurotypes or disabilities that focus on the social experiences of people rather than solely the medicalized aspect of these conditions is important to humanize disabled people beyond their symptoms and limitations. However, the issue with much of this research is there is still a largely predominant focus on negative experiences and deficits associated with being disabled. This often leads to the perpetuation of harmful ableist stereotypes and narratives that position disability as a tragedy and that a disabled person should be pitied for their circumstance (Loseke & Green, 2020).

For example, Schilpzand et al. (2018) published a study on ADHD from Australia on the connection between traumatic experiences and the emergence of observable behaviours associated with ADHD. Their hypothesis proposed that children with ADHD would have higher rates of exposure to trauma, and that those who had experienced trauma would experience greater impairment than children with ADHD who had not experienced trauma (p. 811). The study involved 179 children meeting the criteria for ADHD, and a control group of 212 children who did not have ADHD between the ages of 6 and 8 years old. Schilpzand et al. (2018) confirmed their hypothesis that the group with ADHD were more likely to have experienced

trauma versus the control group. The authors report that "[t]he relationship between ADHD and trauma may potentially be explained by family sociodemographic or environmental factors", factors the authors describe as, stressful home environments, poverty, instability, and poor parental relationships (Schilpzand et al., 2018, p. 816). It is important to note that this study does not examine issues of race, culture, or Indigeneity and I only highlight this to demonstrate that literature such as this, that maintains deficit-based perspectives and narratives is abundantly accessible and provides nothing more than a shallow narrative of a hypothesis that is arguably "low hanging fruit". It is even clear in their research methodology which was survey-based that the researchers did little to contextualize the experiences of these neurodivergent children in relation to their reported experiences of trauma, nor does it look at their strengths or resiliency, or acknowledge the influence of other intersecting identities relevant to their experiences.

Similarly, in Canada, the 2011 Ontario Looking After Children Survey (ONLAC) found higher rates of ADHD diagnoses amongst children in the child welfare system compared to non-involved children (Klein et al., 2014). While both articles use these findings to argue the need for trauma-informed care and support for children when considering why and how ADHD may show up, focus is maintained on how negative experiences turn into negative outcomes, in this case, undesirable behaviour associated with ADHD.

In a Danish study examining the impact of ADHD diagnoses on young people's sense of identity and belonging, Jones and Hesse (2014) looked at nine youth between the ages of 15 and 21 years old (seven girls and two boys). Through semi-structured interviews, the young people were asked about their family relationships, friendships, school experiences,

stigmatization, and their perception of their ADHD diagnosis and their experiences related to ADHD (p. 94). A resounding theme that emerged was the negotiation of normality and abnormality between self and others, feeling different from their peers, and failing to "fit in". There was a difference, the researchers found, in whether the participant was diagnosed in early-childhood or adolescence. Those who were not diagnosed until later in their youth spoke of a period of self-reflection and assessment of their self-image (Jones & Hesse, 2014, p. 96). Some shared that even though some relief came to them through diagnosis, they were resigned to the fact that they were still different from their peers and to them that was negative. While this information is very important to the discourse to demonstrate the complexity of identity and belonging and how one may be impacted as a neurodivergent person, the researchers do not explore any of strengths or positive attributes participants may perceive about themselves.

2.5 Strengths-Based Research

There are researchers challenging the deficit-based narrative. Bryant et al. (2021) assert that deficit-based approaches in research with Indigenous peoples focuses predominantly on "risk behaviours". They posit that these stories lead to the over-pathologizing of Indigenous peoples and perpetuating the view that Indigenous people are prone to health issues (p. 1406). Evaluating *strengths-based* approaches from a number of theoretical perspectives, Bryant et al. (2021) highlight sociocultural approaches rooted in Indigenous knowledge. The sociocultural perspective focuses on the collective strengths and identities that are present in Indigenous communities, similar to what was described by Lovern (2008; 2017).

The stigma associated with disability labels incites fear of negative consequences or blame put on the parent (Wright et al., 2005, p. 41). As Christensen (2019) notes, this fear is

entirely valid, and it bears reiterating that the intersectional identities of disability and Indigeneity often become a double disadvantage (p. 32). Challenging this stigma and shifting this perceived fear to one of possible hope and optimism involves validating and bearing witness to the experiences of the neurodivergent Indigenous person as a whole. By lifting voices up that challenge stigma and make the invisible—visible (Absolon, 2022, p. 12), representation alone can begin to tip the scales toward balance. It is time to demonstrate that there are stories of being disabled and being Indigenous to learn from that do not need to sensationalize the experience of overcoming odds and barriers of systemic oppression.

When a safe space of belonging is created for these identities to exist and be witnessed, it opens the opportunity for people with shared or similarly marginalized identities to relate to and validate each other and form a collective bond. Validation from others who can relate and understand personal experience can take pain bore by the individual and turn it into collective responses to oppression (Reynolds, 2002, p. 89). Davis-Delano et al. (2021) state, "identity is important to groups that face oppression, and interaction is improved when interactants validate others' key identities" (p. 4). Reynolds (2002) explains how they carefully and mindfully created these spaces in the context of facilitating "cultural witnessing" circles as a therapeutic method where the conscious purpose of conversations, attention to safety, and reflexive practices of witnessing would allow participants of a shared cultural group to experience the celebration of their cultural practices, rites of passage, rituals, and connections (p. 89).

2.6 Conclusion

This literature review aims to demonstrate how nobody will ever fit in the box called "normal" in its current definition, as it is deliberately exclusionary. Normal continues to be

pervasively understood in mainstream academia as a baseline measure that indicates there are no pathological problems that affect a person. Therefore, deviance from the baseline measure is abnormal, undesirable, and should be remedied with interventions that aim to align a person as closely to the acceptable baseline of normal as possible. Such a binary understanding of normal/abnormal is arguably more harmful than helpful. To challenge the definition of normal, we must be able to define normal for ourselves whatever our identities may be and be able to create spaces of belonging that are inclusive of people not because of their sameness, but because of their different strengths and gifts they have to contribute. Again, this is not a novel concept. This is long held in many Indigenous worldviews on how communities have space for their members to contribute in their own ways using their own unique gifts (Anderson, 2016; Eastwood, 2021; , Ineese-Nash 2020; Robinson, 2024; Simpson, 2017). The concepts of normal and disability are tools for constructing systems of oppression (Clare, 2017; Mooney, 2017; Withers, 2012), but tools have the capability of functioning equally in deconstruction and we can use our strengths and gifts to wield the same tools to break the box that built it.

Chapter 3: Reclaiming the Narrative, the Research and Methodology

The purpose of centring the intersecting identities of neurodivergence and Indigeneity is that it comes from my own lens of experience in which I hoped to gather stories from other people who may have experiences that share similarities with my own. However, it was also important to look at the ways their experiences are also very distinctly unique to each participant. For example, my experience as a late-diagnosed, cisgendered female may bear similarities to other late-diagnosed, cisgendered females I may speak to. However, their experiences and perceptions of belonging may be quite different from mine in circumstances where they grew up connected to their Indigenous culture and community, which I did not. Understanding the nuance of even slightly different contexts of experience helps to construct a larger, more dynamic narrative.

The stories gathered to answer the research questions posed in the following section are discussed through theoretical lenses from Indigenous and disabled scholars that centre people of these identities as strong, resilient, and most importantly—they are the experts. Radical Resistance Theory (RRT) (Simpson, 2017) and Radical Disability Theory (RDT) (Withers, 2012) were both equally important in the process of gathering these stories from participants in a good way; as well as constructing the following data analysis and discussion of findings. Two methodological frameworks are relied upon to support the data analysis and dissemination. The first is adapted from Kim Anderson's (2017), *A Recognition of Being: Reconstructing Native Womanhood* in which she discusses empowerment of owning your own identity, resisting those negative identities placed upon us by others in the context of the experiences of Indigenous women. The second framework revisits Allen et al.'s (2021) framework for understanding,

assessing, and fostering belonging to bring together the discussion of how the intersecting identities of being Indigenous and neurodivergent are inherently connected to how a sense of belonging is developed throughout the lifespan.

3.1 Research Questions

In my search for perspectives on belonging in relation to identities that are similar to my own of being a neurodivergent Indigenous person, this research asks two questions:

1) What are some of the common experiences and distinctly unique experiences of neurodivergent Indigenous people in Canada who have ADHD; and
2) How have these experiences influenced or impacted one's identity development and sense of belonging?

3.2 Theoretical Perspectives

To deconstruct colonial individualistic binary notions of typical versus divergent or normal versus not normal (which are inherently rooted in white supremacist and ableist ideology), this work very intentionally embraced theoretical perspectives from Indigenous and disabled scholars and researchers. While this topic features discussion and focus on the experiences of neurodivergent Indigenous people, it is important to hold in mind that the overall takeaway from this research is an understanding of the importance of belonging for everyone. No human would or could even be able to navigate the world without the inherent instinct to seek connection with others. By discussing experiences of belonging at the intersections of being Indigenous and neurodivergent, it demonstrates the ways in which our sense of belonging is influenced and impacted both positively and negatively. However, the

framework for analysis that I use in this work could apply any number of intersecting identities to demonstrate experiences of belonging within their unique contexts.

As this work is about distinct identities that intersect with one another, it was only appropriate to ensure that distinct theoretical perspectives from each were equally represented. Leanne Betasamosake Simpson's (2017) Radical Resistance Theory (RRT) became a valuable perspective in both contexts of telling my own story as a neurodivergent Anishinaabe-kwe. Simpson (2017) describes Indigenous resurgence as the regeneration and reestablishment of Indigenous nations though methods and knowledge, which she learned from working with Elders within Long Lake #58 First Nation in the 1990s.

Simpson said that this theory first emerged from witnessing the research practices of her non-Indigenous colleague, Dr. Paul Driben. She states she had never seen anyone conduct research the way her colleague did, in which he very deliberately and intentionally demonstrated a divestment from the false power that those in academia often carry. Simpson states, "he came into their circle on the terms of the experts, the Nishnaabeg Elders, not the other way around" (p. 12). From knowledge gifted to her, she states, "I got a sense from them that our intellectual systems are our responsibilities, that they are an extension of our bodies and an expression of our freedom" and states further that there is no room in her world for the desire to seek affirmation from white people (p. 17). Not only do I see this as an important in engaging in my own Indigenous research, but I also see this as important in translating this into the context that we as disabled people also do not need to seek the validation of abled people, nor do we need to dilute ourselves for the comfort of abled people.

The second theoretical perspective held within this work is that of Radical Disability Theory (RDT) (Withers, 2012). Withers (2012) uses RDT to define disability as, "a social construction used as an oppressive tool to penalize and stigmatize those of us who deviate from the (arbitrary) norm" (p. 98). There are four key concepts that are part of RDT. The first is to acknowledge that disability is linked and intersected with other forms of oppression, not separate from them. The second is understanding that what is considered typical or normal needs to be deconstructed. The third concept recognizes that the label of disability is used to marginalize specific types of people to obtain power and dominance over others, and it is a political determination, not a biological one. The fourth and final concept is understanding that addressing disability must be approached holistically with acknowledgement that universality does not exist (p. 98-99).

Holding these theoretical perspectives throughout the process of completing this work was paramount, meaning, the participants who chose to contribute to this work are the experts unto themselves and they would be the ones steering the direction of the conversation. While there were prepared questions presented to the participants, they served only to support the conversation, and participants could discuss anything they saw as relevant or important to contribute to the narrative about their experiences as neurodivergent Indigenous people. Following the interviews, participants were advised that no further participation would be required or expected of them, but they would be presented with the opportunity to review findings and interpretations at their discretion, related to the knowledge they shared for affirmation to ensure that the context of their knowledge would not be presented inaccurately or in ways misaligned with their intentions. This was an important part of my research process

demonstrating participants' ownership over their personal data and how the discussion would be presented.

3.3 Methodology

This work began with the intention to centre methodology from Kim Anderson's (2017) medicine wheel framework/process, which she used to approach reconstructing definitions of Indigenous womanhood. Anderson first developed this work for her own master's thesis in 2012, which she then expanded upon in her 2017 book, *A Recognition of Being: Reconstructing Native Womanhood*. Using oral story work as method, Anderson gathered stories and perspectives of Indigenous women to deconstruct negative definitions of Indigenous womanhood to create a definition that, in itself, makes space for Indigenous women to belong as their whole selves, without compromise. Anderson said, "I felt the validity of the oral knowledge in our communities has been underestimated. As a young Native woman seeking information about my identity, I didn't want to rely on a body of questionable literature…" (p.24). Anderson was very deliberate to ensure her methods and methodology were grounded relationally and that relationships with her interview participants were very important, saying "We exist because of and for the relationships we hold with everyone around us. Knowledge is therefore of no use if it does not serve relationships" (p. 24).

Anderson's (2017) framework (herein referred to as the "Recognition of Being Framework") uses the medicine wheel to delineate her process of defining Indigenous womanhood in a very poignant and meaningful way. This strongly resonated with me, as an Anishinaabe-kwe myself, and thus became the foundation for doing this work in a good way. The four components she describes starts with **resisting negative definitions of being**, meaning

the stereotypes that negatively impact Indigenous women's wellbeing. Next, she seeks to **reclaim Indigenous tradition** through her methods of oral story work and representing the voices of Indigenous women to define themselves. Then, **construct a new definition of being**, a positive identity that brings traditional Indigenous knowledge into the contemporary context. Finally, Anderson says **action** is the step in which she identifies her responsibilities that have come from the knowledge gained and representing the new definition of being in a way that nourishes the overall wellbeing of Indigenous women and their communities (p.xxvii).

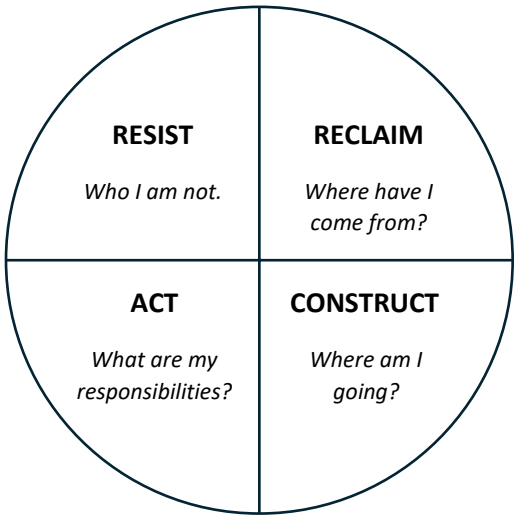

Figure 3 Kim Anderson's (2017) Recognition of Being Framework (p. xxvii)

My interpretation of Anderson's (2017) Recognition of Being Framework in the context of sharing stories of intersectional identities of being a neurodivergent Indigenous person begins with resisting Eurocentric, white supremacist ideologies that alienate both Indigenous and neurodivergent peoples, as discussed in previous chapters of this work. Furthermore, my research demonstrates resistance by examining the existing research (or lack thereof) and identifying gaps in the narrative and highlighting the over-saturation of clinically based research

on ADHD that fails to identify the strengths and positive attributes that neurodivergent people may have that neurotypical people may not.

This work reclaims Indigenous ways of knowing and being with the assistance of the many Indigenous scholars referenced throughout including but not limited to Wilson (2008), Linklater (2014), Anderson (2016), Absolon (2022), Simpson (2017), and Eastwood (2021). I also rely upon many disabled scholars and authors such as Withers (2012), Mooney (2016), Nerenberg (2020), and Bacon (2020), to ensure that this work is grounded in ways that are disability-informed, strengths-based, and represent the lived experience of people with ADHD centring the knowledge my participants have felt most important to share, without invading privacy or asking participants to provide more than what they are comfortable with sharing.

Moving forward in the process to **construct a positive identity** of being Indigenous and neurodivergent, I incorporate the use of Allen et al.'s (2021) integrative framework for understanding, assessing, and fostering belonging (p. 6). Three of the four components of Allen et al.'s integrative framework (competencies, opportunities, and motivations) serve as the foundation for the high-level themes, with a slight modification of the competencies component by adding characteristics to more accurately represent that belonging is not just based upon social skills a person does or does not have. Perceptions, the fourth component, is not a stand-alone theme. Rather, I have reframed the perceptions component in accordance with my interpretation of defining belonging using the medicine wheel as a way of guiding discussion wholistically, weaving these perceptions throughout the discussion (See Table 3 below).

Theme	*Subtheme*	*Perception of Belonging*
Competencies and Characteristics	Adaptability and Masking	Mental (self), Physical (place), Emotional (relationship)
	Concurrent Diagnoses and Disabilities	Mental (self), Physical (place)
Opportunities	Displacement and Instability	Physical (place), Mental (self), Emotional (relationship)
	Priorities and Responsibilities	Mental (self), Physical (place), Emotional (relationship)
	Virtual Connectedness	Emotional (relationship), Physical (place)
Motivations	Justice Seeking/Justice Sensitivity	Spiritual, Emotional (relationship)
	Finding our People and Place	Physical (place), Emotional (relationship), Spiritual, Mental (self)
	Breaking Cycles and Raising Warriors	Mental (self), Spiritual, Emotional (relationship)

Table 3: Discussion and Analysis Themes and Subthemes

The conclusion of this research will outline what identified responsibilities lie within the future of **acting upon** this work for both myself as the researcher and for those reading and learning from this work. Anderson (2016) is clear that completing the circle does not mark the end of the pathway. There is a period of reflection on the work that has been done and what could have been done differently. Then it is time to prepare to navigate the circle once again; meaning that this is only the beginning, with many future possibilities and pathways this work could branch into and what may come next.

3.4 Methods

3.4.1 Participant Selection

This project set out to recruit ten (10) individuals who would be willing to participate in a semi-structured interview process (approximately 90-120 minutes in duration) where they would share about their perspectives and experiences related to their identities as neurodivergent Indigenous people and how they frame those experiences around their sense of belonging. The inclusion criteria for this research were broad. Selected participants would be identified as:

- Indigenous from Canada, either First Nations (Status or Non-Status), Inuit, or Métis;
- Adults over the age of 19 years of age;
- Neurodivergent (clinical or self-identified diagnoses both valid); and
- People of all genders.

The research set out to interview participants with different circumstances of self-identifying with ADHD or receiving a clinical diagnosis at any age. However, of the clinically diagnosed participants interviewed, all identified as late diagnosed at various ages in adulthood, with the youngest age at the time of diagnosis being 19 and the oldest being 44. Out of a selection pool of 20 prospective participants, only one person identified themselves as having a childhood diagnosis of ADHD, but they did not move on to participate in an interview.

While a clinical diagnosis of ADHD can be useful, this research was very intentional in validating self-identified neurodivergent individuals who have not been able to complete (or have not sought out) a diagnostic assessment with a clinical professional. This decision was made to acknowledge that, for many people, there are many various barriers to obtaining

clinical diagnoses. Stated differently, there is an inherent privilege in being an individual who holds a clinical diagnosis given the validation it receives through things such as pharmacological options and the right to receive personal accommodation in one's workplace or school environment.

Of the nine people interviewed, seven participants identified as cisgender women, one participant identified as a two-spirited person but spoke about experiences related to being assigned female at birth (AFAB), and one participant identified as a cisgender man. Six participants identified themselves as a parent, none of whom were diagnosed with ADHD prior to becoming a parent, and most of whom first self-identified as possibly neurodivergent when their children received ADHD diagnoses.

Recruitment began in December 2024, following ethics approval. Social media platforms, Facebook and Instagram, were used to share a public post from the researcher's personal Facebook account, advertising recruitment for the research. The recruitment poster included a proprietary email address[4] for interested individuals to contact with inquiries that were set up to forward all emails to the researcher's university email address. The poster also included a QR code linking directly to a Microsoft Forms screening questionnaire for anyone who wanted to proceed with registering as an interested participant. Recruitment information was also shared with the University of Victoria's Indigenous Academic and Community Engagement (IACE) Listserv, as well as distributed to colleagues associated with the Indigenous Children and Youth with Support Needs (CYSN) Advisory Council via the Ministry of Children and Family Development (MCFD).

[4] indigenousadhdresearchproject@gmail.com

Twenty-one (21) prospective participants completed a brief screening questionnaire on Microsoft Forms requesting data to identify those meeting the broad inclusion criteria but also aimed to capture more specific data that would help identify diverse perspectives amongst prospective participants. All the questions were structured in a way that would avoid gathering too much identifiable personal data. Required fields included:

- The participant's first and last name;
- Confirmation that they were a person aged 19 or older;
- The location of the person (Province only);
- A valid email address;
- Preferred method of contact (phone, text message, or email);
- Indigenous Identification;
    - First Nations
    - Inuit
    - Métis
    - non-Indigenous
    - other
- Identification of ADHD diagnosis to identify diverse diagnostic experiences;
    - Clinically diagnosed as a child
    - Clinically diagnosed as an adult
    - Self-identified diagnosis
    - Unsure, ADHD suspected
    - No

Optional fields participants could respond to included:

- The person's identified pronouns;
- Gender identity;
- Phone numbers (if phone calls or text messages were preferred); and
- If prospective participants would still like to receive any updates or results of the published study if they are not selected to participate.

Overwhelmingly, a majority of the interested participants indicated that they were Indigenous women who were clinically diagnosed in adulthood with ADHD, much like myself. Fifteen (15) respondents identified themselves as female, eleven (11) of whom identified as clinically diagnosed with ADHD as an adult. Two (2) female respondents identified as clinically diagnosed during childhood; one (1) female respondent self-identified as neurodivergent with ADHD; and one (1) female respondent was uncertain but suspected they had ADHD. Four (4) respondents identified as non-binary or did not disclose gender, three (3) of which identified as having received clinical diagnoses as adults, and one (1) with a clinical diagnosis from childhood. Only one (1) respondent identified themselves as male and identified themselves as uncertain but suspected they may have ADHD. Most respondents were in British Columbia, with two (2) located in Alberta, one (1) in Manitoba, and (3) from Ontario. Figures 3 and 4 on the following page shows the representation of Indigenous identities amongst prospective participants, and the representation of identifying ADHD diagnoses.

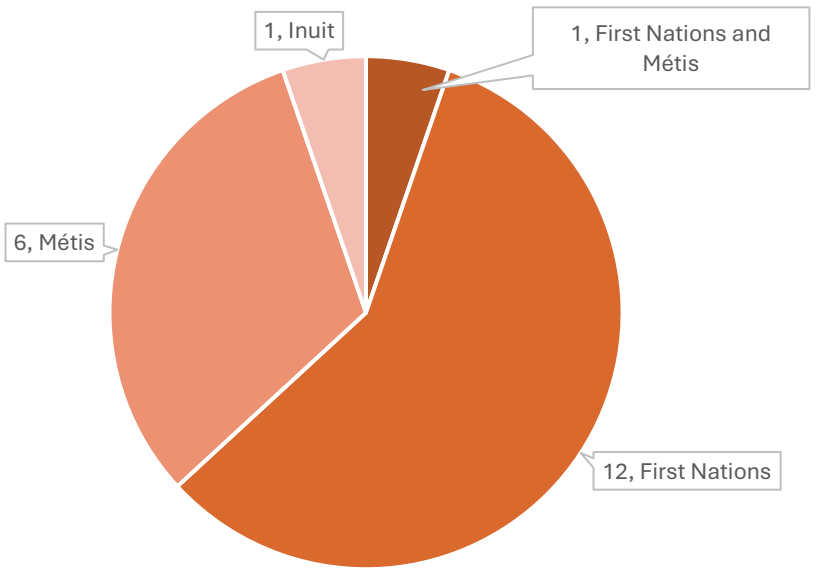

Figure 4 Indigenous Representation of Prospective Participants

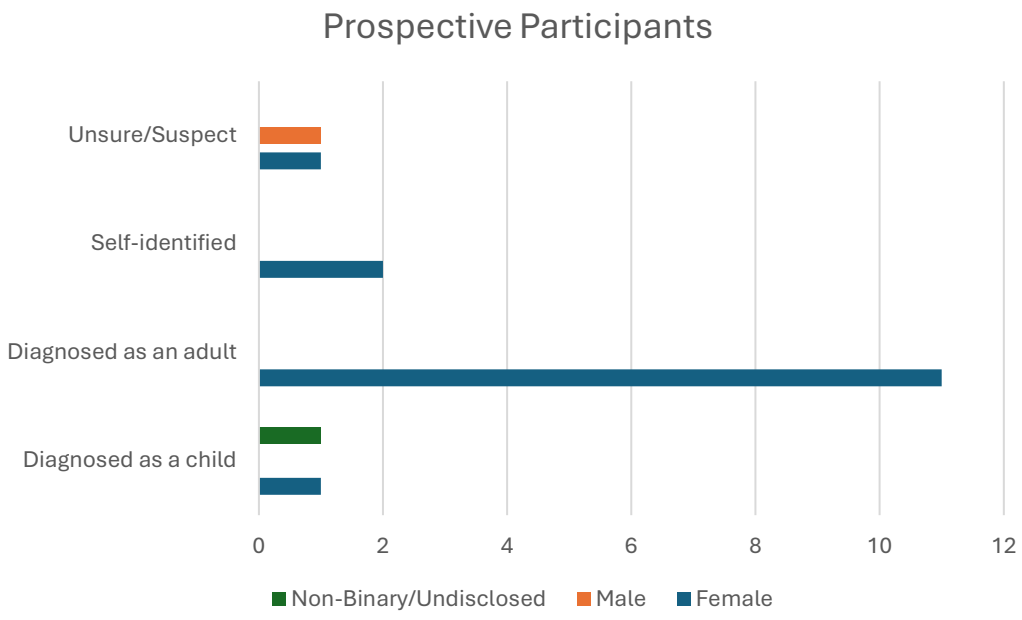

Figure 5 Prospective Participants by Diagnosis and Gender Identity

Invitations to participate in an interview were sent to prospective participants with additional information for recipients to consider prior to finalizing their decision to participate.

Scheduling time to meet with participants was intentionally done very flexibly, to ensure that participants would not feel pressured to commit to meeting during times that would not work for them. Scheduling was offered to participants during weekdays, evenings, and weekends, with the most complex limitation being differences in time zone for participants located in provinces outside of British Columbia. One participant requested that they meet in the late evenings as they had a child with support needs and the best time for them was after the child was put to bed for the evening. These kinds of requests were very easily accommodated.

Most participants were comfortable with using Microsoft Teams to engage in a virtual meeting where it could be recorded using the application itself. One participant requested to meet via telephone as they resided in a more remote area of their province and could not guarantee a reliable internet connection. This was a simple accommodation, and the audio of the call was recorded using audio recording equipment connected to the researcher's desktop computer.

Overall, nine (9) interviews were completed, with one participant who withdrew prior to their interview. Seven (7) interviews were completed using Microsoft Teams, one (1) was completed via telephone with external recording equipment, and one (1) was completed in person. A second call-out to participants was sent via email on April 3, 2025, extending the invitation to participate, advising that further communication would not be sent out unless they responded indicating they wanted to continue to receive updates or move further with participation. Participants who completed interviews were located primarily in British Columbia, with one participant located in Alberta, and one participant located in Ontario.

Each participant was offered a $50 financial honorarium for their time spent and shared knowledge. Eight participants were provided with the honorarium following their completed interview, with one declining the offer. Honoraria were provided regardless of participants electing to support this work further through reviewing and affirming the data analysis and conclusions. Participants were able to keep their honorarium regardless of whether they decided to withdraw from the study after the interview had been completed. Funds enabling the ability to provide honoraria to participants came from an anonymous donor to the University of Victoria, awarded as a graduate student scholarship in the sum of $1000 to the researcher.

3.4.2 Ethical Considerations

This research project was very mindfully and deliberately designed in ways to ensure that the knowledge being sought would be gathered respectfully, acknowledging the past implications of research done *on* Indigenous peoples rather than *with* Indigenous peoples. Approval to move forward with the research phase of this work was granted through the University of Victoria's Human Research Ethics (HRE) team, and prior to ethics approval the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans (TCPS2) tutorial was completed as a requirement.

This research design was very deliberate to acknowledge that many neurodivergent people appreciate clear, concise communication that does not expect them to assume anything that is not clearly communicated directly to them. In all correspondence between prospective participants, replies always indicated my expectations as the researcher and my intentions to ensure that the space we gathered in would be safe and comfortable for them to engage in and

that I would make any reasonable accommodation I could to ensure that they could participate in a good way. The sample questions for the semi-structured interview were provided to all participants at least 24 hours in advance of the scheduled meeting time and it was communicated clearly that these questions served only to guide or support the conversation. Participants could speak to whatever they felt was the most important to share about being neurodivergent and Indigenous and were under no obligation to share anything they did not feel comfortable with. Participants were assured at any point they could withdraw from the research study without explanation at any time after the interview process up until the review and affirmation process concluded; and withdrawal would not require returning the honorarium provided for their time.

Participants were notified that they would receive follow-up correspondence after the interviews concluded to share progress about the research, emerging themes, and any other relevant information to share. In July 2025, participants received an email update (Appendix E.1) with a summary of the themes (Appendix E.2) and framing of the research to date, as well as an invitation for any feedback, but again with no expectation or obligation for participants to engage further unless they wanted to. No feedback was returned at this time.

On September 1, 2025, participants were offered a final opportunity to review and affirm select excerpts of the discussion and findings of the research pertaining to interpretations of the information they shared. Participants were asked to indicate their interest in reviewing their segments of the analysis within the next two weeks (by September 13th) to ensure time for preparing review copies for those interested with sufficient time for participants to review. Three (3) participants responded with interest in reviewing their

analyses, in which they were sent condensed documents with quotes and references specific to the participant.

The opportunity to review and affirm interpretations and findings was an important component of this work to ensure that the knowledge they gifted aligned with their own intentions of participating in this research. It also supported researcher accountability, ensuring that the spoken intentions of this research being a shared collaborative project was demonstrated through real action before the research was concluded and presented in its final form. Once again, participants were not obligated to participate in this process, but it was an opportunity afforded for every participant.

3.4.3 Protection of Information and Confidentiality

Eight (8) interviews were conducted from the researcher's private home office with participants locating themselves in the comfort of their own private spaces while connecting on Microsoft Teams or via telephone. The in-person interview was held in a private conference room reserved through the public library where the participant was comfortable attending. Interviews conducted on Microsoft Teams were recorded for review purposes only to verify the accuracy of the transcript automatically generated by the application. Raw transcripts were reviewed by the researcher alone; no other persons assisted with any transcription services.

Video recordings will be deleted following the conclusion of this work, raw transcripts will be maintained and saved on in a secure Microsoft SharePoint server hosted by the University of Victoria for up to five (5) years for the purposes of possible future use of data which participants agreed to in the review of their informed consent. Future use of data

includes the participants registration form gathered via Microsoft Forms with their contact information and raw transcripts of the interview. Participants could opt that their information be used in this research project but were not obliged to agree to have their information retained for future purposes. Future use of data includes possible further research about neurodivergent Indigenous identities and belonging and/or similar research topics. Participants referred to in the analysis are identified by pseudonym for protecting privacy. No specific locations of where the participant resides or is from are provided, only approximate geographic regions.

3.4.4 Data Analysis and Dissemination

With the intention to approach the analysis of the data wholistically through an Indigenous lens of meaning-making and maintaining the principles of Radical Resistance Theory (RRT) (Simpson, 2017) and Radical Disability Theory (RDT) (Withers, 2012), I used three of the four components (competencies, opportunities, motivations) of Allen et al.'s (2021) integrative framework for understanding, assessing and fostering belonging as the foundational themes. Interviews were reviewed and analyzed using the fourth component, perceptions of belonging, to aid in the discussion of the emergent subthemes (see Table 1), centring the importance that the knowledge being shared is subject to the perception of the participant and what was important to them in sharing about their experiences and understanding of belonging. Throughout the discussion, I integrated some supportive literature relevant to the themes and subthemes as well as some of my own relevant experiences and perceptions of belonging alongside the experiences of participants. While Skye did not have a diagnosis of ADHD, I also brought some analysis of experiences shared within Skye's Legacy: A Focus on Belonging

(Representative for Children and Youth, 2021) and how her experiences as an Indigenous youth in foster care may align with the themes and subthemes[5].

3.4.5 Challenges and Limitations

Within the timeframe and scope of completing this project for a master's level thesis, and the chosen method to engage with participants through semi-structured interviews, this work had to be kept to a relatively small scale and number of participants. The ability to reach a more diverse range of prospective participants was also limited based on reliance on snowball sampling through the sharing of information publicly on social media and hoping that people would share the invitation with other people they knew. The pool of prospective candidates that responded to the research invitation was largely that of Indigenous people connected to post-secondary institutions. Therefore, this research recognizes a selection bias that represents a participant pool that is representative of people with various levels of (mainstream recognized) post-secondary education.

Due to the limitations of the scope and time to complete the research, there are voices not represented by those who have had journeys down other pathways of knowledge and experience that have their own strengths. As the researcher, I acknowledge that those journeys are no less valid than the voices represented in this work and have hope for the future to gain more perspective that is inclusive of a wider breadth of different kinds of knowledge and

[5] The information shared about Skye pertains to only what is publicly available within the investigative report and the interpretations made are based on perceptions of what was shared about Skye by those who knew her. It is important to acknowledge that this work is connected to the legacy that the Representative for Children and Youth set out to establish when Skye's Legacy was released in 2021. Although I am no longer connected to the Office of the Representative for Children and Youth, I will always carry her story with my best intentions and actions as I would not have come into this work without first having had the privilege of working on Skye's Legacy.

perspectives on the importance of belonging within an Indigenous context, especially those of traditional knowledge keepers and Elders.

Chapter 4: Analysis and Discussion, Constructing a New Positive Definition of Being

The following analysis and discussion will introduce you to the nine (9) participants (Section 4.1). Some of the specificity of the information shared has been limited to protect details that may be too identifying of the participants. Each story is unique, but of course there are many ways in which the experiences of the participants, as well as my own have relatable similarities that have become the basis for the subthemes focused on throughout the discussion. Each participant brought their own unique perspectives on being Indigenous and neurodivergent—with their stories painting pictures of how they grew up and came to understand the world around them, how they understood themselves as they are today, and what belonging meant to them.

Three of the four components from Allen et al.'s (2021) integrative framework for understanding, assessing, and fostering belonging (competencies, opportunities, and motivations) served as the foundation for discussing eight (8) identified subthemes related to being neurodivergent and Indigenous (See Table 1). Although there were other subthemes that could have expanded the discussion further, the scope was kept limited to allow for a more focussed, comprehensive discussion on the selected eight (8) subthemes. As previously mentioned, modification was made to the language of the "*competencies"* component to better represent the understanding that social acceptance is not just based on skills and abilities a person can demonstrate. While the authors do acknowledge differences in race or class influencing one's sense of belonging and how it may influence the ways a person may interact with others, these differences are not necessarily about competency, and it is important that it is understood that characteristics of disability do not equate to incompetency.

The fourth component of Allen et al.'s (2021) integrative framework for understanding, assessing and fostering belonging serves as an overarching guide for the discussion, demonstrating how the identified subthemes within the three other components have been interpreted and woven throughout each of the discussions as each story is being told from the participant's first-hand perspective. Furthermore, reframing the perceptions to align with my interpretation of defining belonging in the context of the physical, mental, emotional, and spiritual components of the medicine wheel helps to contextualize the discussion in Indigenous ways of making meaning and understanding from a wholistic perspective.

Belonging to Self (Mental)

Belonging to self is an understanding of self. However, this can be very difficult when undiagnosed and disconnected from significant facets of identity results in making meaning of self by relying on the perspectives of others and how they define self; such metrics may not necessarily align to one's own identity.

Belonging in Place (Physical)

Belonging in place is multidimensional, ranging from the macro level of nationhood or citizenship in which we might attribute part of our identity to our nationhood. At the mezzo level, we might consider our primary spaces where we share communal places with others such as school, workplace, or community third spaces. At the micro level, we could consider our home, a place that is specifically for us as family units or individuals. However, no matter the place, having a sense of belonging within those places is important as it means that we know we are welcome to safely belong in those spaces without question. This is not to say that we

have the right to exist in every space, but rather we have the right to exist somewhere at all times.

Belonging to Spirit (Spiritual)

Belonging to spirit does not necessarily mean one must be connected to a spiritual belief or pantheon/religion, rather it could be interpreted as any connection to beliefs, values, cultural practices, connections to land, or virtues a person holds important.

Belonging in Relationship (Emotional)

Belonging in relationship may hold the most importance considering that from a perspective based in relationality, belonging is relationship and relationship is belonging. "When all things exist in relatedness, it is inconceivable that an entity, idea or person could exist *outside* of this network or be considered as 'other' to this system of relationality" (Tynan, 2021, p. 601).

In the following sections, I begin by first introducing the participants and then move to presenting the themes and subthemes that emerged from my analysis. Each subtheme is identified by a heading and accompanied by a subheading to indicate which perception of belonging aligns with the topic of discussion ahead.

4.1 Participants

Ruth

Ruth (she/her) is a Métis woman and is the mother to a teenage daughter and stepdaughter, as well as a young son who is on the autism spectrum. Ruth is not formally diagnosed with ADHD but has suspected the diagnosis since her own daughter was diagnosed over two years ago.

Bethany

Bethany (she/her) is a Métis woman from Ontario and is the mother to a teenage daughter and son. Much like Ruth, Bethany did not have reason to suspect she had ADHD until her daughter was diagnosed at the age of nine. Bethany received her diagnosis about four years ago and has found a connection with many neurodivergent colleagues at the Indigenous organization where she works, affectionately calling themselves 'neurospicy'.

Anna

Anna (she/her) is a Coast Salish woman and is a self-employed consultant and educator on cultural competency and decolonizing practice. She is a single parent to her seven-year-old daughter. Anna was diagnosed four years ago with ADHD following a difficult pregnancy and challenging years following raising her young daughter.

Max

Max (he/they) is a Two-Spirited Anishinaabe and Métis person and is the parent of two children ages 9 and 11. Max was not diagnosed until he became a parent and unfortunately went through several misdiagnoses before finally being diagnosed with both ADHD and Autism

Spectrum Disorder (ASD) and has other concurrent chronic health diagnoses that affect his daily living.

Mel

Mel (she/her) is a Gitxsan woman and was diagnosed the youngest of any participant at the age of 19 when she was attending university. She had gone through most of her undergraduate degree undiagnosed without support. She eventually sought medical care as she thought she was having difficulty with her hearing, and when hearing tests indicated no issues with her hearing, it was suggested that it could be ADHD as auditory processing disorders are a common co-occurrence.

John

John (he/him) is a Métis man from Alberta, and in his early adulthood worked in the oil and gas industry until he was injured in a workplace accident that caused permanent disability. John says that he was diagnosed with dyslexia when he was younger but did not receive his ADHD diagnosis until he first began his post-secondary education journey, which enabled him to gain the support he needed to succeed despite many challenges and barriers along the way.

Cara

Cara (she/her) is a Métis and Dene woman from the Northwest Territories and is mother to three children. Cara completed an undergraduate and a master's degree undiagnosed and was only diagnosed with ADHD after one of her sons was diagnosed with ADHD in the second grade.

Doreen

Doreen (she/her) is a Cree woman from Saskatchewan, who also has spiritual connections and ties to the Coast Salish territory where she grew up, and where she says she feels like an accepted member of the community. Doreen is the mother of an adult son and daughter who were diagnosed with ADHD around the ages of 10 and 11 and received her diagnosis of ADHD ten years ago at the age of 44, becoming the latest-diagnosed participant in the group.

Leah

Leah (she/her) is an Inuit, Cree, and Métis woman with familial ties to the Northwest Territories. Leah is a social worker who works with high-risk Urban Indigenous youth. Leah was diagnosed with ADHD three years ago after taking a leave of absence from her work to prioritize her mental and physical wellbeing.

4.2 Discussion

4.2.1 Theme: Competencies and Characteristics

Allen et al. (2021) describe competencies as skills and abilities needed to connect and experience belonging. With the addition of characteristics, this component will also discuss traits the participants have (or do not have) that are needed in addition to skills and abilities as there are important intersections to consider in how one experiences belonging through this lens. Within each of the conversations that I had with the nine participants, many competencies and characteristics were observed and identified that connect to both their neurodivergent and Indigenous identities, which intersect and interact with the other components of Allen et al.'s (2021) integrative framework: opportunities, motivations, and perceptions. There is an evident

societal misperception of neurodivergent people with the assumption that they lack the ability to develop social skills, they lack feelings or empathy, miss social cues, etc. There is some validity in this notion to the extent that it is true neurodivergent people process information differently and perceive social interaction differently than neurotypical people. However, rather than have neurotypical people adapt to understanding neurodivergent thinking and perception of social situations, the onus is put back on neurodivergent people to adapt and fit the social norms of the neurotypical (Milton, 2012, p. 886).

The subthemes within this component look at discussions of *adaptability and masking* in which the ability to shift and change one's external behaviours are a necessity within both the neurodivergent and Indigenous context to navigate environments of belonging they may not fit. This is both a skill and a limitation when it comes to fostering a sense of belonging because the ability to mask helps construct a sense of belonging; however, the individual is performing in a way that is not necessarily natural to them and ultimately it is the masked perception of the individual that is being accepted and not the individual's whole self. The other subtheme for discussion within this component focuses on *Concurrent Diagnoses and Disabilities*, looking at the prevalent barriers that come from being a disabled Indigenous person and the common experience of having multiple concurrent health diagnoses or disabilities which compound the difficulties of being neurodivergent with ADHD. This discussion is why it felt necessary to adjust the competencies component to include characteristics because the context of what disabled people and Indigenous people face as barriers are not due to incompetence or inability, it is the external environs that limit skill growth and use by way of inaccessibility and insufficient accommodation to support a person's functional needs.

Subtheme: Adaptability and Masking
(Belonging in Relationship, Belonging to Self, Belonging to Place)

Adaptability and masking are strengths that many neurodivergent people must develop to navigate a neurotypically dominated world in which a person suppresses or camouflages their neurodivergent traits, behaviors, or needs to fit into neurotypical spaces (Praslova, 2025, para. 3). It is a behaviour that is learned as a protective mechanism when a person is forced to exist in an environment that expects a presentation of oneself that is actively in conflict with one's natural ways of living and being. Masking is a performative effort where there is a chronic expectation to wear and maintain a mask that does not fit their bodies or minds; and without being able to remove that mask, it can be physically and emotionally impactful, and overall unsustainable over a long period of time. This expectation to wear and maintain a mask is learned in early childhood where the child learns that certain behaviour is undesirable and results in shame or corrective action that teaches the child to suppress what are likely natural and instinctual actions that may not be inherently inappropriate, such as vocal sounds or movements often referred to as "stimming". For neurodivergent children where their behaviours are seen as pathological problems, they often are subject to therapies and interventions such as Applied Behavioural Analysis (ABA) where external positive and negative reinforcement (operant conditioning) are used to train behaviours out of them, which in some circumstances has been proven to be traumatic or harmful practice (Sandoval-Norton et al., 2019, p. 2).

Environments that positively foster autonomy give a child ways they can openly explore and develop their own perception of self that feels right to them. However, neurodivergent children are not often encouraged and supported in ways that bolster their sense of belonging,

letting them know they are safe to explore these facets of self without fear of shame or experiencing harm because what is expected of them neurotypically is not a natural instinct. A recent study published by Lamash et al. (2025) demonstrated that autistic youth who experienced more acceptance regarding their autistic identity, exhibited greater autonomy and social participation. They said:

> A well-defined self-identity enables individuals to engage in goal-directed autonomous behaviour. It enables individuals to recognize their strengths and limitations, fostering a belief in their ability to control their lives and function successfully in society. Those with a well-defined self-identity are more likely to engage in activities promoting their personal growth and achievement, enhancing their psychological wellbeing. (Lamash et al., 2025, p. 2)

Whether subject to behavioural modification therapies or simply learning through negative social experiences, the pressure to mask and keep that mask on can be traumatic and trauma can be a significant disruptor to a child's sense of belonging to self, place, and in relationship with others. Furthermore, without a supportive adult understanding the child's social-emotional needs, especially neurodivergent children, they may grow up to have a more limited understanding of whom they could seek safety and comfort from in the future because of their experiences of unbelonging in relationships with others. The earlier children develop a positive sense of belonging and have the support to maintain that sense as they age and the world around them expands, will no doubt lead to less questioning of where they belong in the future.

For undiagnosed neurodivergent adults, masking is likely a subconscious action they are unaware of, but regardless of intentionality, it is extraneous effort that is physically and emotionally taxing and realistically cannot be sustained. The impact of this effort to maintain a state of masking can and likely will have a negative impact on one's sense of belonging resulting in negative self-perception and diminished opportunities to find spaces of belonging where they could safely be themselves as a whole. A 2022 study by Chapman et al. that looked at the connections between masking and mental health in teenagers on the autism spectrum reported that to them, masking increased their feelings of disconnection from other people. Participants described masking as a lonely experience as well as a physically demanding and draining experience all of which had impact on their overall mental wellbeing (Chapman et al., 2022, p. 12).

Masking is also not just performing in the sense of appearing neurotypical in neurotypically dominated spaces, it also extends to racial and cultural masking. In some contexts, this has come to be known as "code-switching", which specifically derives from members of the Black community in the United States who feel compelled to alternate between "standard" English and African American Vernacular English (AAVE), avoiding AAVE when speaking within white dominated spaces (Baker-Bell, 2017, p. 103). Regardless of the terminology used, it is deliberate effort that a person who deviates from the dominant sociocultural population makes to adjust their behaviour and interactions in ways that diminishes one's divergent characteristics to appear aligned more closely with the dominant sociocultural population around them to gain greater acceptance and safety. This is an

important subtheme that demonstrates the reasons why this component was adjusted to not only include competencies but also characteristics.

For the participants of this study, some identified masking or code-switching as necessary for safety in an otherwise unsafe space for them to exist as an Indigenous person, a person with a disability (or multiple disabilities), and/or another marginalized identity. Where culture was not embraced by their families due to intergenerational trauma, experiences of racism, or other reasons, participants learned that if they had phenotypically white-passing features, masking their Indigenous identities was a necessity for safety and belonging at some point in their lives. For John, he was very persistent in trying to complete his high school education and part of that persistence he said involved working hard to not be seen as Indigenous because where he lived in Central Alberta, he witnessed the way other Indigenous people were poorly treated.

> John: If I was [identifying as] Indigenous, there seemed to be a lot less support and a lot less interest in supporting me, certainly in the educational context…I remember watching teachers treat other students who were [more visibly] Indigenous so differently than the typical white kid was treated. It was really kind of an alerting experience.

Max had a similar experience with having to suppress or disconnect from the Indigenous parts of his identity. Part of this was genuine disconnection and limited understanding of his Indigenous identity. He did not meet his father until he was an adult, so he was not very aware of his father's Anishinaabe and Métis roots. As a child, Max's mother vaguely shared with him that he was Indigenous and tried to connect him to the nearby Coast

Salish community; however, he felt uncomfortable with these efforts as he knew so little about his father's heritage. However, the pressure to mask and suppress any connection to his Indigenous identity was also out of safety to belong in relationship with his non-Indigenous family members, whom he lived with and witnessed racist and hateful perceptions of Indigenous peoples expressed by some members of his maternal family.

Max shared that there was a lot of conflict with being not only Indigenous but also in coming to terms with his Two-Spirited identity to the point where the effect on his mental health led to attempts to end his life. Eventually, he leaned into his creativity and artistic talents by writing comics about his experiences and sharing them with people by publishing zines (self-published, small-circulation magazines) where a new sense of belonging unexpectedly started to blossom.

> Max: I made comics that were about my experience, which quickly connected me to other people who were trans and on the [autism] spectrum...I started to explore my Indigeneity more because the door was kind of opened with my gender identity. My [white] family disowned me when I came out, which was really hard, but also like an extreme gift, because it allowed me to start pursuing my Indigeneity and connecting to my [paternal] aunt.

Max may not have been knowingly masking his Indigenous or Two-Spirited identities and did not know yet that he too was on the spectrum. Conscious or not, the kind of rhetoric his maternal family exposed him to demonstrated that it was not safe for him to belong in many ways. Rather than continue to conceal who he was, it became necessary to disconnect from them to seek belonging elsewhere.

In positive ways, the adaptability of people with ADHD can lead to creative approaches to solving problems, overcoming barriers, and sometimes fitting in to wherever they happen to land. John shared that as a teenager, when he was struggling to get through high school, he managed to navigate the education system in a way that allowed him to attend different high schools in his area at the same time, taking different classes at different schools to get the most support he could from instructors he felt he could trust. While he was not diagnosed with ADHD at this time, this is a good example of creatively accommodating one's disabilities when not even realizing it and demonstrates that "universal" systems often create barriers instead of opportunity, as one size can never fit all. In fact, many undiagnosed/late-diagnosed people with ADHD may come to realize that many of the things they do in daily life to help them function are tools they developed unconsciously and are sometimes the culprit in delaying a diagnosis. This was the case for almost all participants in this study and also explains a lot about how many of the participants were late-diagnosed women (or trans/non-binary) who were diagnosed after becoming a parent.

In the case of Anna and Max (and even myself as the researcher), it was experiencing difficulties post-partum where unbalanced hormones and the gravity of parental responsibilities were so disruptive to executive functioning that any previously established coping mechanisms or supportive strategies were ineffective. For participants, Cara, Ruth and Bethany, their children had been diagnosed in middle childhood or adolescence, and they began questioning themselves about the traits they had that were similar to their children. The number of participants in this study identifying as late-diagnosed women or as a trans-AFAB

person aligns with the discussion earlier in this paper speaking to the misconceptions about ADHD being a "male disorder" and the spike in adult women's diagnosis of ADHD in recent years. They all have experiences of feeling like "lost girls" and are all now learning how to unmask in ways that allows them to feel more comfortable as themselves. For those who are parenting, being supportive of their own neurodivergent children in ways that they wish they could have been supported in childhood was a significant theme.

> Bethany: I really struggled to articulate feelings before [diagnosis] and even struggling to identify what the feeling is. Like, you just have that whole entire tense body but not understanding why you are feeling so tense. So now it's starting to be able to identify like, oh, I'm over stimulated, it's not supposed to be this hard…it's so sad that there's so many of us who were just lost and forgotten about we were just told, 'you're too this, you're too that, you're too much'. It feels good to be able to actually say here are the reasons why now.

Doreen's children too, had been diagnosed in elementary school, but she did not seek diagnosis for herself until her children were adults and they encouraged her to seek answers as they observed the neurodivergent tendencies they had, within her. She noted that medication was not something that she felt was necessary for her and with the support she had from her husband she never needed a lot of accommodation. However, something that was interesting that emerged in conversation with Doreen is that her daughter, although she was diagnosed in childhood, was almost overlooked and could have been a lost girl herself. Doreen said that her son's teacher raised concern about his inattentive tendencies and recommended he be assessed for ADHD, for which he was identified under the inattentive subtype. However,

Doreen's daughter had not been identified by her teachers, and only when she began asking questions when her son was diagnosed, was her daughter's ADHD identified. This was surprising because she was (very much) exhibiting hyperactive and disruptive tendencies that would have likely been flagged as a concern by a teacher if she had been a boy. When asked if she thought her daughter's ADHD would have ever been identified if her son had not first been identified, she responded definitively that she believed her daughter would not have been diagnosed as a child despite all of the signs.

Subtheme: Concurrent Diagnoses and Disabilities
Perception: Belonging to Self, Belonging in Place

It is critical to understand that experiencing multiple diagnoses of mental health or chronic illnesses as well as physical disabilities that impede the use of one's skills and abilities is not necessarily because of incompetence, but rather the social implications disabled people face. These social implications directly impact a person's sense of belonging to self, place, and in relationship as it imposes the internalized shame of the problem being within them. ADHD in and of itself is a disability that is not only met with stigma, but also not taken seriously as a disability as there still is a resounding misconception that people with ADHD need to just try harder. What is not acknowledged widely enough, however, is that individuals with ADHD may also have other somatic health conditions, mental health diagnoses, or other neurodivergent diagnoses that compound the difficulty of utilizing the skills and abilities they have to function in environments that are not accommodating or supportive of such disabilities. Some evidence suggests correlations of comorbidity in people with ADHD and with concerns such as obesity, sleep disorders, asthma, migraines, and celiac disease, for example (Instanes et al., 2018, p. 203). This is not to suggest causal relationships, but rather it is brought up for consideration

that chronic illnesses compounded with having a diagnosis of ADHD can exponentially make executive functioning more difficult. Furthermore, it is an important consideration given the social determinants of health for Indigenous people indicate significant health disparities compared to non-Indigenous populations in nearly all areas of health related to experiences of colonialism, social exclusion, and racism (Sauvé et al., 2022, p. 518).

Many participants in the study expressed having multiple chronic health conditions in addition to ADHD including but not limited to postural tachycardia syndrome (POTS), chronic regional pain syndrome (CRPS), hypermobility and connective tissue disorders, autism spectrum disorder (ASD), dyslexia, anxiety, depression, polycystic ovary syndrome (PCOS), anemia, adrenal disorders, diabetes, and more. All of these diagnoses are capable of being disabling on their own but compounded with ADHD, can make navigating daily roles and responsibilities much more difficult.

> Anna: The hormones that came along with pregnancy itself really deeply contributed to the burnout that I'm experiencing; and then it's also like made other chronic health issues that I have worse… There are all these layers of things that make everything worse and when these chronic health issues require things like diet and exercise, I am incapable of making changes to my diet and exercise because I lack the executive functioning to make those plans.

While Anna is saying that she is incapable because of executive dysfunction, what it really means is that Anna does not have the adequate support to be able to make time to make those plans and carry them out because of many other responsibilities taking precedence. Anna is a single parent who has her parents to support her with some of her childcare needs. She is also

self-employed with only one other business partner, requiring a lot of work to ensure that she is fulfilling her obligations to her clients. A great deal of energy goes into simply getting out of bed in the morning and ensuring that parental responsibilities are met.

For many people, changing diets is difficult because healthier food choices can not only be more costly, but many also fail to understand that dietary and nutritional issues are a common issue that neurodivergent people struggle with, and it is not just limited to food allergies or sensitivities. For some neurodivergent people with ADHD or on the autism spectrum, eating disorders like avoidant/restrictive food intake disorder (ARFID) are commonly linked sensory-related issues related to the texture, taste, smell or appearance of food (Thomas et al., 2025, p. 3). Furthermore, neurodivergent people may also have interoceptive processing issues, that impact the signals that the brain sends in response to the body's need to use the bathroom, or the feeling of hunger or thirst making it difficult to adequately meet nutritional needs throughout the day (Thomas et al., 2025, p. 9).

While nutritional habits, disordered eating, and body image were not necessarily a topic of discussion amongst participants of this study, I personally resonate strongly with Anna and her expressed difficulty with changing her diet. I have struggled with body dysmorphia since my teenage years, targeted by bullies because of obesity. Being a teenager in the early 2000s, I was among the young impressionable kids exposed to shockingly thin celebrities being idolized and held as the ideal. I only now recognize that my undiagnosed ADHD, poor interoception and unaddressed trauma manifested itself as a binge eating disorder, habits in which I still struggle with to this day. Pregnancy made things worse as I gained a lot of weight and developed gestational diabetes while carrying my son and following his birth, I was on the road to Type 2

diabetes. Physically, I was fit and strong, I had a gym routine and even competed in fitness competitions, but I could never manage my weight or my eating habits. In 2022, right before my son's third birthday, I had bariatric surgery resulting in a loss of 80 pounds and reversal of my blood glucose levels out of the range of type 2 diabetes. Still, I am not immune from gaining back the weight that I lost, and I still struggle with patterns of binge eating behaviour that I am trying to overcome and may always be fighting this battle with the fear of weight gain and body dysmorphia.

Multiple participants also expressed the effort it takes to advocate for personal needs, whether they are accommodations to support functioning and task completion, or getting appropriate care and support from service providers. For those that do not require modifications and support to complete daily living activities, there is a lack of understanding the effort and energy that goes into simply fighting for the support needed. Anna expressed the effort that it takes to get the proper health care that she needs because of the persistence of self-advocacy she has to take up in order to be taken seriously. This includes the time she spends extensively researching and learning to understand what could be going on within her and then the effort that it takes to further engage in conversations with her medical practitioners. Many people facing undiagnosed chronic illness are met with practitioners that are resistant to exploring rare or uncommon diagnoses, yet common diagnoses have already been ruled out.

Even when there are diagnoses that give rationale to supporting a person with accommodative tools, equipment, or technology, these requests for support are not always taken seriously by employers or educators. John has multiple diagnoses including ADHD and

dyslexia, as well as physical disabilities that limit his ability to complete physical daily living tasks due to the experience of chronic pain resulting from the workplace injury he sustained in his early adulthood. John spoke of the exhausting effort that he had to expend to get support to make it through his schooling, including having his physical textbooks converted to digital copies through scanning because e-books were not yet widely accessible.

> John: Getting textbooks was hell. I'd have to have them [school administrators] scan [the textbooks]. So, I'd have to go buy the textbook for them to cut it apart to scan it and then get it back…I was paying extra money, I'd have to pay $200 per textbook or more and then it was another $200 if I wanted the university to scan it for me.

Not only is this financially stressful, but it creates further limitations like being unable to resell the textbook when finished, like other students can.

When John entered the workforce as a social worker, he clearly made his needs known and what kind of support would assist him in doing his job but struggled with being taken seriously because his requests for accommodation were related to his dyslexia and not necessarily his physical disabilities. He said that he felt like his peers or colleagues that had visible disabilities such as using a wheelchair seemed to have an easier time getting accessible accommodations, but he struggled to get approval for a simple software update to his work computer to use speech-to-text note taking tools.

> John: Part of my challenge is that my disabilities are invisible. I don't always use the cane. You know I don't appear that I have a disability whether it's you know the ADD or the dyslexia or the physical stuff…I find that people can't see it, so they don't think it exists.

When there is a simple solution to a problem that is not met, the shortcomings are not placed upon the lack of accessible tools. Instead, the onus is placed on people like John being unable to complete his work the way his neurotypical peers can. Quickly, a workplace can become a place of unbelonging when a person is made to feel inadequate or unable to do their job because accessible accommodation is not being provided. It is further alienating that to advocate for accommodations that a disabled person has the right to receive then requires disclosure of personal details related to the support need as rationale for accommodating accessibility requests. This in turn affects one's sense of belonging to self and could impact belonging in relationships with colleagues that now are privy to intimate details of one's disabilities and health history. John said, "there was so much bureaucracy that they had to get permission from more and more people to do something as simple as updating the software on the computer, meaning disclosing [my disability] to more people".

4.2.2 Theme: Opportunities

Opportunities include the availability of groups, people, places, times, and spaces that enable belonging to occur, as well as experiences of various barriers that may have or currently impede opportunities to belong. As previously discussed, people do not have the right to necessarily belong in any or all spaces. People do however have the right to belong somewhere at all times whether they are spaces uniquely their own or the right to be afforded opportunities to belong in open, public "universal" spaces. United Nations Special Rapporteur in the field of cultural rights, Karima Bennoune, submitted a special report in 2019 saying public space is the space of all and that includes persons with disabilities. Section 43 of the report states, "accessibility is precondition for the enjoyment of human rights and a means for

economic, social, cultural and political empowerment, participation and inclusion" (Bennoune, 2019, p. 13).

A further consideration Bennoune highlights that is not talked about often enough is that spaces of belonging include virtual spaces given that in this digital age much of our human interaction takes place in cyberspace. The internet has become a place where violence is perpetrated without significant consequence as the precedence for enacting law and protections simply has not caught up with the advancement of technology. Section 70 of the report says, "in the digital age, public spaces are no longer limited to strictly physical spaces but also include cyberspace. This implies that human rights guarantee continues to apply online" (p. 18). Virtual communities are not a replacement for physical spaces of belonging but should be acknowledged as valid and real spaces of belonging that hold significance in bringing people together across the world. The power of virtual community that arose during the emergence of the COVID-19 pandemic is an example of how technology has expanded spaces of belonging. People driven into isolation across the globe banded together to support each other through social media groups giving space for people to voice their concerns and needs. Children attended schools virtually, people who could work from home shifted from their commuter lives and began connecting with colleagues online. In this digital age, the use of technology for spaces of belonging will only continue expanding and evolving.

The subthemes for discussion speak to barriers that limit opportunities for belonging due to experiences of *displacement and instability*, highlighting circumstances that prevented participants from finding opportunities to belong because of being displaced. The subtheme of *Priorities and responsibilities* includes a discussion about how participants sometimes are not

able to seek out spaces of belonging because there are too many other priorities and responsibilities that come first. Lastly, *Virtual connectedness*, is a discussion about how the internet is a common tool for creating the opportunity for connection and belonging when physical spaces are not always available and provide some comfort for neurodivergent people who struggle with accessing physical spaces.

Subtheme: Displacement and Instability
Perception: Belonging in Place, Belonging to Self, Belonging in Relationship

Many circumstances can lead to feeling displaced and without physical connection. This could be disconnection from traditional lands and culture, but for some participants, it was also experiencing unstable housing situations throughout formative years that affected their perception of belonging in place and relationships and limited their opportunities to find those connections due to chronic change and movement. For children and youth who experience the foster care system like Skye, the intention is to provide safety and stability for them when their parent/caregiver is unable to. However, stability cannot be achieved in the foster care system because it is not a system that establishes physical belonging, if anything it further diminishes belonging that was already unsteady. In my experience as a former child protection social worker, child safety interventions are rarely planned or prepared for and with limited resources available, many children are placed in emergency short term placements with nobody really knowing if that child will remain there a day, a week, a month, or a year. Skye experienced numerous moves in her early years while under the care of her mother as they sought community connection and stability. The Representative for Children and Youth (2021) said, "rather than achieve more stability and continuity after coming into care, she was not allowed to realize much, if any, sense of physical belonging" (p. 78). Skye's 11 years spent in foster care

involved 15 moves including eight different foster homes, five different communities, and attended eight different schools. Skye's belonging was further fractured by the fact that some of these placements she was promised permanency as her caregivers were prospective adoptive parents, only to have those arrangements break down and result in her moving yet again.

Johnson, et al. (2020) gathered the stories of 46 youth in foster care in the United States to examine the ways in which the youth make meaning of their sense of belonging while navigating the trials of attending high school. Unsurprisingly, the authors point to frequent and abrupt placement changes being a significant impact to their sense of belonging in school. They reported that some students had experienced as many as 20 different placements/living arrangement throughout their time in foster care, group homes, living with kin and extended family, with some even experiencing juvenile detention (p. 5). The authors said:

> Residential and school mobility not only results in academic challenges but also poses social ones. Participants spoke at length about how such changes negatively impacted social connections teachers, administrators and peers…for some participants who had experienced a number of school changes, it was difficult to establish productive and authentic relationships with peers and teachers.

The experiences shared by these youth are highly reflective of what Skye's experience was like as she was never in any one placement for more than three years (Representative for Children and Youth, 2021, p. 80). Correspondence from one of the school districts told the Representative that "Skye's records verify little or no attendance between the period of 2013 to 2015 as she moved between four different schools" (p. 84).

None of the participants who shared their stories for this research spoke specifically to foster care experience—however, chronic change and movement impacted Ruth's sense of belonging as she said her family moved so frequently in her youth that she thinks that kept her from settling long enough in a school where her support needs could be noticed by a teacher.

> Ruth: My brother and I sat down about a year ago and tried to remember all the times we moved [during childhood] and came up with between 18 and 20 moves. I could never settle anywhere, and just when I did get settled, my dad would uproot and move us again.

Ruth described her father as having a tendency to romanticize moving as a fresh new start where all the problems they were facing would be gone and everyone would be happier. Unfortunately, that was never the case, and the same issues would recur, and the cycle of movement would continue until she left home at the age of 15.

Ruth was not the only one to decide to leave home at a young age due to experiencing chronic instability. John similarly struggled with belonging in place and in relationship with his family in his youth, leaving home at the age of 14, experiencing periodic involvement with the child welfare system in Alberta[6]. John also said that he never really fit in with any specific peer group at school as he would navigate multiple schools through his teens in pursuit of completing his high school diploma.

[6] John did not speak in detail about his experience with the child welfare system and did not specifically speak to any foster care placements.

John: I didn't belong to one peer group of any kind. I had friends in all kinds of different genres of life. I bounced around a lot and never really had a strong community or support system that was consistent.

While there were limitations in opportunities to belong for John and Ruth when they were younger that they should not have had to experience, they developed strengths that they carried through to adulthood. Ruth felt a strong need to ensure that her children had the stability she did not have/experience in her youth and has worked hard to ensure that her family has only moved 2-3 times in the last 15 years; her youngest child having experienced moving homes only once.

John does not have children, but what he learned while seeking stability and safety for himself was the clever ways in which he could navigate the system to better suit his own needs and then become a social worker in the future where he could help people to navigate systems and create stability for themselves. The frustrating part for John was that he was perhaps more limited in his role as a social worker than maybe he had experienced when he was navigating the system for himself.

John: I worked in an acute psychiatric unit with some doctors that they would basically tell clients that if they didn't take medications, they were just going to kick them out of the hospital, and that was the only thing that was going to help them, and I didn't agree with that.

John said that in his time working in the psychiatric care unit he would get into trouble with his supervisors because the doctors would complain that he was spending too much time with

patients, but he felt that he was doing what was needed in his role to help them find stability and set them up for success when they would discharge from the hospital in the future.

Subtheme: Priorities and Responsibilities
Perception: Belonging in Relationship, Belonging in Place, Belonging to Self

When we have priorities and responsibilities that other people rely on us to fulfill, often the priorities and responsibilities we have for ourselves fall to the wayside. For neurodivergent people, sometimes this happens to a more extreme level as many have internalized tendencies of perfectionism and people pleasing to the extent that a person may give more of themselves to others than they receive in return. These tendencies along with the energy expended in masking and adapting in neurotypical environments are leading contributors to neurodivergent burnout. This is particularly prevalent in women and girls due to the way we have been socialized with emphasis and importance placed upon masking and blending in. Nerenberg (2020) said "at some point in their lives, often when adult responsibilities become too much, the amount of energy required to continue pretending, or "passing" simply becomes too much" (p. 81). This constant masking is often unconscious and only when the mask breaks down does it become evident that much of their behaviour has hinged on tremendous effort to uphold learned social obligation (p. 81). Mel spoke about how she is very conflict avoidant and is often willing to bend on matters that she should likely push back on, which can come at the cost of sacrificing her own needs for the needs of others. However, she says that her husband is supportive in ways that encourage her to come out of her shell and push back against him because then he knows that she is trying to communicate what she needs.

In other circumstances, some responsibilities fall upon us that are simply greater than our capacity to provide, and we extend our capabilities beyond our limits for those we love. As

a parent of an autistic child with high support needs, Ruth prioritizes his needs before her own and then devotes her remaining capacity to her other two daughters, one of whom has a diagnosis of ADHD. It leaves Ruth with very little energy left for herself and says that she has goals and desires for herself, but they will continue to sit in a future state until her son is older and has better support to alleviate some pressure from her. Ruth, while she is truthful about her feelings of being in a state of caregiver burnout, does not talk about this in contempt or resentment of her children's needs. Rather, her frustration comes from the inability to get the full support she needs for her son and spends a great deal of her time and energy looking for any financial support or supplements that could help go towards therapies and services that could give her son the support and inclusion in the community he deserves.

> Ruth: I take care of my son full time, he is very high needs, non-verbal autistic and he is also not in a typical school setting. He has four hours of supported learning a week, so I'm with him a lot.

Like any parent or child, there are bad days and good days. Ruth simply states it as, "if he's doing okay, I'm doing ok" when it comes to putting her sons need ahead of her own. She said, "anything I enjoy doing with my son are things that feel safe for me and him and that are regulating for him to help him be more comfortable in his own body," noting that many of the activities she does with her son involve swimming, hiking, trampoline, lots of activities that keep his body moving and stimulated.

While her son requires a lot of her time and attention, she also recognizes that her daughters still need connection and attention as well and does her best to fulfil that in meaningful ways. Ruth enrolled one of her daughters in a youth leadership program in the

community where they do trips into the wilderness learning planning and preparedness life skills.

> Ruth: My daughter just left for a five-day snowshoeing trip and one of the things that I helped her with was helping her prepare three of the camping meals that she was responsible for. So, we did that together and got it all organized. Unfortunately, I'm not able to go with her because of her little brother's stuff but we did enjoy doing the planning and preparation together.

With her stepdaughter, she tries to meet her where she is at, understanding that she has experienced trauma not unlike Ruth experienced at a young age. "Sometimes, we butt heads a little bit, but we do things together like cooking. We're both foodies and we'll bake bread or make a fun meal plan, or crazy dessert…stuff like that".

During my conversation with Anna, like in many of my conversations with the participants, I asked if there were any hobbies she had or things she enjoyed doing when it came to her own self-care. Unfortunately, the responsibilities of a single parent and a self-employed business owner take a lot of priority over other things.

> Anna: I'm trying to do things I was supposed to do 2 ½ years ago and then my mom got cancer, and my dad had a hernia operation. So, I find conversations about how I ground myself and what do I do for hobbies are actually super triggering for me.

Anna did not express this negatively, but rather she was just being matter of fact when talking about how the things she cannot do are upsetting and that is completely understandable. It is important to acknowledge and validate that the culture of preaching "self-care" does not

recognize the numerous barriers that hinder self-prioritization; and that every day, many people are simply trying to get from the start of the day through to the end. Acknowledging and understanding Anna's perspective, I instead asked how she tries to make time for coping with the challenges and hardships that limit taking time for herself. Anna responded by then talking about how they (she and her daughter) have been unable to feel truly settled and comfortable in their home since moving in the early days of the pandemic, and that working at creating a comfortable space was something she was trying to make time for.

> Anna: I've been working really hard at getting my home set up so I can have the feeling I used to have [in my old home]. I've been framing and hanging art and building in tools and support directly [into the home] as I've been unpacking so that I have spaces where I can go that are calm and nurturing and grounding that will bring me back to when I felt like I was thriving.

Anna's perspective is very relatable from one person to another with ADHD, about how a space that is cluttered and disorganized can disrupt executive functioning significantly and disrupt belonging in one of the most important places, home. A clean and organized space is ideal for setting the tone for a very calm and less distracting environment. However, the problem is that when we do not have the time, energy, or capacity for dealing with obstructions, it can turn into an endless cycle of knowing that things need to be different and better, but with no idea how or where to start. This can be referred to as a type of decision "paralysis" (Oroian et al., 2025) where executive functioning is disrupted if there are too many steps, or there is no clear goal to motivate taking on a large task. When faced with this "paralysis", rather than engaging in anything else productive it can turn into a full shut down of executive functioning where the

person with ADHD can only grasp at quick sources of dopamine, like scrolling social media or other time-consuming activities. This cycle can be particularly impactful on mental wellbeing and belonging to self as well, where if there is a disconnection from place then the question is, where does oneself belong?

Subtheme: Virtual Connectedness
Perception: Belonging in Relationship, Belonging in Place

The Ubuntu phrase of "it takes a village" has been understood as a message conveying that child rearing takes many people to create a safe, healthy environment for children (Reupert et al. 2022). While the villages have changed drastically and our society has been enveloped by more individualistic values, the ability to find a village of support has expanded in ways probably not fathomable to many of our ancestors. I am referring to how we can now find our villages worldwide with the freedom to connect with people almost anywhere with access to the internet and social media. This became even more apparent in the emerging crisis that became the COVID-19 pandemic in early 2020. I was fortunate that when I became a mom for the first time in 2019, my village lived with me. This meant that when social distancing measures required isolating us to our homes in efforts to keep ourselves safe, we had support that made managing this world changing shift easier for us. The world saw people come together in ways that we had not seen before where social media groups could share news and helpful information. People could ask questions or ask for help, and simply just connect with other people over the internet to stimulate our inherent need to belong and be social with other people.

I acknowledge that this research project would not have been as possible as it was without the technology that grants us this connection through virtual means. Recruitment and

information inviting people to participate in this research study was distributed through social media channels and shared publicly by others coming across the posters on their news feeds or receiving them as messages from a friend. I was able to connect and see people on camera using Microsoft Teams and recording our meetings together so that I could capture as much information as accurately as possible and have a conversation face to face with most participants.

For Ruth, virtual connectedness is a vital resource that keeps her connected to many communities as a neurodivergent parent, a mom to an autistic child with high support needs, a part of the 2SLGBTQIA+ community, and more.

> Ruth: I do a lot of things over zoom as much as I can. There's a couple really good community organizations for parents of special needs kiddos and they do these online zoom hangouts that are really nice to get together with other parents. Because my son's needs are so high, it can be really difficult to find peers and people that I connect to and feel safe with not only as neurodivergent inclusive, but also people that can handle my reality.

In the future Ruth has goals to pursue more post-secondary education, but right now her responsibilities as a full-time caregiver for her son do not suit the requirements for a lot of post-secondary programs. Hopefully, as technology advances, accessibility to remote education opportunities will become more available, as it is the reality for many caregivers of people with high support needs that work and education opportunities are very limited.

> Ruth: I've looked everywhere to find a program that's 100% online that I can do at night and they all require an in-person practicum, and I'm only able to work between 6 and 10 hours a week right now in-person.

The reality for Ruth is that even if she could arrange for support to provide care for her son in ways that would allow her to go to school and work towards her personal career goals, the cost of a suitable caregiver for her son costs between $45-160 per hour.

Social media has been a powerful tool that shares information quickly and brings together people from all over the world with the click of a button. Information consumed on social media, of course, needs to be taken with caution and complex reasoning to ensure that mis/disinformation is not being taken for truth. However, it needs to be acknowledged that it is likely that a lot of people who are now being diagnosed later in adulthood as neurodivergent stems from information they learned through social media and conversations that have demystified and destigmatized neurodivergence in positive ways.

> Anna: So, how I came to my conclusion [that I was neurodivergent] was a friend of mine on social media sharing lots of content [about ADHD] and the constant 'wait a minute, that's not neurotypical?' that whole thing explains me to a T…so, I sent him a message one day saying I'm relating to a lot of the things you're sharing and we had a really nice exchange. He talked about the process [of getting a diagnosis] …and he's like when you're ready for more conversations about diagnosis and process, I'm here to answer your questions.

Anna's experience is not dissimilar to my own. While ADHD was initially suggested by my post-partum psychiatrist in 2019, I did not look any further into it until I saw how many people on

social media were sharing their experiences of ADHD and found myself relating to them in ways that I could not deny. Given this research project, everyone knows I am very openly and unapologetically neurodivergent, but I started out quietly pursuing a diagnosis in 2020 and not openly talking about my ADHD with other people except for close friends and family.

There was a turning point somewhere before I decided on this research that keeping my diagnosis to myself was not working for me because of how aware I was of the negative rhetoric that was making rounds on the internet. While there are people actively trying to destigmatize and raise awareness about what neurodivergence really is, there are just as many people sharing negative opinions that diagnoses are rising because ADHD or Autism are "trendy", they are just "attention seeking", or "everyone's a little bit ADHD". I started to open up and speak out about my ADHD (and subsequently self-identifying autistic as well) and shared content that I thought was enjoyable and informative. Reflecting on this, I realize that I unintentionally (at the time) created a safe space of belonging for not only many close friends to explore their own identities and suspicions of being neurodivergent, but it also created a space for my mom and her sister to explore their own identities as neurodivergent Indigenous women. I occasionally get messages much like the one Anna sent her friend when she was initially questioning her neurodivergence and I will always welcome those messages in my inbox; ready to share any information that could be useful or lend an ear about something a friend is working through that could be challenging. However, I also recognize that I can only help when my own capacity allows it.

4.2.3 Theme: Motivations

Motivation includes what participants have experienced that has motivated or discouraged seeking out belonging; or experiences that have motivated them to create spaces of belonging for themselves or others. Motivation to belong can be particularly difficult for neurodivergent people, especially if prior negative experiences have set a precedent for expecting negative outcomes in the future. Alternatively, some people with ADHD can be very extroverted and get along well with many kinds of people, where belonging feels quite easy in the opportunities presented to them. A lot of resistance can be found in fear or unease of the unknown, perhaps not knowing what kind of mask they will have to wear as they enter a new social situation. On the other hand, sometimes motivation comes from spite (as it was jokingly framed by participant, Max) and the drive to do something simply because somebody said they could not. This component identifies subthemes related to *justice seeking/justice sensitivity* and the neurodivergent tendency to have a strong sense of justice. These are common traits of neurodivergence that may lend to the motivation to pursue change in the name of justice for oneself or others. The motivations of many participants also related to their role as parents working hard to *break the cycle* of trauma for their children and future generations and strengthening their sense of belonging. Finally, this section discusses the motivation behind the feeling of finding *your people and place*.

Subtheme: Justice Seeking/Justice Sensitivity
Perception: Belonging to Spirit, Belonging in Relationship

Justice seeking is very much connected to the skills and traits of demonstrating resilience through acts of resistance and the ADHD tendency to hyperfocus on a chosen goal. It is uncertain whether neurodivergent brains are simply wired to demonstrate more compassion towards equity and justice for others; or if it could be the higher likelihood of neurodivergent children to experience adversity, leading to a desire to address injustice for the sake of others experiencing similar adversity (Kandeger et al., 2025). There is research to support the notion that socioeconomic status can affect empathetic perceptions towards others whereby individuals who have experienced lower socioeconomic security demonstrate greater compassionate responses to the suffering or wellbeing of other people (Stellar et al., 2012). There are clearly limitations in the reach of my study reflected in the sample size of this research. While no conclusions can be made about Indigenous or neurodivergent people to say that they are inherently more compassionate and driven toward justice seeking endeavours, there is something to be said about the fact that every participant no matter what level of post-secondary education they had, were in a field focused on supporting people in their community. Bethany, Ruth, Mel, and Cara are all in health care related fields. Ruth aspires to go back to school in the future to enhance her training and education, supporting people in long-term care facilities when she has more resources to meet her son's support needs. Bethany manages a network of Indigenous health programs delivered in Ontario, on and off reserve in her region. Cara first became a nurse before returning to school to complete her master's and soon will complete her doctorate. Mel manages a program dedicated to supporting Indigenous cigarette and cannabis cessation.

Max is pursuing doctoral research on Individualized Education Plans (IEP) and how gender identity and stigma create barriers related to mental health care; Anna is self-employed providing consultation services to non-Indigenous employers on cultural safety and decolonizing practices. John and Doreen both completed their Master of Social Work to do work in their communities supporting mental health and wellness; and Leah will soon finish her Bachelor of Social Work in pursuit of a master's degree in the future while she continues to work with Indigenous youth in her community.

As the researcher, I can say for myself definitively that my intent with this research is very justice and equity motivated based on my experiences as an Indigenous person who descends from many family members subjugated to the residential school system. For example, my mother attended a catholic day school in her community as a child and has experienced racism and discrimination at many points in her life. I feel a responsibility toward elevating issues of justice and inequity for Indigenous people with the privilege I have, using not only my access to post-secondary education, but also the power that I acknowledge comes with being a fairer skinned individual. On the side of understanding myself and my neurodivergence, what I am compelled to do is not only uplift voices of disabled people but also continue the conversation that shares awareness for what ADHD is and is not. This work aims to help empower other people to advocate for themselves as neurodivergent people or advocate for their children and get the support that their parents may not have had as a child. What we experience certainly has to be a motivating factor in what we aspire to achieve and do within our communities.

Subtheme: Finding Our People and Place

Perception: Belonging in Relationship, Belonging in Place, Belonging to Self, Belonging to Spirit

Trying to piece together identity in adulthood is much more difficult than if one had been supported to connect and explore facets of themselves growing up. The Representative for Children and Youth (2021) focused on cultural belonging as a key domain of belonging that was absent for Skye. In fact, so many Indigenous people are intergenerationally disconnected from belonging to their communities and cultures, as evidenced by the legacy of residential schools and the 60s Scoop. The overrepresentation of Indigenous children and youth in the foster care system continues to perpetuate this disconnection despite policies and legislation that speak to an Indigenous child's right to belong to their community and culture. The Representative said, "research has shown that cultural continuity can prevent physical illness and suicide and is a major predictor of overall mental wellness and stability" (p. 64). However, the report further states:

> While Skye was in foster care, cultural connection appeared largely dependent on her placement. Her first foster parent was non-Indigenous, and Skye's social worker noted at the time Skye was not given much opportunity to attend cultural activities…In 2009 Skye was placed with an Indigenous family who had known her from the time she was three. While this family was not Dene, she was given an opportunity to explore Indigenous identity, spirituality and ancestry, while participating in and learning from local ceremony and practices (p. 69).

While this placement seemed to be the ideal place for Skye at the time, there was a heavy focus on planning for her permanency by way of adoption, and when she was no longer in that placement her cultural connections were once again severed.

Our experiences in childhood and throughout adolescence is so foundational to the identities we will eventually come to know as adults. For Skye, we saw that she never had the chance to put down the roots needed to form her sense of self and that may have motivated her seeking belonging elsewhere in unsafe places. Reflecting upon Skye's experiences in connection to my own, I acknowledge the privilege I had, knowing that even slightly different circumstances could have shifted my pathway in any direction. Despite our differing circumstances, I do not think our motivations would have been very different. Skye longed for what she did not have and so did I, and there was an absence of cultural identity for both of us. I think if Skye had the chance to connect to her cultural roots and community, she might be here today. Many people with the best intentions tried to help Skye in any way they could, but so much had already been done to affect her sense of belonging. By the time she reached adolescence, Skye's trust in others was not there, nor were the resources that should have been provided by the government responsible for her care. This is again reflected by Johnson, et al. (2020), who said the word "trust" came up numerous times amongst the 46 youths experiencing foster care that shared their experiences. Participants were distrustful of teachers and authority figures, uncertain if their best interests were truly being kept in mind. The authors said:

> For some participants who had experienced a number of school changes (as a result of home placement changes), it was difficult to establish productive and authentic relationships with peers and teachers; and past negative experiences and concerns about trust heightened their skepticism toward others at school and their intentions. (Johnson, et al., 2020, p. 6)

What is being described here about Skye's experience and the experiences of the youth who shared their perspectives with Johnson, et al. (2020), is that their opportunities to belong were diminished by the instability of the foster care system, thus affecting motivations to belong the more disruption they experienced. When presented with opportunities to belong Indigenously, Skye accepted them and was excited by them—and if they had been consistent throughout her stay in foster care it may have mitigated some of the negative impacts to her sense of self and belonging that accumulated as she grew older.

Although I was not connected to my own culture in my adolescence, I did have protective factors that gave me a sense of belonging enough to carry me through the trials and tribulations that come with being a high school student. I was fortunate to have a close relationship with my mother, who at the beginning of my transition into high school, became my only parent as my father left the picture. This is something that was an impactful loss for me as a teen, but I also recognize it as a tremendous gain for both of us. My father was our primary source of instability throughout the entirety of my childhood as his addiction and chronic unemployment kept us living in significant poverty. If my mother had not made that decision

for us to continue our lives separate from my father, I believe my pathway would have been different and not in a good way.

Instead, my mother saved us from drowning under his debts and control. I watched her bring us out of his financial debt and she got a job where a real liveable wage allowed for us to thrive as she bought her own home. She made sure I had every opportunity possible to engage in my interests, which I had found passion, joy, and belonging through music as a member of my school's concert and jazz bands. These opportunities paved the way for me to go to university, something I do not believe would have been possible without my mother's decision to separate from my father. I owe this acknowledgement to her and cannot express enough that the privilege of witnessing her be the strongest, most badass, independent Indigenous woman no doubt was influential in beginning the process of connecting with my Indigenous identity in university.

Exploring my Indigeneity from the lens of a student felt safe, and I gradually built the confidence to step out into the Indigenous community to experience it directly. However, once I began to test the waters of the Indigenous community around me, those experiences were not always pleasant or positive. Like myself, all the research participants were of mixed Indigenous and European ancestry, which comes with challenges on both sides of the coin (Indigenous and non-Indigenous). While the non-Indigenous side can be frustrating and harmful with experiences of covert or overt racism, micro-aggressions, tokenization, etc.; it is also difficult being on the Indigenous side when there's been disconnection from culture as there is a resounding fear of not being Indigenous *enough.* This can contribute to a feeling of

unbelonging in the Indigenous community due to the prevalence of lateral violence related to the concepts of blood quantum and the problematic belief that the amount of Indigenous ancestry one has determines the validity of the claim to be Indigenous.

In my early adulthood I experienced this from a well-respected Indigenous person in the community when I inquired about volunteering with their organization. Instead of being met with welcome, I was met with questions about my authenticity as an Indigenous person. Not only did this person look down on me and my claims to be Anishinaabe but tried to explain that I should be identifying myself as Métis. It was only when I presented my status card showing my membership to my Nation that she resigned from her argument and after that exchange I left and did not return. This sadly, is a frequently shared experience for Indigenous people of mixed race. These actions seem to be validated by "catching" the few people of notoriety who have claimed false Indigenous ancestry but comes at the cost limiting safe spaces of belonging for people who already hold some notion of unbelonging due to their severed connection to culture to no fault of their own. I am grateful that I persisted despite my negative experiences, because I eventually found Indigenous spaces that welcomed me and embraced me. However, there are many people that still may not have the motivation to seek belonging out of fear of rejection, limiting not only one's connection to self and place as an Indigenous person, but also can be harmfully limiting one's belonging to spirit.

Ruth spoke similarly about her struggles with connecting with her Métis community until she was able to get her official Métis citizenship.

> Ruth: I have struggled with embracing that [my Métis] identity a little bit because I feel like I appear so Caucasian. So, getting my citizenship was very empowering because I feel like if people question me, I can say the government says I am, so there you go.

However, it is disheartening to have to feel like you have to carry proof in your pocket to have your identity validated and Ruth said that she does not bring up her Métis identity often, even with close friends because of the way she has been received in the past when disclosing her Indigeneity.

Max shared about his experience about the complexities of navigating so many different identities that kept him from feeling like "a real person" because while pieces of him fit in some places of belonging, a lot of it was masking and concealing parts of himself from those around him. As a child, he said that connection to land and nature was something that gave him a sense of comfort and safety when he did not have that with his own family.

> Max: I spent a lot of time by myself and sometimes I had a cat that would follow me around. I really like bugs and spiders and that's where I was just very happy. All my happiest memories [in childhood] are just being alone in the forest.

A person hearing this kind of revelation might feel sadness or pity if they perhaps do not fully understand the significance of belonging to spirit and place. However, in my interpretation as an Indigenous researcher seeking deeper understanding of belonging, I can see where Max's spirit was called to the forest to find that safety and comfort when he needed it most. He, as a young child, could not make meaning in that way, but instinctually humans are drawn to find connection, belonging, safety, and comfort.

As an adult, Max's motivations to belong to himself in a genuine way unfortunately came at the cost of losing his belonging in relationship to his maternal family, saying "my white family disowned me when I came out to them, which was really hard, but it was also an extreme gift because it allowed me to start pursuing my Indigeneity". Max said during that time he connected with his Indigenous paternal aunt and other members of his paternal family who welcomed him and supported him in all aspects of his identity. He also met an Indigenous editor who never questioned his Indigenous identity and through her, introduced him to another trans-autistic Métis writer who approached Max to illustrate a story he had written. Max said, "I had never felt a connection to a story like I felt with this. I felt so seen…just so connected to this person". Max had no frame of reference as an adult that another transgender person who was also autistic who was also Métis existed, but when they finally met them, the connection was instantaneous.

While culture and tradition may not have been experienced during childhood, we as descendants of the original people of those territories still hold memories of those lands within our blood memory and that is evident when we are able to return to those places. Leah said that when travelling to the Northwest Territories in the summer a couple of years ago she met many relatives for the first time and immediately felt at home, a feeling that she lacks in the urban Indigenous community in the city she lives in.

> Leah: I actually felt at home for once, like I could just go to cultural events [in the community]. I got to go where my great-grandmother used to trap wolverine and go out on the river and do these things that really brought culture back for me.

Being in an urban Indigenous community where there are diverse Indigenous people from many different cultures is wonderful in its own way, with many opportunities to engage with different kinds of cultural events and ceremonies. In other ways it can be hard to connect with the land and culture because of our roles in the community. Leah is a social worker, and she said that it is hard for her to engage in the Indigenous community in her city as she does not want to feel like she is intruding upon families that she works with if she were to come across them at a community event. That lack of belonging may have become more evident for Leah in those moments where she experienced travelling back home where she said, "no one sees me as a social worker there, so I could just be me, you know?"

Cara and Mel shared similar positive sentiments about their connection to their respective communities. Although Cara did not directly live in her Indigenous community, she lived close by and was fortunate to have connection to many of her family members there, visiting frequently. She said, "I definitely had a strong sense of belonging in community and it's one of those places where everybody knows your name and knows your family, knows your mama, you know like that kind of thing". Mel also spent her early years in her home community, and said that her family ties are very close, giving her a sense of belonging to her community even though she moved away from the community later in her childhood.

> Mel: I consider myself having grown up in my community, even though I moved away when I was a little bit older… A lot of my cousins still live up there; I talk to them regularly and go back and visit.

Doreen spoke fondly of having connection not only to her Cree community in Saskatchewan where she travelled regularly to visit during her childhood; but also shared that being raised on

Vancouver Island, she was fortunate to have a strong connection to the Indigenous community where she still lives and has been treated as one of the community her entire life.

Connecting to the neurodivergent community as a late or self-diagnosed individual can be complicated for many similar reasons. For one thing, an undiagnosed or self-diagnosed individual may have a lot of internalized fear and doubt that they are "pretending" to be neurodivergent. Which is somewhat ironic, because *impostor syndrome*, in which a person feels deep internalized anxiety that they are misrepresenting themselves is commonly (although, not exclusively) experienced by people with ADHD (Saline, 2023, para. 4). The impostor syndrome that may be experienced by self-diagnosed individuals stems from pervasive negative rhetoric that stigmatizes self-diagnosis because the people self-diagnosing are "not medical professionals". They are often viewed as "attention seeking", and other harmful sentiments that are invalidating and discouraging enough to keep neurodivergent people from seeking greater connection to themselves and relationships with other neurodivergent people. Most literature that speaks to the issue of people who feign their symptoms of ADHD focuses on malingering, in which a person exaggerates symptomology to their physicians in pursuit of prescribed ADHD medications (Patel, 2023). This concern, given that stimulant medications prescribed for the treatment of ADHD are controlled substances that carry concerns of dependency and misuse (p. 2). This may be a contributing factor to the hesitancy of some physicians to refer patients for ADHD assessments; however, these stigmas keep people with actual untreated and undiagnosed ADHD from accessing potential support for their neurodivergent needs. It is an unfair assumption that keeps people from feeling comfortable with identifying themselves as neurodivergent, when some of the motive to seek assessment to

confirm their suspicions is to simply validate their belonging within the neurodivergent community.

Scrutiny of self-diagnosed individuals is also connected to the ability to use social media platforms as a way of garnering large audiences of attention; and for some, the benefit of financial gain. Seeking power through influence is nothing new, but given the reach and accessibility of social media, influencer culture has evolved much more quickly than perhaps what the world can keep up with. Holward (2025) says that "the rise in diagnoses [in ADHD] is mirrored in the increase in ADHD-related social media content" (p. 1). The social media platform TikTok particularly has been effective in sharing information through their short-form video format in which anyone can make content anywhere from 30 seconds to 10 minutes, providing bite-sized amounts of information for people to consume. The other way TikTok is effective is that viewers can interact with content through comments and other functions known as "stitching" or "dueting" in which a person can record a direct video response to a person's video to share their own perspective. This creates a one-sided dynamic of belonging in which some people find connections and belonging through a parasocial kind of relationship with these content creators.

Holward (2025) points out that increasing privatization of health care systems (specifically the United States, but also relevant in the Canadian context) create barriers to adequate mental and physical health care, which puts a lot of pressure on people to seek validation from other sources when diagnoses are unattainable. This can become problematic, where there are vulnerable undiagnosed neurodivergent people seeking support and may have these parasocial bonds with "influencers" who create social media content for the purposes

commercial and financial gain. Koay et al. (2024) report that brand collaboration with influencers is highly lucrative, saying that "the relatively deep personal relationships that social media influencers develop with their followers have made their influence more authentic and potent than that of conventional celebrities" (p. 2). Pseudo-pharmaceutical companies have particularly taken advantage of this by partnering with popular neurodivergent content creators to market unregulated, non-prescription supplements that claim to treat ADHD symptoms without scientific evidence proving its efficacy (p. 3). An article published by *The Guardian* in 2023 claimed that in the UK, marketing firms took advantage of a national shortage in ADHD medication to push alternative supplements (Das, 2023). At best, people are being taken advantage of financially and they buy into something that is ineffective, when they should be supported by a medical practitioner. At worst, however, this is modern day "snake oil" that has the potential for causing harm if these supplements were to cause detrimental health side effects with little consequence to the brand or the promoter with many saying that these practices are unethical, exploitative and irresponsible (Das, 2023, para. 9).

Is it possible that a participant who identified as self-diagnosed in this research was untruthful about their neurodivergent claims? Sure, but does it matter? Not really, because there was nothing significant to gain from their participation, aside from the very small financial honorarium provided. Validating self-diagnosis is a small act that I as a researcher can provide to support people who have experienced barriers to accessing assessments and give a person a sense of belonging in the community that may support them in ways that helps them get to a clinical diagnosis (if that is their wish to pursue). It is also not my business to deny a person's self-identification because they are the ones who know themselves best. Furthermore, I do not

have the clinical qualifications to diagnose a person with ADHD, therefore, I have no more authority to invalidate a person's self-diagnosis. To invalidate self-diagnosis within the scope of this research would, in my opinion, be complicit in the perpetuation of creating spaces of unbelonging which is the antithesis of intention of this research.

Related to feelings of impostor syndrome, another limitation that may discourage or demotivate a neurodivergent person from seeking connection in the neurodivergent community is the common experience of anxiety regarding uncertainties. Uncertainty can cause a lot of stress and anxiety for neurodivergent people, partially because of the inability to anticipate how they will be received and accepted in those spaces, but also partially because of the uncertainty of the space and environment itself. The anxiety of uncertainty can be so significant that a person may decide that something new and unfamiliar is not worthwhile, preferring to remain isolated and in their spaces of safety and comfort, therefore limiting opportunities for belonging in relationship. Some of this hesitancy is natural and many neurodivergent people are very comfortable and happy in their own spaces and places of belonging. However, some of this hesitancy comes from the trauma of experiencing rejection and unbelonging in spaces in the past and fear of these experiences recurring. This is known as rejection sensitivity dysphoria (RSD), described by Asselt et al. (2025) as "…profoundly overwhelming, exhausting emotions and thoughts related to rejection and criticism…these responses were triggered by either explicit and ambiguous, anticipatory and reactive rejection and criticism" (p. 2706). Arguably, these kinds of reactions are more likely to occur in spaces where neurotypicality is the norm and expectation, and this feeling of failure or criticism may stem from a failure to maintain the appropriate mask for the environment.

Coincidentally, a lot of late-diagnosed neurodivergent people may find that among the people they have close relationships with, there is a likelihood that those people are neurodivergent themselves (whether either of them know it or not). Our most comfortable relationships are the ones where we do not have to wear our masks, where we are able to be unapologetically ourselves. Bethany shared about how, after she was diagnosed and opened up about her neurodivergence at work, it opened up the conversation that quite a few of her colleagues were also neurodivergent and it created a space of belonging and bonding amongst them.

> Bethany: We talk a lot about it [being neurodivergent] at work because there are quite a few of us. Some of us are diagnosed, others are self-diagnosed. We have huge neurodivergent tangent rants and conversations almost daily about so many different topics.

Bethany fondly shared how much she enjoys how different each of them are in their "neuro-spiciness" saying that one of her colleagues loves to hyperfocus on new things and will share everything she's learned with them. There are others with fewer hyperfocus tendencies, she said, saying "we all have our strengths which create one big superhuman ADHD superpower when we're all together. It's no longer tabooed to say at work that you have ADHD".

To be clear, neurodivergent people do not *only* get along with other neurodivergent people, but it is really dependent on the other person's ability to provide a safe space of belonging. According to Hee et al. (2024), researchers have been examining intimate relationships through the lens of attachment theory, citing that a secure attachment style bonds between romantic partners appear to have higher relationship quality and positive

marital outcomes (p. 229). This secure attachment is demonstrated through behaviours falling under three categories which Hee et al. describe as: *accessibility,* referring to the emotional availability partners provide to emotionally support each other; *responsive* behaviours in which partners demonstrate attentiveness/awareness to have their partner feel seen and heard; and *engagement* behaviours in which partners demonstrate a level of emotional investment in their relationship together (p. 230). I jokingly refer to my husband as the most neurotypical person I have ever met, not that he is a better functioning person than me, or that he is an unflawed individual. He simply experiences nothing that diverges from "typical" in ways that affect his executive functioning and mental wellbeing to the extent that I do. We met and began dating five years prior to my diagnosis, and he may very well have been a factor that masked my undiagnosed ADHD (in ways I would consider positive). We have common traits, like our introverted and reserved natures. We share the same values and worldviews and enjoy a lot of the same interests in movies, games, and other nerd culture. He gave me a safe space where I did not have to mask (even though I did not know I was masking) and I could always rely on him for support when I was going through difficulties of burnout and overwhelm in my work or other personal matters. Although he does not always understand or relate to some of the ways that I am impacted when it comes to my sensory needs, or the emerging neurodivergent tendencies of our son, he is endlessly supportive. He encourages me to do what I need that is best for me and when I am able to communicate what I need from him he will always respond.

Mel also spoke about her relationship of 10 years, saying her husband was one of the first people that encouraged her to pursue an ADHD diagnosis. She said that he noticed things that she struggled with that maybe she was unaware of.

> Mel: He didn't know anything about ADHD when I started the diagnosis process, but he was like, 'clearly something is bugging you' and if you feel like it would be helpful for you [to get diagnosed] then you need to do that, and I can help you do that.

While there are very strong connections that come from neurodivergent people interacting with each other, it is not the neurodivergence that bonds people, it's the way people demonstrate how they understand the other person. People can bond over any point of connection between them and then demonstrate empathy and understanding to that person's needs in affirming, non-judgmental ways. Cara said that with her husband she finds the most challenging element of their relationship is the dynamics between her neurodivergence and his neurotypicality. However, they have a connection to each other coming from very diverse but intersectional backgrounds. She grew up in a small town in the Northwest Territories, and he grew up in a large suburb of a city in a country in South-East Africa. They both grew up in very different environments geographically and culturally but with similar socioeconomic experiences and strong connections with community and family. Connections that they share together with their three children.

Subtheme: Breaking Cycles and Raising Warriors
Perception: Belonging in Relationship, Belonging to Spirit, Belonging to Self

Children learn a lot about parenting simply from the way they were parented. We learn from their love and encouragement, but sometimes we also learn what we do not want to do when we are parents ourselves. Being an undiagnosed child with ADHD, this can be especially apparent where indications of need and struggle may have been there but never identified, and the support never given because nobody talked about it as children growing up in the 90s and early 00s. As mentioned previously, the majority of participants in this study identified as

women or trans-AFAB, many of whom were diagnosed or self-identified as having ADHD after becoming a parent. In some circumstances this occurred when their own children were identified by their schools and diagnosed with ADHD in middle-childhood or adolescence. In other circumstances, it was previously used tools and strategies used for coping with executive dysfunction that became ineffective in the significant transition from pregnancy to parenthood that eventually revealed the masked symptoms of ADHD. Regardless of the circumstance in which diagnosis revealed itself, diagnosis overall and being able to identify as neurodivergent had a positive impact on participants in a way that could be described as freeing or enlightening.

Parenting while neurodivergent was not originally a question that was provided in advance with the semi-structured interview questions presented to participants, but it was a naturally emergent conversation. Participants were asked, knowing what they know now about their neurodivergence and sense of belonging, and what they experienced growing up how that has been reflected in the way they were parenting (or parented) their children? While the discussions about parenting approaches all varied amongst participants, the overwhelming commonality among the conversations was the way neuro-affirming practices and approaches were centred in supporting their children's needs overall.

> Bethany: I think if I had the diagnosis and having had better supports in place with school, relationships, friendships…just having somebody understand what I couldn't articulate [would have helped as a child]. I find this is why I advocate so much more for my kids because I can identify their body language and can understand what they're feeling like. It literally brings me back into my body and into those feelings when I see

them struggle with something related to the ADHD and I feel like I need to over advocate for them now because I know exactly what they're going through.

Anna said that she makes a lot of parenting choices reflecting on the things she did as a kid that she thinks was (unknowingly) helpful for her ADHD, such as dance. She said, "dance provided me tons of opportunity to hyperfocus where I could quiet my mind…working on when I breathe, when I turn, when I jump and how that was meditation". When Anna's daughter took to dancing with the same kind of connection and passion, she said that providing her daughter with those opportunities to dance was important to her, observing that her daughter has many of the same ADHD tendencies that she has.

Living in a multi-generational home where she and her daughter are living with her parents, Anna says that she is very aware of how differently she is parenting and how differently they are parenting as grandparents, and at times it can be challenging and frustrating.

> Anna: I find that I have to frequently undo the things he says [to his granddaughter]. Like her and I were having a moment the other day when she hurt her foot and was overstimulated and was sitting in tears; my dad came upstairs to check on us, and he told her don't cry. I waited until he left and said 'don't do anything granddad just said'…so, it's a lot more steps in my parenting.

Understandably, there's a generational gap where many of our parents had even less awareness of neurodivergence when they were children and young adults and to come to that understanding might be difficult when their adult child has told them about their recent diagnosis. It is a process of unlearning the notions that have been ingrained for too many

decades that autism is detrimentally bad, and ADHD is not real. Max is working on shifting this within his own family and says he's so proud of his daughter, saying "my daughter will tell anyone who asks. She'll be like 'I'm autistic' or 'I have ADHD'. She's not ashamed of it at all which makes my heart so happy".

Mel is not a parent, but given that this topic of conversation had been quite prevalent in other interviews, I asked her if she had any reflections of how her parents raised her and if she were to have a child in the future would she do anything differently? This conversation was very different from previous conversations, and it is important to raise this and connect back to Indigenous perspectives on disability and differences. Mel's early years were spent in her community close to much of her family. She was diagnosed when she left her community to attend university, the first in her family to be identified with ADHD, but not the last, as many family members afterwards began receiving diagnoses.

Reflecting on the way she was parented, Mel said as a child she was extremely curious and felt that her parents did a pretty good job with the way they parented her. She was a very talkative child, a quite common trait for neurodivergent girls with ADHD, yet still often overlooked by teachers. Mel's curiosity sparked a lot of questions with her parents wanting to know why or how things worked, why things were done in certain ways, etc. She said, "[my parents] never shot me down, they were never like 'that's not important right now'". Instead, they fostered her curiosity in moments where they may not have had an answer but responded with "let's find out" or "let's figure it out and then talk about it". This may not seem very significant, but these small actions in moments of wonder gave Mel a safe space to question things that may not have made sense, knowing that it is okay not to have the answer, and how

to navigate the process of knowing and understanding. This is how Mel says she learned to interact with children as she grew up and is how she would parent her children in the future.

> Mel: A lot of my [non-Indigenous] friends are moms, and people tend to think that I'm funny in how I interact with kids…but I'm treating them the way that I would expect my family to treat me. To us, culturally, kids are people. They're not less than just because they're young. They're a full person, so I'm speaking to them like a person. I'm engaging with them.

By providing a safe space for Mel to be curious, to be excited, to be outgoing, her parents had no reason to look for problems or issues with her attention. They accepted her as she was and supported her through her learning and growing journey through childhood and ADHD only really became a problem when she was in a completely different environment, specifically a mainstream academic environment. This is not to say that growing up in an Indigenous community means that ADHD does not have an impact and is not disabling in that environment, many other contextual factors will always influence and impact how our brains develop and how we process neurologically.

Chapter 5: Act, a Conclusion that is only the Beginning

It is overwhelming to think about drawing this work to a close, when it has only just begun. This conclusion, in a sense, is a place where I want to lay out my blue sky thinking and perhaps manifest what kind of future I would idealistically like to see. Realistically, however, I must be truthful about the feelings of resignation and pessimism about the uphill battle before me, should I choose to pursue this work further. The systemic problems we face in our society are deliberately complex so that deconstructing them is more difficult. The solutions to these problems, in my opinion are simple and they all point to the importance of belonging. To be well, people need to belong to a secure, safe, home environment, somewhere to physically belong. They need to be able to access necessities for living, education, and health care—all of which involve belonging to a community to access these resources. The wealth exists, the resources exist, but greed controls them.

However, pessimism aside, my motivations are not diminishing. If anything, they are growing as I have started to build this community of belonging with the voices of nine (9) other Indigenous neurodivergent people who all believe in this work and saw importance in their participation. I am grateful to have the support of my family, friends, supervisors, and colleagues. I have never been so full of support and encouragement that this work can and should continue. As I move forward, I think about how this work has and will affect my son as he grows up into whomever he wants to be. In real time, as I write this conclusion, I am experiencing exactly why conceptions of normal, and the medical model need to change as I advocate for my son's wellbeing while we navigate his first years of elementary school. I am

also seeing hopeful change on the horizon for the many Indigenous people who may see validation for their Indigeneity in the future—and hope for my son who may be eligible for registration with our Nation if amendments to the *Indian Act* come to fruition.

Now it is time to let this work emerge and start to grow. This is a conclusion that is the beginning of another chapter. Acknowledging that the circle I have navigated through Anderson's (2016) Recognition of Being Framework does not end, I must pause and reflect on the path forward identifying my responsibility and asking myself, how must I act with the knowledge I have gained? My reflection starts with thinking about my past and my son's future. I think about what focusing on belonging can do to shift mental health and wellbeing and why we need to do better by our children and youth now, not later. I consider what belonging means in the context of being Indigenous in the spirit of addressing lateral violence. We struggle enough fighting against the systems that oppress us and pushing each other down only benefits the colonizers. It is time for lifting our Indigenous brothers and sisters up in the spirit of healing, fostering belonging, and making space for each other. Finally, beyond my responsibilities and my intentions, I offer the opportunity for readers to take responsibility for this work as well. Taking in the knowledge alone is not enough. For readers, I offer suggestions of how they can translate knowledge gained into active participation toward creating and maintaining spaces of belonging.

5.1 Pause and Reflect

The change we may want to see in the world, in the systems that affect us, may never be noticeably significant. However, there is one place where I am certain that I see noticeable change that gives me hope for a future of inclusion and belonging—it lies within my son and his

generation. My son is the reason my world changed, giving me a new perspective on myself and my identity. He is a mirror of my former child self, both inside and out.

Figure 6. My son in 2021(left) and myself in 1990 (right)

There are feelings of grief and loss for what I missed in my childhood, but as my son grows older, I see so many parts of him that are healing my younger self. I am able to foster his sense of belonging, understanding now what I should have had at his age. I try hard to give him language and reasoning that makes sense for him rather than placing expectations upon him to obey commands without question. His motivations are not affiliated with a fear of emotional or physical repercussions, and he knows there are no demands he must meet to be valued, loved, or cherished—all that is expected of him is that he leads his life with kindness.

The more I know about my needs, the better I can meet his. This work has been part of processing my diagnosis and healing from my experiences of unbelonging. I chose to process and work through parts of myself through research and knowledge sharing because I know that

my personal healing is not enough, and sharing my one perspective alone is also not enough. By extending the opportunity to share their own experiences, I hope my fellow neurodivergent Indigenous participants have had a chance to experience some healing for themselves, while also contributing to a greater wealth of knowledge that will be shared with others. One participant who reviewed a portion of this work containing excerpts of her story said, "I have to admit it was a little bit confronting and sometimes made me a little bit sad, but I'm really happy this will be part of your thesis". Only a few participants opted to review portions of this work prior to its completion, so I hope that similar sentiments would be shared about how the other stories have been presented.

From the stories shared by participants, I speak to ways in which their sense of belonging has been limited in ways related to their intersecting identities of being neurodivergent and Indigenous. However, my intention is that this has been framed and will be received in a way that demonstrates that internal neurodivergence and Indigeneity are not the shortcomings. The limitations come from external influences that are largely outside of the control of the individual. Those external influences can be changed and modified to accommodate the individual with collective effort of family, peers, community, government, etc. Belonging can be fostered for others without alienating those already within the space and the strengths of these beautiful neurodivergent Indigenous people are highlighted in this work to demonstrate ways they can and do contribute to spaces of belonging with their own talents, skills, knowledge, and passions. This is beautifully expressed by Bethany, who states:

> The biggest part of it [belonging] for me is just the acceptance piece of it. Feeling accepted no matter what, for who you are. Listen to everybody's stories, right? Like just

having the ability to talk and feel validated and accepted for whatever it is and being able to share and listen openly with a kind heart.

Taking this learning to heart, what could spaces of acceptance and belonging look like in the future?

5.2 Implications for Mental Health and Wellbeing

The stories shared by participants demonstrated how adaptability and masking become a tool for survival while navigating the education system, workplaces and, for some, even just trying to safely exist with family. This applies to not only masking neurodivergence but also cultural identity, gender identity and sexual orientation, and masking other co-occurring disabilities. Furthermore, there is significant shame and stigma associated with the burnout experienced when masks no longer become tenable; sometimes, this burnout can even be life threatening. Research has shown that adolescent and young female women with ADHD had a 2.5 times higher risk of experiencing major clinical depression comorbid with ADHD leading to higher rates of suicidality (Furczyk & Thome, 2014, p. 154). Poorer mental health outcomes are not a result of the ADHD itself, rather it is the expectation and pressure of the neurotypical environment that becomes unbearable.

I have done a lot of tough jobs over the course of my career including child protection social work, bearing witness to families of missing and murdered Indigenous women and girls, and investigating cases of critical injuries and deaths of children and youth in British Columbia. Whenever I am asked about what I do for a living I am almost always met with a response of "that must be so hard, that is something I could never do". When I respond, I acknowledge that yes, they are very hard jobs—but at the end of the day working with children and families,

listening to their stories, validating their needs, and finding the truth in pursuit of justice has never been in question for me. One hundred percent of the time when I have burned out in any job it has been the hierarchy, politics, and misalignment of values with the colleagues and superiors I have had to work with that are the problems. My strong sense of justice tends to overpower my internal filter, and what I have learned working within both Indigenous and mainstream governmental organizations is that speaking truth to power is not often appreciated. Eventually, I feel pushed out the door because I can no longer safely belong in those spaces without an ironclad mask.

What I have come to understand the most about myself related to my neurodivergence connected to mental health and wellbeing, is that when my sense of belonging is secure and positive, my mental health and ADHD symptoms are mitigated. That is not to say that belonging is a cure to ADHD, I will always have ADHD in the sense that my brain will always be wired the way it is. What I am saying is that I see the ways in which belonging is medicine. I know first-hand that I have excelled in learning environments that have given me a strong sense of belonging. I floundered at a large university in my early adulthood and then I thrived when I attended NVIT. Even through this program, and writing this thesis, what carried me through all the struggles to make it to the finish line I must credit to the dedicated Indigenous faculty that helped me get here. When my aunt passed away during the early days of the COVID-19 pandemic I felt the need to step up to support my mom and her sisters and help them navigate systems that I was already very attuned to as a former social worker. My instructors that term not only gave me grace on the work that I needed to complete for my courses, but I even

received a care package and condolences from the school of social work. I've never forgotten that.

In March 2025, I delivered a webinar at the National Summit on Episodic Disability and Employment, hosted by Realize Canada[7]. My presentation was about fostering belonging in the workplace with an audience of hundreds of employers, supervisors, and human resources specialists. Much of my presentation was not based on my knowledge from academic research, rather it was based on the experiences I have had throughout my career that were good examples of belonging and those that were not. After introducing myself and giving a brief summary of my story and qualifications to speak about this topic, the first thing I led with was a quote from Mister (Fred) Rogers. *This Beautiful Day: Daily Wisdom from Mister Rogers* (2024), is a compendium of quotes that I came across last year and looking through this book there is no shortage of quotes on belonging, demonstrating how much he valued each and every person he met. The quote I chose for the presentation was, "our deep sense of knowing that we are cared for is probably the most important thing we human beings have for coping with the perpetual changes in our bodies, in our lives and in our world around us" (Rogers, 2024, p.10). I chose this quote to acknowledge that everything is changing quickly around us, faster than we can even comprehend sometimes—and while belonging is a complex and nuanced concept, it often gets overcomplicated and shrouded by political discourse. Rogers makes it simple, we need to be cared for by others, and we have to care for others in return. He

[7] Realize Canada is a national non-profit advocacy organization, promoting the social inclusion of people living with HIV and other episodic disabilities by leading a network of employers, insurers, rehabilitation providers, representatives from community organizations, and government stakeholders for advancing social inclusion and financial security for people aging with chronic illness (Realize Canada, n.d., para 13).

demonstrated the importance of belonging in simple digestible ways for the sake of supporting young children to develop an understanding, but arguably I think we need to consider going back to the basics even as adults.

Children's shows like Mister Roger's Neighbourhood (1968-2001), and even more modern children's entertainment like Bluey[8] (2018-present) and Ms. Rachel[9] (2019-present) tell children that they matter and those messages do not become irrelevant as they become adults. They still matter at every age, and I think many adults do not hear this enough. Another quote from Rogers says, "whether we're a preschooler or young teen, a graduating college senior or a retired person, we human beings all want to know that we're acceptable, that our being alive somehow makes a difference in the lives of others" (Rogers, 2024, p. 231). Watching children's shows with my son (both from my childhood and his) is just as enlightening and important for my learning about belonging as much as doing this research and bearing witness to the wonderful neurodivergent Indigenous storytellers portrayed here. Furthermore, by consuming this media with him, I can communicate with him my interpretation of these messages in real time, sharing my understanding of belonging to help inform his.

[8] "Bluey" is an Australian animated children's program featuring anthropomorphized dogs navigating their world much the way we do as humans. Bluey, her sister Bingo, her mother Chilli, and father Bandit are a family of Heelers, and the series features many different breeds of dogs, representing diversity in different ways.

[9] Rachel Accurso, "Ms. Rachel" is an American children's entertainer on YouTube focused on early childhood development. Accurso originally started this in response to supporting her own toddler's speech delay. Her platform has grown into the millions and has become a household name for many families of young children. Accurso has been viewed as controversial due to her unwavering use of her platform to speak out about the Palestinian genocide in Gaza.

Bluey for example, has an episode focused on a young boy, Jack (a Jack Russel Terrier) with ADHD[10] on his first day of school at Bluey's kindergarten. Throughout the episode it is evident that Jack struggles with things like impulsivity, sitting still, forgetfulness, and other very outwardly visible signs of ADHD. However, what Bluey does differently than other mainstream media representations of ADHD is that they take time to show Jack's internal struggles as well (and they do it very well in just a 7-minute episode). Jack's little sister Lulu says things like "Jack can't remember anything" and "why can't you do as you're told?" (Brumm, 2020). Viewers can visibly see his emotions as he quiets himself and starts to look saddened by hearing these things said about him. As he starts to make friends, he's asked by one of his peers named Rusty, "why did you come to this school? Was there something wrong with your old school?". Jack responds "no. There's something wrong with me. I'm not good at doing what I'm told. I can't sit still, and I can't remember anything…like numbers or letters or my hat". After a few seconds, Rusty shrugs and says "well, you're really good at playing army". In one single statement, Rusty has made space for Jack to make him feel like he belongs in multiple ways. Firstly, he does not invalidate Jack's feelings about what he struggles with. Secondly, he moves on very quickly by highlighting what he likes about Jack and focuses on what he thinks Jack is good at. By the end of the episode, as Jack is picked up from school you can see him run to his dad with his tail wagging, demonstrating happiness.

[10] Bluey, Season 2 Episode 16, "Army"

Figure 7 "Bluey" Season 2 Episode 16

Watching this episode with my son was a window of opportunity to talk to him about my ADHD and what I thought about Jack's story. The context of Jack is important in making it understandable for him. Likewise, if a neurotypical adult were to ask me to help them understand ADHD, I would not refer them to my chapter talking about the DSM-V and the medical model, nor would I go into the discussions about normalcy being an ableist and white supremacist concept (not yet anyway). While they are important discussions, that is not the understanding they are seeking in that moment. I might instead recommend they watch that episode of Bluey as a very simple, clear representation. Just because it is made for children, does not mean that it is not a valuable way to learn things as an adult. I want to be clear that representation in children's media such as this is not a dilution of ADHD for the comfort or acceptance of abled people. Primarily, Jack's representation is for neurodivergent children to see somebody relatable like themselves. Jack tells children like him that the struggles they experience are real and valid, but they have strengths and abilities too that outweigh those

struggles. Using it as a teaching tool to enhance other people's understanding is a secondary benefit.

5.3 Implications for Children and Youth

Neurodivergent children and youth are much more likely to experience bullying from peers. For children with ADHD, literature shows a high risk of children with ADHD being involved in experiences of bullying both as the perpetrator and the victim (Mastrokoukou et al., 2025). Mastrokoukou et al. (2025) speak to the ways in which inattention, hyperactivity, and impulsivity affect a child's social functioning, leading to precarious friendships, poorer quality relationships, and mean that children with ADHD are approximately four times more likely to experience peer rejection compared to their neurotypical peers (p. 3). In the context of considering the participants of this study here, none of them were identified with ADHD during childhood. Meaning that they not only had a higher likelihood of experiencing these social difficulties during school but also had no explanation or way to support these difficulties because they were overlooked.

More attention needs to be paid to appropriately screen and identify children who may have more internalized manifestations of ADHD symptoms than the external hyperactive traits that are more often noticed (and other neurodivergent conditions). Some of the participants have children who have been identified and diagnosed with ADHD, leading to a connection and recognition of neurodivergence within themselves. This awareness is beneficial because they are now able to identify their children's social-emotional struggles in relation to things they may have experienced themselves as children. As I said before, being more attuned to my own neurodivergent needs has been an important part of becoming an effective parent to my son

who very much has evident neurodivergent traits like me. However, for myself and Anna, we both recognize the neurodivergence in our children, but they are not clinically diagnosed with ADHD. In fact, I do not believe my son is necessarily on the spectrum of ADHD, rather he is more aligned with the autism spectrum. I do not talk about autism much in this work because I primarily focused on participants with ADHD and my own clinical diagnosis of ADHD. However, in the years since receiving my ADHD diagnosis and the learning I have done with this research and learning about neurodivergence in general, I self-identify as having a combination of ADHD and autistic tendencies—sometimes referred to as AuDHD in the neurodivergent community (Craddock, 2024, p. 2162). I have been asked if I am planning to pursue a diagnosis for myself, or even my son. Which, honestly, I am uncertain about because I can identify us on a spectrum of relatively low support needs. My son is incredibly smart and does not have any identified concerns academically since he started school last year. However, he has some social-emotional needs that require more support from us.

Supporting his needs proactively is already proving to be a challenge, demonstrating to me that his needs must escalate to the point of causing him consistent distress (potentially to the point of causing long term harm) before his pediatrician will even consider referring him for any kind of assessment. While his pediatrician was responsive to ruling out any medical concerns, it has been difficult to fully discuss my rationale for why I wanted to possibly pursue an autism assessment with my son present in the room. I do not see the social behaviours my son exhibits as problems, but I do see them as indicators of future needs that could be supported proactively. The doctor was very centred on the “pathological” and that there is nothing in his mind that meets any clinical basis for thinking about autism or ADHD, just that

my son was a more “slow-to-warm-up” type of child. I felt like the pediatrician perceived me as looking for a problem by suggesting autism, but I am not. I am seeking validation for the way I already know how my son’s brain diverges from the typical and how I can only help him to a certain extent, drawing on my own knowledge and experience. What is most frustrating is that I come to these appointments as a parent who knows how to speak the clinical language of disability. Meaning, that I am able to communicate my concerns using the kind of language that a practitioner would use. It makes me consider how a parent must feel without the foundational knowledge of what their child might be going through and without knowing the clinical language of pathology and being told there is nothing wrong. Without that language, how does one advocate for further support? Where do they go without a diagnosis after being told nothing is wrong, although the parent is struggling with certain things that could be better supported with somebody with knowledge and expertise on the subject?

Currently, my son’s first-grade teacher has been a good fit for him. She has been responsive to discussions about my own experience of being neurodivergent and how he is undiagnosed but has a lot of similar neurodivergent tendencies like me. However, I worry about my son as he gets older and moves through the education system, experiencing different teachers with different styles of educating may not align well with his needs. This concern comes directly from my own experience throughout my education. If I had the right teacher, I was a great student, but a poorly fitting teacher caused me to shut down and disengage. This is a pattern that I can see from my early grade school years all the way through university. They were not necessarily a bad teacher, but they were not a good fit to meet my learning needs, and nobody identified that I had learning needs that were divergent from my peers.

My son's teacher agreed with me that the pediatrician may not be clearly listening to what I am requesting and that she sees the social-emotional behaviours that I do. However, the pediatrician seems focussed on the fact that I have a clinical diagnosis of ADHD, but no formal diagnosis of autism. He requested the teacher complete the SNAP-IV- Teacher and Parent Rating Scale questionnaire related to identifying indicators of ADHD in children, which the pediatrician knows will not identify any significant concerns. If the pediatrician denies any need for identification now, without recognizing that he may he need additional supports in the future, they may not be afforded to him without psychoeducational assessments or clinical diagnoses. This is because the Ministry of Education and Child Care (MECC) is grounded in an eligibility-based system for developing and implementing individual education plans (IEPs) for children with learning needs in the classroom. The DSM-V characterizes criteria for a level 1 (mild support need) diagnosis of autism spectrum disorder as:

A) Persistent deficits in social communication and social interaction across multiple contexts.

B) Restricted, repetitive patterns of behaviour, interests, or activities, as manifested by at least two of the following, currently or by history:

1. Stereotyped or repetitive motor movements, use of objects or speech.

2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns.

3. Highly restricted, fixated interests that are abnormal in intensity or focus.

4. hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment.

C) Symptoms must be present in early developmental period (but may not become fully manifest until social demands exceed limited capacities or may be masked by learned strategies later in life).

D) Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning. (Autism Canada, n.d., para 7-16)

I can name very specific instances where I see my son exhibiting behaviour that meets criteria A and B, but at age 6 it might not be clinically significant impairment subject to criteria D. However, what I believe we should pay most attention to is criteria C, noting that his behaviours may not cause clinically significant impairment until social demands exceed his capacity. There is no way to predict that in two, five, or seven years whether he will exhibit clinically significant impairment—but the issue remains that he will not likely be validated for a need for an assessment until that impairment is evident and causing him distress. That impairment is going to come from experiencing unbelonging in his life in ways that affects his mental and emotional wellbeing. Impairment, that could be avoided if we were to be equipped with tools and strategies to help him understand his brain and body and feel confident in himself and his strengths and abilities.

British Columbia is working on implementing support services for children and youth that are needs-based as opposed to diagnosis based, with the piloting of *family connections centres* (FCCs) in four locations (Kelowna, Prince Rupert, Terrace, and Smithers). These FCCs opened their doors in 2023 and are a self-referral model, meaning they do not require a referral from the Ministry of Children and Family Development (MCFD) (Province of British Columbia, n.d., para 1.). This is a positive step forward in getting more support for children and

youth that have suspected or confirmed support needs but lack certain assessments or diagnoses for eligibility-based services. While this has lowered barriers for some children and families, enabling them to access support services for the first time in these regions, the demand for services still outweighs the capacity to provide them—leaving many still waiting and wanting. It remains to be seen whether the FCC model will expand to other areas of the province. As a neurodivergent parent, parenting a neurodivergent child who does not have a diagnosis, this is the kind of model that I would ideally like to see accessible to more people like us. We need services that do not require multiple steps to access and navigational support to reduce the administrative burden placed on families to locate their own resources. However, even if needs-based community services were available through MCFD, there will still be a misalignment with the MECC, as they will continue to require those diagnoses for in-school support unless their approaches change too. While there is collaborative work that occurs across ministries, each ministry is still subject to their own mandates—and their respective Ministers have different priorities[11][12]. As my current work is in policy with MCFD and the Children and Youth with Support Needs (CYSN) programs, I have been and will continue to use the learning I have gained from my research to uplift the importance of belonging and accessibility within government policy and practice in whatever capacity my future role entails.

5.4 Belonging Indigenously

The stories shared about participants' experiences as Indigenous people brought up the common thread that there is a lot of lateral violence in our communities. Lateral violence is an

[11] Ministry of Education and Child Care mandate letter
[12] Ministry of Children and Family Development mandate letter

act of aggression by members of a marginalized group directed towards members of their group instead of toward the oppressor (Whyman et al., 2023, p. 183). This can happen in different shapes and forms, but most commonly I have seen it used in invalidating Indigenous people of mixed ancestry that have white-passing features. I shared a story in which this happened to me; however, it was far from the first or last experience in my life. It feels contradictory and perhaps hypocritical to criticize the Indian Act and how problematic it is to have a physical racial identification card and yet rely on that card to validate my identity as an Indigenous person when it is called into question.

When my son was born, it was my hope to have him registered with our Nation, however my status falls under the second-generation cut-off under section 6(2) of the Indian Act. Section 6(2) applies to a child when only one parent is entitled to registration under section 6(1) and may only pass down status to their own children if the other parent also has Indian status as well (Lawrence, 2025, para. 10-12). Sections 6(1) and 6(2) of the Indian Act were introduced in 1985 to restore the rights of First Nations peoples who were forced to relinquish through enfranchisement, their "Indian status" in exchange for the right to own land, vote in federal elections, practice medicine or law, or if they were a status First Nations woman marrying a non-status man (para. 7) . With the number of people that would be entitled to reclaim their treaty rights, 6(1) and 6(2) were instituted as a control measure in which the federal government rationalized that children born to only one parent entitled to registration was a "voluntary" act of enfranchisement (relinquishment of rights) (Lawrence 2025, para. 10). Speaking to the long-term future implications, should the second-generation cut-off remain, Lawrence (2025) said:

> If left unchanged, this cut-off will significantly reduce the status Indian population in Canada. Within the next few generations, there will be many children born to a First Nation parent who will not be entitled to status under the Act. One senator has called this cut-off a *bureaucratic extinction formula*. (Lawrence, 2025, para. 15)

My son's father is non-Indigenous, so I had resigned myself to the probability that my son would not be entitled to receive status of his own with our nation. Regardless of his ineligibility, I still celebrate his Indigeneity no matter what and have done so by bringing in many Indigenous children's books, sharing what little Anishinaabemowin language I can with him, and bringing him to events in and around the community where we live. However, the fact remains that my son's ineligibility for registration with our Nation has been called by many, discriminatory. People who are registered with their Nation under section 6(1) objectively have more rights than their children registered under 6(2), introducing a hierarchy of superiority that those registered 6(1) are more Indigenous, more worthy of their treaty rights (Wah-Shee, 2008, p. 18). Wah-Shee (2008), in a factum challenging section 6 of the Indian Act, said:

> Although the government constructed the notion of Indian status, it is clear that this notion has come to form an important aspect of cultural identity. This is especially so in the context of Crown-Indian treaties and the continuity of the treaty relationship between successive generations of treaty Indians and the crown. (p. 18)

Belonging to Tlicho Nation in the Northwest Territories, Wah-Shee (2008) argued that his child being denied treaty rights under the Indian Act is unconstitutional and undermines the historical and cultural importance of Treaty 11, signed in 1921 (p. 18). He stated that treaties must not be construed by their technical language, but rather in the way that they would be

naturally understood by the signatories of the Nation (p. 18-19). To endorse his position, Wah-Shee (2008) shares testimony from a Dene elder who was present at the signing of Treaty 11 in 1921 indicating that the Indian Agent facilitating the process assured the Tlicho Chief that:

> as long as the river flows and the sun rises from east to west in this land of yours, nothing will be closed…your children after you will also continue on living your ways of life…it will not be closed for you nor for your children. (p. 19)

According to the Community Specific Data Sheet provided by the federal government to help inform citizens about the impacts of the second-generation cutoff, it is estimated that 324 of the 1336 individuals registered with Naotkamegwanning First Nation have a single entitled parent and are registered under 6(2) of the Act (Indigenous Services Canada, 2024, p. 173). I am one of those 324 individuals who collectively represent 24% of the Nation's population. This data is to demonstrate the consequential impact of children born to a 6(2) "status Indian" with another parent who is non-status, saying:

> Their future descendants will no longer be entitled to registration under the *Indian Act,* and they may no longer have access to the rights, benefits and services that the government provides for individuals who are registered under the *Indian Act.* This also means that even as your Nation's population grows over time, Naotkamegwanning's total registered populations are likely to decrease in size. (Indigenous Services Canada, 2024, p. 173)

Bill S-2, *An Act to amend the Indian Act (new registration entitlements)* was introduced for its First Reading in May 2025, with Second Reading in June 2025. It currently sits before the Standing Senate Committee on Indigenous Peoples, who as of November 2025 voted 10-1 in

favour of the amendments to change the second-generation cut-off, implementing a one-parent rule to allow passing legal identity and rights to their children (Pugliese, 2025, para 1). Honourable Senator Paul Prosper introduced the amendments, telling the Committee:

> I chose to champion this amendment because I believe there is nothing more vital to the survival of First Nations than this change…the fact is that we cannot govern who First Nations fall in love with. This change says, love who you love and do not worry because your children will not fall by the wayside. (Pugliese, 2025, para. 15-16)

There is currently open consultation until January 2026 to hear feedback from individuals impacted by the second-generation cut-off and processes for the Section 10 Voting Thresholds that allow First Nations to maintain their own membership lists (Government of Canada, n.d., para. 5-7). So, there remains hope for the future if this Bill reaches its Third Reading with the Senate with the possibility that it moves through the House of Commons in the future.

Treaty Status is not the most important thing in validating a person's Indigenous identity, but it presents some optimism for me that it may address some of the pervasive issues with lateral violence in the Indigenous community towards mixed-race Indigenous people. It also will benefit many families with children who may become entitled to registration with their Nations in ways where their status may enable greater access to things like post-secondary education and Non-Insured Health Benefits. These amendments may also support Indigenous children and youth in foster care access treaty entitlements that may foster a greater sense of belonging and connection to their Indigenous community, should the barriers to registration be removed. For many Indigenous children and youth in foster care, connection to the community is lost when connection to the parent is severed.

This was the case for Skye and her mother. Skye's mother was part of the Sixties Scoop and adopted and raised by a white family and experienced a great deal of trauma and abuse that led to her life-long mental health and substance use challenges (Representative for Children and Youth, 2021, p. 3). Skye was born on Vancouver Island, a great distance from her mother's Dene community, of which her mother had been disconnected from since the age of one. While Skye was in foster care, her "cultural connection appeared largely dependent on her placement" (Representative for Children and Youth, 2021, p. 69). Social workers who knew and worked with Skye were interviewed by RCY, with one noting that cultural planning involved "a lot of conversations, not a lot of connection" (p. 70). Some of the cultural planning done for Skye did involve communication with her Nation, but this was mishandled despite there being viable options to connect her with, and possibly even place her with family in her community in the Northwest Territories. In 2008, Skye's social worker at the time corresponded with an aunt and uncle in the community who were interested in caring for her. However, a simple question of what kind of support they could receive financially led to the social worker severing contact and not exploring this further. RCY said:

> Records indicate that Skye's Nation had requested more time to explore ways to support familial and cultural connections—including with her grandmother—and asked that the ministry continue to support Skye in foster care and not proceed with another plan for adoption [after the first plan failed]. (Representative for Children and Youth, 2021, p. 69)

The ministry unfortunately continued with their plans to locate an adoptive placement as the primary plan for Skye's permanency and moved to considering non-Indigenous homes. A

troubling decision that certainly affected her ability to connect to her Indigenous identity and sense of belonging as a young Dene person.

There are stronger policies in place now in British Columbia than there were when Skye was younger, pertaining to ensuring Indigenous children and youth involved in child welfare have an opportunity for meaningful connection and belonging to their communities. The *Child, Family, and Community Service Act* (CFCSA) have requirements embedded in the legislation to notify an Indigenous child's community of involvement in alignment with section 12 of the federal *Act respecting First Nations, Inuit and Métis children, youth and families* (2019), which reads as follows:

> **12 (1)** In the context of providing child and family services in relation to an Indigenous child, to the extent that doing so is consistent with the best interests of the child, before taking any significant measure in relation to the child, the service provider must provide notice of the measure to the child's parent and the care provider, as well as to the Indigenous governing body that acts on behalf of the Indigenous group, community or people to which the child belongs and that has informed the service provider that they are acting on behalf of that Indigenous group, community or people. (An Act respecting First Nations, Inuit and Métis children, youth and families, 2019)

The federal *Act respecting First Nations, Inuit and Métis children, youth and families* was passed in 2019 affirming the inherent right to Indigenous self-government, which includes jurisdiction related to child and family services. It also served to set principles for the provision of child and family services to Indigenous children and youth to inform minimum standards for provinces to

align their child and family services legislation and practices (An Act respecting First Nations, Inuit and Métis children, youth and families, 2019, s. 8).

As many First Nations are preparing to assume jurisdiction to provide child and family services under their own Indigenous laws and governance, Bill S-2 may carry considerable significance in determining how an Indigenous child receives child and family service intervention. If a child is not a registered member of a self-governing Nation, but they may be entitled to registration it may come into question whether that Nation has jurisdiction to provide services or if it falls to the provincial government. While a child being unregistered as a member with a Nation does not necessarily mean the Nation will be excluded from planning or child welfare proceedings, many Nations lack sufficient resources to support every child they receive notifications about. With simplifying registration entitlements, it may enable a Nation to more quickly recognize and support a child with the services and support they should be entitled to and start fostering a sense of belonging to the community in ways that provincial child and family services simply cannot.

One of the ways British Columbia is leading the pathway to supporting Indigenous jurisdiction over child and family services, while also supporting Indigenous children and youth who will remain under the jurisdiction of mainstream provincial child and family services is the 2024 appointment of Jeremy Y'in Nedulklhchulh Williams of the Lake Babine Nation to serve as the province's first Indigenous Child Welfare Director (ICWD) (Province of British Columbia, n.d., para. 4). The role of the ICWD is to oversee the delivery of services through the Ministry of Children and Family Development (MCFD) and the 24 Indigenous Child and Family Service Agencies (ICFSA) that are delegated under the CFCSA (13 of which are fully delegated to provide

protective services), and directly support the implementation of Indigenous jurisdiction over child and family services (Province of British Columbia, para. 4) . The creation of the ICWD is part of the province's commitment to the *Declaration on the Rights of Indigenous Peoples Act* (2019) and the *Declaration Act Action Plan* (DAAP). DAAP commitment 4.17 states:

> In collaboration with B.C. First Nations, Métis Peoples, and Inuit, continue implementing changes to substantially reduce the number of Indigenous children and youth in care through increased prevention and family support services at all stages of contact with the child welfare system. (Province of British Columbia, n.d., para. 1)

To-date, of the 202 B.C. First Nations, 11 have provided a notice of intent to assume jurisdiction of their child and family services and are working with the federal and B.C. government to develop coordination agreements in preparation of transferring jurisdictional responsibility. Many other B.C. First Nations have also worked collaboratively with the government to establish protocols, information sharing agreements, and community agreements under Section 92.1[13] of the CFCSA as measures to support DAAP commitment 4.17.

5.5 Fostering Belonging as Praxis

Only one participant in this study spoke of experiencing involvement with child and family services in their youth, and this experience was not discussed to great detail. However, there could be an opportunity for greater understanding about belonging as an Indigenous person who has experienced the foster care system using the Recognition of Being Framework

[13] S. 92.1 of the CFCSA enables the provincial government to enter into a co-developed agreement with a First Nation to establish procedures for consultation and cooperation with the First Nation when MCFD becomes involved with a child and family belonging to their Nation. These are agreements where provincial jurisdiction remains, but First Nations have a larger role in the planning and decision-making regarding child welfare interventions with families belonging to the Nation.

(Anderson, 2016) and the framework for understanding, assessing, and fostering belonging (Allen et al., 2021) to inform future Indigenous child welfare policy and practice reform (and other areas of social work, health care reform, and more). To think about the future of social work practice, I find myself looking back at my time spent as a frontline social worker and how this greater understanding of belonging and myself would have benefitted my work.

To engage in fostering belonging as praxis, your personal introspective understanding your own sense of belonging must come first. For myself, I understand now that a serious shortcoming of my own practice as a social worker that undoubtedly contributed to my burnout in the field, was that I was undiagnosed and unsupported for my ADHD. Personal introspection and understanding positionality are a basic part of undergraduate social work curricula, but it is hard to do that when you are unaware that something is missing. With the resources I have now, my experience working on the frontline could be very different. I now have the privilege of access to medication, the comfort of owning my own home, and being able to rely on my artistic outlets for self-care—things that were nowhere near accessible to me when I was paying more than 50% of my income on rent and being so exhausted at the end of the day that I had little to no motivation to do anything, let alone anything creative.

With personal introspective understanding in hand, you can then consider how to apply knowledge to direct praxis. Bearing witness will be part of this work, creating or holding space for those who need to be heard and then listening with intention. Anderson's (2017) Recognition of Being Framework can help take what is witnessed to form a greater understanding, and you might even consider navigating the circle together. If space is held in a good way and the person has assurance of comfort and safety in that space, they will hopefully

share details that should help identify what negative definitions of being do they experience and need help resisting. Try to help them identify what they need to reclaim and how you might help them do that. Think about how you might approach supporting their construction of a new definition of being and what actions you will take as the helper, and what actions they are ready to take.

Navigating the circle process, it may be challenging to identify what those negative definitions of being are, and what kind of definition a person wants to construct for themselves. It is important that their perceptions are at the centre of the process, and you participate as a supporting facilitator. This is where you can consider how Allen et al.'s (2021) framework for assessing, understanding, and fostering belonging could be used. Carefully, without answering the questions for the person, rather assist them with finding their own answers, think about:

- What competencies and characteristics does the person have?
    - Where are the strengths and where are the needs?
- What opportunities to belong do they have, or do they lack?
    - What are the barriers?
    - Are there resources available to you that can help remove or diminish those barriers?
- What kind of motivations do they have?
    - Do they want to be a stronger advocate for their child?
    - Do they want to be a stronger advocate for themselves?
    - What is demotivating for them and would some kind of support or resource change that?

- What is their perception of their sense of belonging (think of the four components of the medicine wheel)
    - Physical belonging- Do they have secure stable housing? Are they in an unsafe living situation? Are they at risk of being unhoused?
    - Mental belonging- Do they have a positive connection to themselves? Do they have any mental health needs that are unmet?
    - Emotional belonging- Do they have supportive relationships they can rely on? Do they have connection in the community?
    - Spiritual belonging- What is important to them? What grounds them in their spirit? What do they value and are there ways this can be strengthened?

There are many ways in which these frameworks could be used to support both strengthening social work practice through introspective self-positioning and reflection—as well as a strengths-based approach to assessing what kind of support a person needs that could be applied as a lens on to many different kinds of assessment tools social workers use in the context of their role within their organization (such as eligibility assessments, safety and wellbeing assessments, and more).

5.6 What Now and Next?

This work has served a purpose to demonstrate that we live in a world full of diversity and difference. However, the part of the world we live in is built upon entitlement and privilege that places the most value upon those who most closely meet criteria of “normal” or “typical” as it is understood through individualist, Colonial ideological structures. This is not a system

created accidentally. This system goes back to the belief in the Doctrine of Discovery, as colonizers saw their rights as superior humans to take from those, they deemed inferior (Canadian Museum of Human Rights, 2024). It has been pervasive in rationalizing enslavement, genocide, and eugenics (Clare, 2017; Geddes, 2017; Wald, 2022). Universality is a term used to imply that something is for everyone, but it is fundamentally untrue (Withers, 2012). The reality is that there is a lot of rigidity within universality that needs to shift to be more flexible or adaptive. To achieve this adaptability, we need to understand wholly what needs to be changed and this cannot be done without the perspectives of those who need change the most at the forefront (Withers, 2012).

There are many more stories unheard, not just from neurodivergent Indigenous people. There are many other intersectional identities that are currently experiencing scrutiny and hostility through political manipulation of spaces they have the right to belong in. While I intend to continue sharing my story and my perspective, I will also utilize my power and privilege to elevate other stories of belonging that need to be heard. As a neurodivergent researcher, I would love to expand the scope of this work and hear from more neurodivergent Indigenous people; but there is also an opportunity and flexibility to expand the scope of this work to examine the experiences of different intersectional identities and how those experiences have been influenced by exclusionary conceptions of normalcy that limit belonging beyond those who fall into a very narrowly defined box of typicality.

This whole process started with resisting negative definitions of being, including the deconstruction of white supremacist and ableist conceptions of normalcy and typicality. The work continued into reclaiming traditional knowledge, intentionally deviating from clinical

methods of academic research and decentering the medical model in favour of qualitative experiential data that represents the experiences of Indigenous people with ADHD. With only ten stories presented within this work (including my own), it is obviously not sufficient to construct a new definition of being for all neurodivergent Indigenous people, nor could a single definition ever be encapsulated. However, the knowledge gained from witnessing these stories gifted by each participant, I hope, may help individuals to construct their own new positive definition of being for themselves.

For readers, there are considerations as to what comes next for you too. I believe there is a shared responsibility for readers and learners to support the mobilization of the knowledge gained and carry forth a greater understanding of the importance of belonging as a fundamental human need; and an understanding that connectedness is not possible when people are disconnected from pieces of themselves. As mentioned, when discussing fostering belonging as praxis, readers may consider taking some time for personal introspection and consider even navigating the Recognition of Being Framework for themselves. Think about:

- What negative identities have you resisted or are you **resisting**?
- Are there pieces of your identity to **reclaim** and **construct**?
- How will you **act?**

Moving forward as you examine yourself as a whole; consider:

- Where are your spaces of belonging?
- Who else belongs within them?
- Is there a privilege that you have in your spaces of belonging?

- Who is missing from those spaces?

Once you start asking those questions and seeing elements of belonging and unbelonging in your world, you cannot unsee them.

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Appendices

Appendix A: List of Questions Provided to Participants

Indigenous ADHD Research Project
This is a semi-structured interview. The purpose of these questions is to help initiate the conversation but do not need to necessarily all be discussed/answered. Please do not feel compelled to discuss any matters that you find uncomfortable. Your time spent should be about what you, the participant, feel is most important for me, the researcher, to know about you and your experiences as a neurodivergent Indigenous person.

1. Could you please introduce yourself and tell me where you are from?
2. Do you have a clinical diagnosis of ADHD? (i.e., diagnosed by a family physician, psychologist, specialist, or other medical professional)
3. If you were diagnosed as a child, what kind of treatment/support was offered to you to manage your ADHD?
4. (Self-Diagnosed Participants) At what age did you suspect you might have ADHD, and what led you to your self-diagnosis?
5. Can you please tell me about how you see yourself in relation to your ADHD and how it impacts your daily living? How does it make you feel?
6. Tell me something interesting about yourself, do you have any hobbies/interests, talents, or anything else that you would like to share about yourself?
7. Can you please tell me about your significant relationships? Family, friends, partner, etc.?
8. What does belonging mean to you?
9. Could you tell me what school was like for you as a child/adolescent?
10. What kind of tools/strategies have you come up with for yourself to help manage your ADHD?
11. Can you tell me about any significant experiences in your life that have impacted the way you live/see the world? These experiences do not need to specifically relate to your ADHD. (i.e., life-changing events, the beginning or ending of relationships, community/world events, moving or relocating, trauma or stigmatization, grief and loss, celebrations, significant milestones or achievements)
12. Is there anything else that I haven't asked that you would like to share?

Appendix B: Informed Consent Form

Intersecting Identities: Bearing Witness to Neurodivergent Indigenous People with Attention-Deficit Hyperactivity Disorder

You have been invited to participate in the study, Intersecting Identities: Bearing Witness to Neurodivergent Indigenous People with Attention-Deficit Hyperactivity Disorder, conducted by Caitlin Alder, a graduate student in the Department of Social Work at the University of Victoria.
Caitlin Alder can be contacted by telephone at (778) 875-0546 or by email at caitalde@uvic.ca.
As a graduate student, this research is being conducted as part of the requirements for a master's degree in social work. This research is being conducted under the supervision of principle investigator, Dr. Gwendolyn Gosek, who may be contacted by phone at (250) 228-6561 or by email at ggosek@uvic.ca.
This research study has not been funded by any parties of interest. Funding to compensate participants has been secured through the award of a $1000 University of Victoria Graduate Award.
Your choice to participate in this research study is 100% voluntary, and you may choose to withdraw your consent to participate at any time. If you have already been compensated financially for your time and participation, you will not be required to return the funds to the researcher.

Purpose of the Study

This research seeks the knowledge of neurodivergent Indigenous people who identify as having Attention-Deficit Hyperactivity Disorder. The purpose of this knowledge is to gain a better understanding of the experiences of neurodivergent Indigenous people and how those combined identities may influence the development of a sense of belonging in one's family, community, etc.
The student researcher, Caitlin Alder, is a neurodivergent Anishinaabe person from Naotkamegwanning First Nation in Treaty 3 Territory. As this research is being conducted by a neurodivergent Indigenous person, they are seeking to expand the perception and understanding of neurodivergence as it is currently understood and researched. There is very little research that focuses on representing neurodivergent adults, and even less representing neurodivergent Indigenous people. Neurodivergent research primarily focuses on the medical and deficit perspectives designating different neurotypes as disordered, without recognizing the many positive and notable attributes of neurodivergent people and the gifts that they may use to contribute to their communities.
Your perspective on how being neurodivergent and Indigenous has influenced your experiences shaped your sense of belonging is important in constructing a strengths-based narrative that is needed to counter stigmatizing stereotypes that do not accurately represent us in current research.

Your Participation

You have been asked to participate in an interview, approximately 60-120 minutes in length. Your time to participate in the interview will be compensated in the amount of a $50.00 cash stipend when the interview is completed.
During the interview, there are questions that will be asked related to your personal experiences that connect to your identities of being Indigenous and/or neurodivergent; and how those experiences have shaped your sense of belonging in your community, amongst your family, your peers, and more. General interview questions will be provided to you ahead of your scheduled interview session to allow you to come prepared. The questions are meant for guidance but do not have to be strictly adhered to.

You are only expected to share what you are comfortable with sharing, and you will not be pressured or probed to share more than you are willing.
You may withdraw your consent to participate in this research at anytime, without explanation.
If you withdraw after you have received the $50.00 stipend, you will not be expected to return the funds. Your time is valuable, and that time spent will still be honoured.
If you withdraw from the study, you will be asked permission to use your contributions in the analysis and final report of this study. You may agree or refuse this request without explanation.

Interview Arrangements

You will arrange to meet with the researcher for the interview session either in-person, by telephone, or virtually using Microsoft Teams. Scheduling will be accommodated to best suit your availability as much as possible.
Any further accommodations you may need to support your participation can be requested and discussed with the researcher prior to your session.
If at any time during the interview process you need to pause or stop for your personal wellbeing, please advise the researcher.
Interview sessions may be broken down into 2 or more smaller sessions if that is better suited to your needs. Additional financial compensation is unfortunately not available to account for multiple sessions.
You are welcome to have support persons present with you, however, the conversation should remain focused on your personal perspective as a neurodivergent Indigenous person.

Audio/Video Recording

With your permission, interview sessions will be audio/video recorded. You may request audio only recording if you do not wish to be video recorded. If you do not wish to be audio or video recorded, alternatives will be discussed and agreed upon prior to your session.
Recordings will strictly be used only for the data analysis phase to maintain accuracy of the information you provide.
Following the completion of the study, audio/visual recordings will be permanently deleted.

Protection of Information

Sessions will be conducted in a private confidential space, with only the researcher present and any support person you invite.
Your information will not be shared in any way without your consent, except for when the researcher is obligated by law to report concerns if you have indicated to the researcher any intentions to harm yourself or someone else.
Your information will be gathered and stored securely using Microsoft Sharepoint, managed by the University of Victoria.
Any written notes or information will be transcribed and saved securely using Microsoft Sharepoint and be promptly shredded/destroyed.
Any audio/video recordings captured on a mobile device will be moved securely to Microsoft Sharepoint within 24 hours of your session.
Transcription of your audio/video sessions will be completed by the researcher. No other parties will have access to the recordings or raw information gathered from participants.
Following transcription of audio/video sessions, you will be able to review your transcript for accuracy. When transcripts have been validated, audio/video recordings will be deleted and only transcripts will be retained.

Your name and any identifying information you share during your interview session will be anonymized when referenced in any publications sharing the research findings.
You will be given the opportunity to review writings referring to your experiences prior to the publication or presentation of the information toward the end of the study to ensure that your perspectives are represented accurately and in the manner that you are comfortable with.
If you choose to withdraw from the study, any information already stored will be deleted/destroyed.

Possible Risks

As this study asks you to share details of your personal experiences, this may include sensitive or difficult topics of discussion that may pose a risk to your personal wellbeing. If you have experienced trauma, you are not discouraged from sharing about these experiences if you feel they are important and significant to share as part of this research; but you will not be expected to share details that may negatively affect your personal wellbeing. Your wellbeing is the primary priority and if your participation requires adjustments to make things more comfortable at any time; or if you decide to withdraw from participation, your requests will be supported.

Possible Benefits

Although you may not benefit directly from the study, the contribution of your knowledge and experience will help inform a perspective on what some of the common experiences and unique experiences neurodivergent Indigenous people may have.
The analysis of the data collected may:
Identify approaches to neuroaffirming and culturally safe care.
Help deconstruct negative racial and ableist stigma held about neurodivergent and/or Indigenous people.
Inform future work that supports the expansion of literature and research on neurodivergent and/or Indigenous experiences.

Further Voluntary Participation

You may be requested by the researcher to follow up at points following your interview session(s) for the purposes of:
Following up on your wellbeing and inquiring if any aftercare support is needed.
Requesting clarification of information on notes or transcripts that may be unclear.
Reviewing preliminary themes and findings for affirmation.
Reviewing writings that refer to the knowledge you shared and affirm that the researcher's interpretations and representations of your experiences are accurate; and that it aligns with the degree of information sharing that you have agreed to.
All further participation is voluntary, but appreciated to ensure that this work is presented as informed through collaboration and not solely by the researcher's interpretations and conclusions alone.

Presentation of Information

The findings of this research will be used in part to fulfill requirements for completion of a master's degree in social work and will be presented by the researcher to an academic panel for evaluation.
The findings of this research may be submitted to peer reviewed academic publications or presented at conferences with relevant subject-matter.
The dissertation of this research will be publicly available online via the University of Victoria Library.
Use of information in future research:
The findings of this research may be used by the researcher to inform further expanded inquiry into the research topic.

None of your personally identifiable data will be made available publicly in any future use of this data.

Ongoing Consent

Each time you complete a research activity and meet with the researcher, you will be reminded that your participation in the study is voluntary, and asked if you wish to continue to take part.

If you have any questions or if you would like to discuss this study further, please contact Caitlin Alder by telephone at: 778-875-0546 or by email: caitalde@uvic.ca

You can also contact the Human Research Ethics Office at the University of Victoria at 250-472-4545 or ethics@uvic.ca, to check the ethical approval of this study, or to raise any concerns you might have.

Please submit your signed consent form in the method most accessible to you. Your consent can be submitted:

By scanning or photographing your consent and sending to: caitalde@uvic.ca; or

By digitally filling out the form and signing using Adobe Acrobat and sending to: caitalde@uvic.ca; or

By letter-mail to: [Address TBD, Post-office box will be obtained]

If you requested to receive the consent form by mail, a pre-posted envelope has been provided for your convenience.

A copy of your consent form will be scanned and emailed to you when it has been received.

Please review and initial or sign in the indicated areas below. Please remember that participation in this study is voluntary.

Future uses of data

The stories you share are your own. With your consent, your data will be securely retained and stored in the manner described in section E, for the purposes of possible use in other relevant research to expand on the topics of neurodivergent and/or indigenous identity and concepts of belonging (e.g., future PhD research, community research studies, publications etc.). The information/data retained may include: your registration form with contact information, raw transcripts from your interview and will be retained for up to five (5) years. You may decide you do not want the researcher to retain your data for future research and do not need to provide a reason. If you do not want your data to be retained, it will be deleted after the final dissertation and thesis submission. You may request a copy of your data to be retained as you see fit.

Please select one:

I give my consent for the researcher to retain my information for up to five (5) years for the purpose of use in future research about neurodivergent Indigenous identities and belonging and/or similar research topics: _____ (Participant to provide initials)

I consent to be contacted in the event my data is requested for future research: _____ (Participant to provide initials)

I do not consent to the use of my data in future research: _____ (Participant to provide initials)

I would like to receive a copy of my data for my own purposes: _____ (Participant to provide initials)

How will the study results be shared?

Findings from this study will be reported in a dissertation as part of completion requirements of the Master of Social Work program and may be submitted for publication in academic journals or presented publicly (e.g., conferences). Your name and any information that may publicly identify you will not be used in these publications or presentations. The dissertation of this research will be publicly available online via the University of Victoria Library.

Audio/Video Recording

For the purpose of accurately analyzing collected data, you will be requested to have your sessions video recorded, audio only recording may be requested if preferred*. Audio and video recordings will not be used in the presentation of information and will be deleted following the completion of the research study.

**Participants may decline both video and audio recording but must understand that this choice may affect the researcher's ability to complete a comprehensive analysis of the participant's contributions.*

Please select one:

I consent to the video recording of my interview session _____ (Participant to provide initials)

I consent to recording my interview session via audio only _____ (Participant to provide initials)

I do not consent to video OR audio recording of my interview session (Participant to provide initials)

Consent:

I have read this consent letter……..YES……NO

I have had the opportunity to ask questions.....YES…….NO

I understand that my participation in this study is voluntary .....YES……NO

I understand that I can withdraw my consent at any time……YES…….NO

I agree to take part in the study……YES……NO

Name of Participant	*Signature*	*Date*

Appendix C: List of Resources Provided to Participants

Indigenous Resources

Hope for Wellness Helpline

1-855-242-3310

https://hopeforwellness.ca

24/7, toll free immediate mental health counselling and crisis intervention available through phone or online chat.

Kuu-Us Crisis Line Society

1-800-588-8717

www.kuu-uscrisisline.com

Crisis services for Indigenous people across BC

Métis Crisis Line

1-833-638-4722

A service offered by Métis Nation British Columbia

ADHD Resources

Canadian Mental Health Association (CMHA)

Dial or text 988 for immediate mental health support. Mental Health and ADHD Information

Centre for Addiction and Mental Health (CAMH)

Adult ADHD Resources and References

Canadian ADHD Resource Alliance (CADDRA)

Resources and Links for Adults with ADHD

Being Me with ADHD

Additional Resources

Frida: Online Adult ADHD Clinic in Canada

Diagnosis, Treatment, Costs, On-going Care