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PARENTAL AGENCY AND MONTESSORI-INFORMED SUPPORT IN THE DEVELOPMENTAL JOURNEY OF A CHILD WITH CEREBRAL PALSY: A MOTHER'S AUTOETHNOGRAPHIC ACCOUNT

Tahmina Bano

Corresponding Author: *
Tahmina Bano

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ABSTRACT

This analytic autoethnography examines how maternal agency, long-term rehabilitation, Montessori-informed educational adaptation, and institutional conditions shaped the developmental and educational journey of a child with cerebral palsy in an urban setting in Pakistan. I write as the child's mother, a Montessori educator, and an education researcher. My son was born prematurely at approximately seven months of gestation, remained in an incubator for one week, and was diagnosed with cerebral palsy at seven months of age. In infancy he displayed profound delays in postural control, voluntary hand movement, visual attention, feeding, mobility, and communication. I recall receiving highly restrictive prognostic messages: that he might never sit, walk, speak, eat solid food, or develop functional vision. The narrative traces how I responded through physiotherapy and occupational therapy, daily home practice, early sensory and communication experiences, Montessori Practical Life and Sensorial activities, adapted literacy and mathematics instruction, and persistent educational advocacy. He sat at approximately two years, walked at four, and began speaking at five. At 13, he walks without support, eats independently, communicates with increasingly clear speech, reads Urdu and English through phonics, understands learning tasks, completes foundational mathematics, and manages major self-care routines under supervision. His nystagmus and fine-motor difficulties continue to shape access, particularly writing and visual presentation. The analysis identifies five interconnected themes: refusing developmental finality; transforming care into participation; separating motor access from cognitive competence; negotiating inclusion between mainstream and special education; and the emergence of the child's own agency. The account does not attribute progress to a single intervention and does not frame cerebral palsy as cured. Instead, it argues that development emerged through the interaction of the child's efforts, sustained therapy, responsive caregiving, educational expertise, accessible materials, and enabling or constraining institutions. The paper concludes with implications for family-centred rehabilitation, inclusive school leadership, assessment alternatives, and parent-professional partnerships in resource-constrained contexts.

Keywords: *cerebral palsy; parental agency; Montessori education; autoethnography; inclusive education; family-centred rehabilitation; home education; disability; Pakistan*

1. Introduction

Cerebral palsy is a lifelong neurodevelopmental condition associated primarily with disorders of movement and posture that limit activity; it may also involve disturbances of sensation, perception, cognition, communication, behaviour, epilepsy, and secondary musculoskeletal problems (Rosenbaum et al., 2007). This multidimensional description is important because a diagnosis does not produce a single developmental pathway. Children with cerebral palsy differ widely in movement, communication, cognition, sensory functioning, participation, and the support they require. Disability is also not located only within a child. The World Health Organization (WHO, 2023) describes disability as emerging through

interactions between a health condition and environmental and personal factors. From this perspective, stairs, inaccessible print, rigid assessment, insufficient staffing, negative expectations, and institutional refusal can be as consequential for participation as bodily impairment.

Parents frequently become the coordinators of complex developmental systems. They arrange appointments, interpret professional advice, practise exercises at home, negotiate school placement, adapt routines, make financial and employment decisions, and sustain the child's motivation across years. Family-centred rehabilitation recognises parents as knowledgeable partners rather than passive recipients of expert instruction. Recent synthesis of family-centred interventions for children with cerebral palsy identifies home intervention, collaborative goal setting, planned home activities, family education, coaching, observation, and supervised practice as important processes (Mota et al., 2024). Yet the language of partnership can obscure unequal realities. Parents may be expected to deliver extensive care without adequate institutional support, while their experiential knowledge is undervalued.

This paper examines these tensions through my lived experience as the mother of a 13-year-old boy with cerebral palsy and as a Montessori educator. My son's story began with premature birth, early diagnosis, profound developmental delay, and predictions of severe lifelong limitation. It continued through approximately ten years of physiotherapy and occupational therapy, daily home practice, supported Montessori schooling, later exclusion from mainstream education, home-based literacy and mathematics, Qur'an memorisation, and his increasingly explicit claim to an identity beyond the label "special child."

The purpose is neither to present an inspirational "overcoming disability" story nor to prove the clinical effectiveness of Montessori education. Such framings would simplify a complex journey and risk implying that children who do not achieve similar milestones, or families who cannot provide intensive support, have failed. Instead, I ask how parental agency operated within and against developmental, medical, educational, and institutional constraints. I also examine how Montessori-informed principles—observation, purposeful activity, sensory experience, graded difficulty, repetition, practical independence, and respect for the learner's pace—were adapted to a child whose motor and visual development differed substantially from conventional expectations.

Three questions guide the paper: (1) How did I exercise parental agency in responding to early prognosis, organising rehabilitation, and constructing educational opportunities? (2) How were Montessori-informed principles adapted across my son's motor, communication, self-care, literacy, and numeracy development? (3) How did schools and other institutions enable or constrain his participation, and how did his own agency emerge within these negotiations? By connecting one family's experience to broader questions of rehabilitation and inclusion, the paper seeks to contribute situated knowledge from Pakistan, where disability, professional expertise, family resources, and school capacity interact in locally specific ways.

2. Conceptual and Empirical Background

2.1 Cerebral palsy, function, and participation

Contemporary accounts of cerebral palsy increasingly move beyond impairment alone toward activity and participation. Rehabilitation aims to support independence in everyday activity and participation in education, recreation, work, family, and community life (WHO, 2024). This shift matters because a child's ability cannot be inferred solely from diagnosis or gross motor presentation. Motor, manual, visual, communication, and cognitive profiles may be uneven. A child may understand complex language while struggling to point, write, stabilise posture, or visually track standard-size print. When schools rely on speed, handwriting, unsupported sitting, or independent toileting as informal entry requirements, physical access can be mistaken for academic capacity.

The distinction between capacity and participation is equally important. Capacity concerns what a person can do under specified conditions; participation concerns involvement in real life. Participation depends on opportunities,

relationships, attitudes, accessible environments, and support. A child may have the cognitive capacity to learn but remain out of school because a building is inaccessible, a support teacher is unavailable, or a principal anticipates difficulty. Conversely, responsive leadership and modest adjustments may permit meaningful classroom membership. My son's changing access across school settings illustrates this relational character of disability.

Premature birth forms part of my son's developmental context, but this paper does not claim a single cause for his cerebral palsy. Nor does it retrospectively assign a subtype or functional classification that was never formally communicated to me. Such restraint is methodologically important: an autoethnographic account must distinguish remembered clinical information from later interpretation. What I can report is that he was born at approximately seven months of gestation, remained in an incubator for one week, and was diagnosed at seven months after I observed severe difficulties in trunk control, movement, and visual attention.

2.2 Parental agency and family-centred practice

Agency is the capacity to act purposefully within particular social, material, temporal, and institutional conditions. It is not simply personal determination. Parents make choices within available resources, cultural expectations, professional relationships, school rules, finances, time, and family responsibilities. The same parent may be highly agentic in one context and constrained in another. In this paper, parental agency includes seeking multiple professional opinions, arranging therapy, learning and repeating exercises, adapting educational materials, negotiating support in school, continuing education at home after exclusion, and revising expectations through close observation of the child.

Family-centred care offers a useful but incomplete lens. It values dignity, information sharing, collaborative goals, enabling, and respectful parent-professional partnership. Reviews suggest that parent education, home programmes, collaborative planning, and supportive relationships can strengthen competence, satisfaction, and engagement, although outcomes vary and evidence does not support simplistic causal claims (Mota et al., 2024). My experience supports partnership, but it also shows how "home involvement" can become an extensive, largely invisible workload. Daily practice continued for years. Educational adaptation expanded when schools were unable to include my son. Agency protected continuity, yet it did not remove the system's responsibility.

2.3 Montessori-informed support and disability

Montessori education is organised around careful observation, an intentionally prepared environment, hands-on materials, progression from concrete experience, purposeful movement, practical-life activity, sensory discrimination, self-correction, repetition, and increasing independence. Manipulable materials can isolate particular properties such as dimension, colour, shape, sound, quantity, or symbol, allowing children to coordinate perception, action, and concept formation (Marshall, 2017). Montessori's history also includes work with children who were marginalised by conventional education, although contemporary claims about disability must be evaluated rather than romanticised.

Research on Montessori education has grown, but evidence specifically addressing children with physical disabilities and cerebral palsy remains limited. A recent systematic review of Montessori approaches for individuals with intellectual and developmental needs found promise alongside methodological heterogeneity and a need for stronger research (Di Blasi et al., 2025). Therefore, this paper uses the term Montessori-informed rather than claiming that a complete, standard Montessori programme was delivered or clinically validated. I drew upon principles and activity areas from my professional practice—Practical Life, Sensorial, Language, and Mathematics—and adapted them to my son's motor, visual, and communication profile.

Adaptation sometimes required departing from conventional presentation. Materials were positioned within reach and visual range; assistance was physical at first and reduced gradually; activities were divided into smaller steps; print was enlarged; reading was allowed to progress despite weak pencil control; verbal,

matching, selecting, and puzzle-based responses supplemented handwriting. Fidelity, in this context, did not mean rigidly preserving every material or lesson sequence. It meant preserving the deeper purpose: active participation, concentration, order, movement toward independence, and respect for development.

2.4 Inclusive education and institutional responsibility

Inclusive education is more than admission to a mainstream building. It requires the removal of physical, communication, curricular, attitudinal, and assessment barriers, together with meaningful participation and belonging. UNICEF (n.d.) notes that children with disabilities remain among those most likely to be out of school and face discrimination, stigma, and the failure to incorporate disability into school services. UNESCO's Global Education Monitoring Report warns that placing children in unprepared mainstream schools can intensify exclusion rather than create inclusion (UNESCO, 2020).

These concerns are highly relevant to Pakistan. The boundary between mainstream and special education can leave families with a narrow choice: accept segregation or attempt mainstream placement without adequate accessibility and support. My son received meaningful assistance in early Montessori settings when leadership and family relationships made accommodation possible. Later, mainstream schools identified mobility, vision, support-teacher needs, toileting assistance, and a different academic pace as reasons they could not retain him. The problem was not a single openly discriminatory statement; it was the accumulation of requirements that defined him as unmanageable. Home education became a family response to institutional exclusion, not evidence that systems were unnecessary.

3. Methodology

3.1 Research design

This study adopts an analytic autoethnographic design. Autoethnography connects systematic reflection on personal experience with analysis of wider cultural and institutional processes. Analytic autoethnography requires that the researcher be a full member of the setting, remain visible in the text, engage with others in the social world, and use experience to develop theoretical understanding beyond the self (Anderson, 2006). I am simultaneously mother, long-term caregiver, Montessori educator, advocate, and researcher. The first person is therefore not a stylistic decoration; it makes my position, responsibility, emotion, and interpretive authority visible.

The study combines chronological narrative with thematic analysis. Chronology preserves the developmental sequence from premature birth to the present. Thematic interpretation connects particular events—an early prognosis, a hand moving toward a balloon, a principal arranging a support teacher, a school refusing accommodation, a child rejecting a special-school identity—to broader questions of agency, participation, inclusion, and competence.

3.2 Context and participant

The account concerns my 13-year-old son. No name or pseudonym is used because the combination of a distinctive developmental history, family circumstances, and educational details could still permit recognition. He was born prematurely at approximately seven months of gestation, remained in an incubator for one week, and was diagnosed with cerebral palsy at seven months. The specific clinical subtype was not formally explained to me and is not inferred here. He also experiences nystagmus, which continues to affect visual access.

I have more than two decades of professional experience in early childhood and Montessori education and previously served as head of a Montessori department. I have continued employment and academic study, although with interruptions, and I am currently writing an MPhil thesis in education. These experiences shape what I noticed, the activities I selected, and how I interpret educational events. They also create a privilege that must be acknowledged: not every parent has comparable pedagogical knowledge, institutional relationships, time, or confidence.

3.3 Sources of experience and reconstruction

This draft is based primarily on retrospective maternal recollection developed through

structured chronological questioning. The reconstructed timeline includes birth and diagnosis, remembered professional messages, therapy, home activities, schooling transitions, developmental milestones, current abilities, and reflective interpretation. At this drafting stage, medical records, therapy notes, school records, photographs, videos, notebooks, and work samples have not been formally analysed. Before submission, available records should be reviewed to corroborate dates and distinguish contemporaneous evidence from later memory. A reflexive journal should also document how the narrative was reconstructed and revised.

Retrospective memory is not a neutral recording device. Emotionally intense events may be remembered vividly but not verbatim; dates may be approximate; later knowledge can reshape earlier meaning. Accordingly, phrases such as "I recall," "I observed," and "approximately" are used deliberately. The paper does not present remembered prognostic statements as a transcript or accuse individual clinicians. It analyses how restrictive messages were experienced and how they influenced maternal action.

3.4 Analysis

The narrative was organised into episodes and interpreted through repeated comparison. I asked what changed, what action was taken, what conditions enabled or constrained action, whose knowledge counted, and how the meaning of independence evolved. Five themes were developed: (1) refusing developmental finality while retaining professional support; (2) transforming care into participation through Montessori-informed activity; (3) separating motor and visual access from cognitive competence; (4) negotiating inclusion across enabling and excluding institutions; and (5) movement from parental advocacy toward the child's own agency.

3.5 Ethics, voice, and representation

Writing about one's child creates ethical obligations that exceed a one-time consent procedure. The child has a present and future interest in privacy, dignity, and control over his story. Before dissemination, his age-appropriate assent should be obtained and documented as an ongoing process. In accessible language, he should be invited to review the parts concerning him and to revise, veto, or remove quotations and details without pressure or penalty. His assent does not replace the researcher-parent's continuing duty to minimise harm.

Relational ethics also requires protection of teachers, school leaders, clinicians, relatives, and institutions. Personal, institutional, healthcare-provider, and precise geographic identifiers are therefore omitted or generalised. Removing names alone cannot eliminate deductive disclosure: a parent's occupation, linked schools, a rare developmental history, and an exact timeline may identify a family when combined. Only details essential to the analysis should be retained. Separate explicit consent would be required for any identifiable photograph, video, work sample, or verbatim quotation. Medical, therapy, and school records should be stored securely, accessed only for the study, and reported in de-identified form.

The manuscript must not claim research-ethics approval or exemption unless it has actually been obtained. Before submission, the author should consult her university and the target journal to determine whether committee review, approval, or a formal exemption determination is required for autoethnographic research involving a minor. Any decision should be reported accurately. This account avoids causal claims about individual treatments, does not endorse unverified therapies, and distinguishes remembered professional statements from documented clinical facts.

The paper also avoids two harmful narratives. First, it does not portray disability as tragedy redeemed by maternal heroism. Second, it does not present milestone attainment as a moral achievement that all children should reproduce. My son's value does not depend on walking, speaking, reading, or self-care. His progress is reported because it illuminates access, adaptation, expectation, and agency—not because independence determines human worth.

4. Autoethnographic Narrative: From Prognosis to Participation

4.1 Premature birth, diagnosis, and the language of impossibility

My son was born at approximately seven months of gestation and remained in an incubator for one week. During the following months, I observed that development was not proceeding as I expected. His body appeared unable to support itself. He spent most of his time lying down, showed very limited trunk and postural control, did not move his hands purposefully toward objects, and did not consistently focus his eyes on faces or objects. At seven months, he was diagnosed with cerebral palsy. The subtype was not explained to me; what I received most clearly was a diagnosis and a future described through absence.

I consulted several medical practitioners. My recollection is that I was repeatedly told cerebral palsy could not be cured through medicine and would need to be managed through therapy. That distinction was medically important, yet it was accompanied by predictions that felt final: he might never sit, walk, speak, eat solid food, or develop useful vision because his eyes did not remain steadily positioned. I heard these statements as instructions to lower hope before his development had unfolded.

I did not reject medicine or professional therapy. At seven months I began physiotherapy and occupational therapy and sought other approaches, including complementary homeopathic treatment. This paper makes no claim that homeopathy treated cerebral palsy or caused functional improvement. What mattered for the story of agency was my refusal to interpret an uncertain prognosis as a completed biography. I accepted that my son had a serious lifelong condition; I did not accept that his possibilities could already be known in full.

The distinction became foundational. Denial would have meant ignoring his impairment and avoiding professional care. Agency meant responding to impairment while continuing to observe the person in front of me. I began to ask not, "Will he ever become normal?" but "What is he attending to now? What movement is possible today? How can I create one meaningful next action?"

4.2 The first movements: balloons, a rattle, and relational attention

My earliest interventions were simple. I hung colourful balloons within his visual field and positioned a rattle on a stand. At first he did not move his hands toward them. I watched carefully, adjusted their location, introduced movement and sound, and repeated the experience. Gradually, he appeared attracted by the objects and began to move his hands. To an observer, a partial movement toward a balloon might have looked insignificant. To me, it was evidence that attention could become action.

I placed different soft objects in his hands and gently supported him to grasp and squeeze. These activities joined sensation and movement: texture against the skin, pressure through the fingers, the experience of holding, and the discovery that an action could change an object. I spoke continuously, named objects and actions, recited poems and rhymes, repeated sounds, and treated gaze, facial expression, body movement, and vocalisation as communication before speech emerged.

These experiences were Montessori-informed, although they were not formal Montessori lessons for a seven-month-old. Observation came first. The environment was adjusted to invite purposeful response. Activities isolated manageable demands and were repeated without assuming immediate mastery. Most importantly, he was treated as an active participant rather than a passive object of care. Even when my hand supported his hand, I looked for his contribution.

4.3 From supported action to practical participation

As my son developed greater engagement, I introduced activities connected to daily life. I supported him in holding a banana, participating in feeding, tearing paper, and spooning. Later work included clay, pegs, colouring, tweezers, zipping, transferring nuts from one bowl to another under supervision, tracing, puzzles, stackers, coin posting, and ball posting. Sensorial activities helped him discriminate shapes, sizes,

positions, textures, and spatial relationships. Practical Life activities connected movement with a real purpose.

The sequence was neither quick nor linear. Materials had to be positioned for visual access and physical reach. I sometimes stabilised his body, guided the hand, or reduced the number of objects. Activities were divided into smaller steps. Time expectations were relaxed. Assistance was reduced when he could initiate or complete part of the action. Success was not only a finished product. It could be longer visual attention, a more purposeful grasp, controlled release, greater finger pressure, less physical prompting, or willingness to try again.

His developmental milestones were delayed across domains. He began sitting at approximately two years, walking at around four, and speaking at about five. Each milestone was preceded by years of smaller changes that age-based charts can make invisible. The charts told me how far behind he was; daily observation showed me that he was not static.

4.4 Ten years of therapy and the continuity of home practice

My son received physiotherapy and occupational therapy for approximately ten years. Therapy addressed postural control, sitting, balance, mobility, hand use, functional participation, and fine-motor development. I repeated recommended exercises at home every day. The clinic and home were connected: professionals contributed specialised knowledge, and I contributed continuity, observation across contexts, and the ability to weave practice into ordinary routines.

This continuity was demanding. A home programme is often summarised as a few prescribed exercises, but in lived experience it reorganises time. Practice must occur when the child is rested, materials must be available, resistance and fatigue must be negotiated, and the parent must remain encouraging while monitoring safety. The work continues when progress is slow and when there is no immediate external recognition.

At 13, my son receives home-based therapy once a week. Every evening I take him outdoors, where he rides a three-wheeled bicycle. Cycling is physical activity, but it is also recreation, choice, visibility in the community, and a form of participation. It reminds me that development should not be reduced to correction. A child requires enjoyment and belonging, not only rehabilitation.

4.5 Early school inclusion through cooperative leadership

At approximately two and a half years, my son began attending an early Montessori school, where I was head of the Montessori department. The school principal and management cooperated, and a supporting teacher assisted him in class. What matters analytically is that leadership chose to make participation possible.

The supporting teacher helped with positioning, material handling, transitions, and classroom activity. My son did not initially use materials at the same speed or in the same way as peers. Yet he could belong to the classroom because expectations and assistance were adjusted. Inclusion was created through relationships: maternal advocacy, professional knowledge, principal leadership, management approval, and daily support.

At approximately five years, he continued at a second family-supported school setting, a school associated with my sister, until about seven. Again, familiarity and family support helped sustain access. These early placements demonstrate both possibility and fragility. Inclusion occurred where decision makers knew the family and were prepared to respond. It was not yet a dependable right that could travel with the child to any school.

4.6 The collision between cognitive competence and school manageability

As my son grew, I observed strong cognitive skills. He understood instructions, remembered information, engaged with symbols, and learned when materials were accessible. However, his motor and visual profile remained uneven. Nystagmus weakened visual access, and fine-motor development made writing difficult. He could understand more than he could efficiently record with a pencil.

Mainstream schools focused on the supports he required: mobility accommodations, large or accessible visual materials, a supporting teacher,

assistance with toileting and personal routines, and flexibility for a different academic pace. Collectively, these needs were treated as reasons not to admit or retain him. His body became the evidence schools used to predict manageability, while his comprehension received less weight.

Special education was presented as the alternative, but my son rejected that identity strongly. He said, "I will not go to a special school. I am not a special child; I am like everyone else." I do not interpret his words as a judgment that special schools or their students have less value. They expressed his desire not to be separated or defined primarily by diagnosis. He wanted support without exclusion and difference without diminished belonging.

His statement also marked a change in our relationship. For years I had acted on his behalf. I selected therapists, repeated exercises, chose materials, negotiated schools, and interpreted small responses. Now he was articulating a preference about his own identity and education. Parental agency had to make space for child agency.

4.7 Home education as adaptation and institutional consequence

When neither mainstream nor special-school options met my son's needs and preferences, I continued his education at home. This decision was enabled by my Montessori background, but it was also forced by restricted choices. Home education allowed individualisation; it also transferred the work of inclusion from the system to the mother.

Because of nystagmus, I wrote and prepared text in a large font. I taught Urdu and English through phonics. He learned to read and understand, and we progressed to word puzzles and simple stories. The word puzzles allowed him to select, arrange, and interpret language without requiring extended handwriting. In Mathematics, he developed counting, shape recognition, addition, and subtraction through concrete and structured experiences. Qur'an memorisation became part of his linguistic, cognitive, and spiritual learning.

The decision to emphasise reading was especially important. Fine-motor delay made pencil use and written production difficult. Conventional academic practice often treats handwriting as proof of knowledge. I refused to delay literacy until his hand could display everything his mind understood. Reading, listening, speaking, matching, selecting, manipulating words, and solving puzzles became legitimate evidence of learning. At the same time, clay, pegs, tweezers, zipping, transferring, tracing, colouring, posting, and other activities continued to prepare his hand for writing.

This was Montessori's isolation of difficulty applied to access. Reading, comprehension, visual discrimination, motor planning, and pencil control were related but not identical. By separating them, I prevented one impairment from closing every route to academic progress.

4.8 Current independence and continuing support

At 13, my son walks without support, eats a wide range of foods, communicates verbally with increasingly clear speech, reads, understands learning activities, and completes foundational language and mathematics work. His nystagmus continues, and writing remains affected by fine-motor challenges. He performs eating, dressing, toileting, and bathing largely by himself under my supervision.

I describe this as independence with supervision. Independence does not require the disappearance of relationships. I remain nearby for safety, sequence, verbal guidance, and unexpected difficulty. Earlier I provided substantial physical assistance; later I prompted; now I often supervise. The reduction in assistance is meaningful, but interdependence remains part of ordinary human life.

I also continued my employment and education. My path included interruptions and slower periods, but I did not permanently abandon professional or academic identity. I am now writing an MPhil thesis. My journey is therefore not accurately represented as a single maternal sacrifice in which selfhood disappeared. It is a process of sustaining motherhood, teaching, work, and study through continual reorganisation.

5. Thematic Findings

5.1 Refusing developmental finality without refusing professional knowledge

The first theme concerns the difference between diagnosis and destiny. The diagnosis helped name a condition and organise therapy. The problem arose when uncertainty was communicated as final incapacity. My response was not to reject professional knowledge but to resist developmental closure. This distinction protected both realism and possibility. I arranged physiotherapy and occupational therapy, repeated exercises, and sought ophthalmological care for nystagmus. At the same time, I treated emerging attention, movement, communication, and learning as evidence that the future remained open.

This finding supports a need for careful prognostic communication. Families require truthful information about impairment and support needs, but statements about what an infant will "never" do can narrow parental expectations, reduce opportunities, and damage trust. Professionals can communicate uncertainty, probable trajectories, and realistic goals without defining the child's complete future.

5.2 Transforming care into participation

The second theme is the conversion of care routines into opportunities for agency. Holding a banana, spooning, tearing paper, squeezing clay, transferring objects, zipping, and posting were not only preparatory exercises. They allowed my son to cause events, make attempts, and contribute to daily life. Over time, supported participation developed into self-care under supervision.

Montessori-informed support was valuable because it shifted attention from doing things to the child toward arranging conditions in which the child could do part of the activity. The adult's role changed from full physical guidance to partial support, prompting, and supervision. Independence became a graduated relationship rather than an all-or-nothing status.

5.3 Separating access from competence

The third theme is the danger of interpreting motor output as cognitive capacity. My son's fine-motor limitations affected writing, while nystagmus affected the size and placement of print. Large fonts, phonics, verbal response, word puzzles, matching, concrete mathematics, and extended time opened alternative routes. These adaptations revealed competence that standard tasks might have concealed.

This theme has implications for assessment. If knowledge is measured only through handwriting speed, copying, or visually dense worksheets, the assessment partly measures motor and visual access. Teachers need multiple response modes and should ask whether a poor performance represents misunderstanding or an inaccessible method of demonstrating understanding.

5.4 Inclusion as an institutional achievement, not a family characteristic

The fourth theme is that inclusion depended on leadership, staffing, and flexibility. In early settings, a cooperative principal, management, a support teacher, and family relationships enabled participation. Later, the combined demands of mobility, vision, toileting, staffing, and academic pacing were treated as disqualifying. The same child could be "included" or "unmanageable" depending on the institution.

This finding challenges narratives that praise an exceptional parent while leaving systems unchanged. My knowledge and persistence mattered, but inclusive education should not depend on a mother being a Montessori department head or having a sister connected to a school. Institutional capacity must become predictable: accessible spaces, support-person arrangements, flexible curriculum, teacher preparation, assistive and large-print materials, and collaborative planning.

5.5 From parental agency to child agency

The fifth theme emerged when my son rejected the label he associated with special schooling. His words—"I am like everyone else"—expressed belonging, equality, and a wish to influence decisions about his own life. His statement requires nuanced interpretation. Equality does not mean identical support. Nor does it require denying disability. It means being recognised as fully human, cognitively capable, and entitled to

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participate with peers while receiving necessary accommodation.

Parental advocacy can unintentionally dominate a child's voice, particularly when the parent has spoken for the child over many years. Ethical parental agency must therefore evolve. As communication develops, the parent moves from deciding for the child toward deciding with the child, while continuing to protect safety and access.

6. Discussion

This autoethnography shows that developmental outcome, educational opportunity, and independence were relational achievements. My son brought attention, effort, preferences, memory, understanding, and persistence. Therapists contributed specialised knowledge. I contributed daily continuity and pedagogical adaptation. Supportive school leaders temporarily created participation. Excluding schools later restricted it. The environment did not merely respond to an already fixed level of ability; it helped determine which abilities could be expressed.

The account aligns with the WHO interactional understanding of disability and with family-centred rehabilitation, but it adds a critical caution. Family involvement can be enabling while also compensating for systemic absence. Ten years of therapy accompanied by daily home practice represents partnership, but home education after school exclusion represents a transfer of institutional responsibility. Researchers and professionals should distinguish parent-chosen participation from parent-enforced substitution.

Montessori-informed practice contributed a language and structure for adaptation. Observation helped identify readiness. Purposeful objects invited movement. Practical Life connected motor work with everyday autonomy. Sensorial activity joined perception, manipulation, and categorisation. Phonics, large print, word puzzles, and concrete mathematics provided accessible academic routes. The child's pace informed progression. However, the account cannot establish that Montessori caused particular milestones. Physiotherapy, occupational therapy, maturation, healthcare, family interaction, school experience, and the child's own development occurred together. The contribution claimed here is interpretive: Montessori principles helped a mother-educator organise opportunities and recognise competence.

The narrative also complicates conventional developmental timelines. Delayed milestones were real and consequential. Sitting at two, walking at four, and speaking at five required support and shaped access. Yet delay did not equal stasis. An exclusive focus on normative age can obscure within-child change. A both-and approach is needed: compare development to evidence-based expectations when planning services, while also documenting progress relative to the child's previous functioning and personally meaningful goals.

My son's school experience illustrates the limits of placement-based definitions of inclusion. Early participation succeeded because adults reorganised support around him. Later rejection arose because ordinary school structures were treated as fixed. His cognitive competence did not erase physical and visual needs, but those needs should have initiated accommodation planning rather than exclusion. UNICEF and UNESCO guidance similarly emphasises that inclusion requires systems to identify and remove barriers, not merely place children in unchanged classrooms (UNICEF, n.d.; UNESCO, 2020).

His declaration that he was "like everyone else" also invites a disability-identity reading. The phrase could be misunderstood as rejection of disability or internalised stigma. Within this account, it expressed a demand for common membership. He did not say he needed no help; his life already included assistance and supervision. He objected to being reduced to a category that, in his understanding, separated him from peers. Adults should explore such statements with children rather than correcting them immediately. What does "special" mean to the child? What experiences produced that meaning? What placement would support both services and belonging?

Finally, the paper makes visible the mother's layered identity. My Montessori expertise increased my ability to adapt, but it also increased

what others could expect me to provide. Continuing work and study with interruptions complicates the familiar narrative of maternal self-erasure. Parental agency included sustaining my professional and academic identity, which in turn enriched the support I offered. The relationship was reciprocal: education shaped care, and caring generated new research questions about development, inclusion, and systemic responsibility.

7. Implications

7.1 For rehabilitation professionals

Professionals should communicate prognosis with precision and humility. Families need honest explanations of cerebral palsy, likely support needs, and uncertainty. Statements of permanent impossibility should be avoided unless strongly justified, and even then should be framed in ways that preserve goals for participation and quality of life. Therapists should treat parents as collaborators, demonstrate home activities, observe parent practice, agree realistic routines, and monitor caregiver workload. Home programmes must fit family life rather than assume unlimited parental time.

7.2 For Montessori and early-years educators

Montessori educators should distinguish fidelity to developmental purposes from rigidity of presentation. For a child with motor or visual disability, useful adaptations may include stabilised or repositioned materials, reduced quantity, larger components, increased contrast and font size, slower presentation, repeated demonstrations, alternative response modes, and carefully faded physical assistance. Practical Life and Sensorial activities can support participation, but educators should coordinate with therapists when movement, posture, swallowing, or safety requires specialist guidance.

7.3 For mainstream schools

Schools should not use mobility, toileting, support-teacher needs, visual access, handwriting, or slower pacing as automatic reasons for exclusion. Before refusing placement, schools should conduct an individualised access review with the child, family, teachers, and relevant professionals. The review should address physical access, personal-care planning, large-print or digital material, seating and positioning, peer participation, support-person roles, emergency procedures, flexible assessment, and a process for reviewing adjustments.

7.4 For assessment and curriculum

Assessment should separate the construct being measured from the access method. A reading assessment need not become a handwriting test; mathematical understanding need not depend on copying; comprehension can be demonstrated verbally, through selection, matching, manipulation, eye-gaze-supported choice, or assistive technology. Large print and reduced visual clutter should be available where nystagmus or other visual conditions affect access. Teachers should document both independent performance and performance with specified support.

7.5 For policy and equity

The story raises an equity concern. Intensive parental support can produce opportunity, but it cannot be the national inclusion strategy. Families without educational expertise, flexible employment, transport, supportive relatives, or money for therapy may face greater exclusion. Policy should fund school-based support, teacher preparation, accessible infrastructure and materials, multidisciplinary consultation, and transition planning. Parent knowledge should inform services without becoming unpaid replacement labour for absent services.

8. Limitations and Directions for Further Research

This paper presents one mother's retrospective account and does not represent all children with cerebral palsy, all Montessori settings, or all Pakistani families. The narrative is shaped by memory, professional identity, emotional investment, and later educational knowledge. Dates are approximate, and remembered professional messages are not verbatim records. The child's clinical subtype and standard functional classifications are unavailable and should not be inferred.

The study cannot establish causality. Development occurred alongside maturation, physiotherapy,

occupational therapy, home practice, schooling, healthcare, complementary treatment sought by the family, and daily relationships. No claim is made that homeopathy cured or improved cerebral palsy, and no claim is made that Montessori education independently produced motor, speech, visual, or academic outcomes.

The current draft relies primarily on reconstructed memory. Before submission, the author should review available medical and therapy reports, school documents, photographs, videos, notebooks, large-print resources, and work samples; construct a dated timeline; keep a reflexive journal; and clearly identify which claims are corroborated. The child's ongoing assent should be documented, contextual details reviewed for deductive disclosure, records secured, third parties protected, and institutional ethical requirements followed.

Future research could include multi-perspective autoethnography or a qualitative case study incorporating my son's own interview, observations of home learning, therapist perspectives, school-leader accounts, and analysis of learning artefacts. Comparative studies could examine how families with different educational, socioeconomic, and geographic resources negotiate similar barriers. Research is also needed on Montessori-informed adaptations for children with physical and visual disabilities, especially in low- and middle-income contexts.

9. Conclusion

My son's developmental timeline was delayed, but it was not static. Born prematurely and diagnosed with cerebral palsy at seven months, he initially showed profound difficulties in posture, voluntary movement, visual attention, feeding, communication, and participation. I recall being told to prepare for the possibility that he would never sit, walk, speak, eat solid food, or develop functional vision. At 13, he walks without support, speaks with increasing clarity, eats independently, reads Urdu and English, understands learning tasks, completes foundational mathematics, participates in Qur'an memorisation, rides a three-wheeled bicycle, and manages major self-care routines under supervision. Continuing nystagmus and fine-motor difficulty still shape how he accesses print and writing.

This is not a cure narrative and not proof of one method. It is an account of development produced through interaction: a child's efforts, long-term physiotherapy and occupational therapy, daily practice, Montessori-informed observation and adaptation, supportive relationships, accessible materials, family continuity, and institutional decisions that alternately opened and closed opportunities.

The central lesson is not that every parent must do more. It is that systems must learn to see what motor and visual limitations can hide. A child who cannot write quickly may still read and reason. A child who needs toileting assistance may still belong in a mainstream classroom. A parent's knowledge can strengthen professional practice, but should not substitute for it. Inclusion becomes real when support follows the child rather than when the child is required to fit unchanged structures.

My agency began as action on behalf of an infant whose responses were difficult to read. It developed through therapy, teaching, institutional negotiation, and the creation of home-based education. Over time, my son's own agency became unmistakable. His statement—"I am like everyone else"—does not erase disability. It demands recognition, belonging, and the right to receive support without being reduced to a diagnosis. That demand should guide families, educators, rehabilitation professionals, school leaders, and policymakers alike.

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