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Mothering the Aggressive Child

Katja Ermann
Antioch University Seattle

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recommend that it be accepted by the faculty of the Antioch University
Seattle at Seattle, WA in partial fulfillment of requirements for the
degree of

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Dissertation Committee:

_____
Jude Bergkamp, Psy.D.
Chairperson

_____
Elin Björling, Ph.D.

_____
Rochelle Coffey, Psy.D.

_____
Date

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ABSTRACT

MOTHERING THE AGGRESSIVE CHILD

Katja Ermann

Antioch University Seattle

Seattle, WA

This qualitative study explores the experience of mothers parenting significantly aggressive children, ages five to 10. Little has been known previously about how women experience this aggression or the social and psychological impacts it has on them. This dissertation highlights the women's understandings to provide a solid basis for theoretical explication using a Constructivist Ground Theory approach. Significant findings include the invisibility and stigma the women feel and the ways in which the experience is similar and dissimilar to other forms of family violence, particularly adolescent-on-parent violence (APV). Differences were found in social stigma between women whose child has a neurodevelopmental disorder and those parenting a child with trauma. Women were found to endorse a narrative that "good mothers" sacrifice even their own safety for their children and use their strong empathy for their children as a source of empowerment. Finally, the relationship of these findings to the literature as well as discussion of their clinical implications of the study findings are presented. This dissertation is available in open access at AURA: Antioch University Repository and Archive, http://aura.antioch.edu/ and OhioLINK ETD Center, https://etd.ohiolink.edu

Keywords: child-on-parent aggression, mothering, constructivist grounded theory, child aggression, parent abus

Dedication

To my children, who have supported me whole-heartedly throughout this process. Being their

mother is the most important work I will ever do.

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Introduction

This qualitative study explores women's experiences of mothering physically aggressive children. Currently, the literature generally only addresses the experience of what is sometimes called child-on-parent violence (CPV) between teens and parents, and little is known about this experience in families with younger children; for example, it is unclear how often it happens and the ways in which it affects the family. This phenomenon has important clinical implications but is currently so poorly understood that practitioners and parent educators have little guidance in how to help parents experiencing physical aggression from their children. This study begins to develop understanding of the impact children's aggression has on women, their relationships, and their conception of themselves as mothers.

My personal and clinical experience both indicate that this experience is much more common than one would infer from the literature. In fact, it has significant effects on the family dynamics and power structure, and the ways in which the family functions in the larger community. There appears to be significant social stigma and shame associated with these incidents; the larger social discourse around motherhood plays a significant role. The participant-mothers have given voice to the experience and informed the language and meaning they make, and the discussion places those results into, and out of, established frameworks of mothering, family violence, and clinical understanding.

Literature Review

Currently, little research addresses the phenomenon of CPV in general, and even less on mothers' experience of it in particular. What research exists has largely examined adolescents perpetrating violence on their parents; most studies look at adolescents aged 14 and up, though a very few include children as young as ten (Biehal, 2012; Charles, 1986; Edenborough, Jackson,

Mannix, & Wilkes, 2008; Ghanizadeh & Jafari, 2010; Nock & Kazdin, 2002). This review will discuss the definitions and features of parent abuse; examine the literature that does include younger children; explicate the understanding of adolescent-on-parent violence, including the characteristics of the families and circumstances described in the literature; and address mothers' experience and some of the relevant themes emerging from the qualitative literature.

This literature search was conducted using multiple databases, including PsycInfo, the OhioLink Electronic Journal Center, and Proquest Psychology, as well as WorldCat's academic library book database. These searches were performed on multiple occasions, primarily in the beginning of the proposal process throughout 2014 and again after results were compiled in the spring of 2018. During that time period, there was a significant increase in the number of studies of APV. Search terms included "child on parent violence," "child aggression parents," "parent abuse child," "child rage," and "child aggression." Review of reference lists yielded additional resources as well.

The lack of information about a frequently-observed clinical phenomenon is both interesting and troubling; studies indicate that younger children are more likely to be significantly aggressive than adolescents, but that families are less likely to seek the services of law enforcement or other authorities for this age group, perhaps due to less perceived physical risk (Lyons, Bell, Frechette, & Romano, 2015). There also appears to be a cultural unwillingness to consider children as violent, as Selwyn and Meakings (2016) note: "Perhaps the term 'challenging behaviour' has disguised the behaviours that mark out APV and a generic term has been an obstacle to developing a deeper understanding of the difficulties" (p. 1235). These issues carry over into the studies considering adolescents. Using the same keywords and databases studies were identified focusing on adolescents' violence towards parents, discussed below.

What is Parent Abuse?

Some aggression in children, particularly younger children, is typical, and often is directed at their parents. These incidents generally occur in the context of a temper tantrum or other dispute in which the child resists parental direction and are generally minor and inconsequential. However, there are also a subset of children who demonstrate significantly more severe aggressive behaviors which can become risky for themselves or their targets. What distinguishes this typical behavior from abuse?

Definitions for parent abuse vary somewhat. Kennair and Mellor (2007) state that parent abuse "can be defined as any act perpetrated by a child or adolescent that causes a parent to feel threatened, intimidated and controlled. As with partner abuse it can include physical, psychological, emotional, and financial abuse" (p. 204); similarly, Cottrell and Monk (2004) used the definition "any act by a youth that was intended to cause physical, psychological, or financial damage to gain power and control" (p. 1080). It could be argued, however, that even a toddler who hits a parent to get their way is using violence as a means of gaining power and control, though few would understand such as abuse. Gallagher (2004) emphasizes that when considering CPV there is a need to "be able to switch lenses rapidly: it is not a matter of whether an individual is 'really' a 'victim' or an 'abuser' but a question of which focus is most helpful at that point in time" (p. 96). The dominant discourse in family violence presents a male perpetrator committing aggression against a female victim, but it is clear that the dynamics between parent and child are somewhat different, even if the acts of aggression or control per se are similar (Baker, 2012, p. 265).

These acts of violence can occur only once or occasionally, or can develop into consistent patterns used to gain power and control. One-time acts can be significantly injurious, but these

patterns of control are generally what defines abuse (Paterson, Luntz, Perlesz, & Cotton, 2002). In most cases of family violence, "the perpetrator is understood to have both 'cultural authority' and greater economic, political and physical power in relation to the victim.… The term 'abuse' generally refers to an 'abuse of power' committed by those with the most power against those with the least power" (Holt, 2013, p. 2). Intimate partner violence is generally understood to involve a pattern of "exerting power and control in an intimate relationship through intimidating, threatening, harmful or harassing behavior" (Hearn, 2012, p. 159) which may include the threat of or actual physical violence. While individual acts of violence are directed from one individual to another, power is not only personal but institutional and cultural. For example, violence, particularly intimate violence, is extremely gendered, with a staggering 25–50% of women worldwide experiencing some form of assault, whether physical or sexual, perpetrated primarily by male partners (Hearn, 2012, p. 154).

These larger cultural influences, particularly patriarchy, also influence the dynamics of parenting. Parents hold certain forms of institutional and cultural power that children do not. They are recognized as holding legal, educational, and medical decision-making power for their children, for instance. They also are culturally supported in making household decisions on where and how to live, including discipline practices, routines and responsibilities in the home, and dictating expected behaviors and other intra-familial cultural practices. Foster parents are subject to additional monitoring and imposition of specific parenting practices, with more imposition from larger cultural norms, but their parental authority is still recognized. Parents also can expect the freedoms accorded to most adults such as bodily autonomy and choices about activities. For parents of children experiencing CPV, these expectations may be constrained by their child's aggression; in a major example, the women are being hurt without their permission,

losing their bodily autonomy, despite their apparent "authority" as the parent. Children and adolescents have more recently gained political power, as child abuse and physical discipline has become less accepted, and notions of children's rights have grown. Holt (2003) notes that attempts to understand power relations in terms of parents as powerful and children as powerless are simplistic and ignore more subtle differences in the parents', children's and adolescents' political and economic power, physicality, knowledge and resource power and legal power. They also ignore subtle shifts in the changing social status of childhood, parenthood, and adolescence. Ignoring these subtleties risks ignoring the abuses of power that can be perpetrated by children and young people against their parents (pp. 96–97).

Women come to mothering from a variety of intersections of race, gender, age, and subculture, and are likely to have already experienced oppression in various forms; it is important to place the experience of CPV within this larger context of gendered violence.

That said, recognition that children may not have the developmental capacity for the intentionality that marks out abusive behavior may also shape how people view aggression in younger children, while teens are acknowledged to have the capacity to use violence instrumentally and use verbal threats of violence to control their parents (Selwyn & Meakings, 2016, pp. 1235–1236). In extreme cases, children or adolescents commit parricide; fathers are the most likely victims, however, and it is quite rare, with fewer than one percent of homicides in the United States being perpetrated by the child of the victim, at whatever age (Walsh & Krienert, 2009). However, it is clear that even fairly young children are capable of significantly injurious violence and can create considerable levels of fear in their parents.

Similarly, there is not ready agreement on what constitutes violence in children. Ulman and Straus (2003) argue that risk of injury is not an essential factor for an act to be considered

violent, giving the example that a partner who slaps another adult may not injure or leave a mark but would clearly be perceived as violent. Ulman and Straus (2003) further note

> "because it can be assumed that a child who kicks or bites a parent wants the parent to experience pain, the lack of injury does not remove CPV by young children from the category of violence. … CPV by young children, though it rarely causes physical injury, may be a source of emotional distress to parents. (p. 42)

They do not address, however, at what age the ability to make the connection between an act of aggression, such as a bite, and the potential for injury may be developmentally possible. . Perhaps most researchers assume that children younger than approximately 12 cannot perpetrate abuse against their parents, given the lack of studies looking at children below that age. It is clear that developmental perspectives are necessary when considering the issue of CPV.

Child Aggression: A Developmental Perspective

Aggression in children may result from challenges with emotion regulation and is often tied to deficits in impulse control, social skills, and distress tolerance. The development of emotion regulation is theorized to begin in infancy and continue developing through adulthood, and aggression at some ages is considered a normative behavior. For instance, in the toddler and preschool years, aggression is relatively common due to immature impulse control and lack of social skill development, but by the elementary years (ages five to 11), physical aggression generally has passed as a common behavior. This development appears to be influenced by temperamental, familial, and larger socio-cultural factors. Aggression in the later years is generally associated with psychopathology.

In infancy, caregivers provide external regulation of babies' internal states through attuned responses until the child can develop self-soothing (Ingram & Price, 2010). Parents

recognize a feeling state in the baby and respond appropriately, often naming the feeling in the process, and so develop verbal cues and provide the child with the understanding that others see and understand their feelings (Siegel, 1999). This attunement process is influenced by the child's temperament, or inborn characteristics such as regularity of bodily cycles, intensity of emotional response, and general mood, which "evoke particular parenting responses and create its own self-fulfilling reinforcements, which further amplify the inborn trait" depending on parental temperamental fit (Siegel, 1999, p. 245). In this way, parents can either increase a fussy child's capacity for self-soothing by responding consistently and patiently or can make a fussy child more dysregulated by responding inconsistently or with a negative affect; when things go well, the child learns that help is available and learns to first wait for it and then to provide it via self-soothing. This coping capacity appears to have three components, namely management of affect, of situations (e.g., problem-solving), and of behavior (Ingram & Price, 2010, p. 212). As children age, they also learn to moderate the way they display their emotions for social effect, for instance approaching someone although they feel anxious. It is clear that affect, social cognition, and behavior are inextricably threaded together from infancy and are key to the formation of the self (Siegel, 1999). It appears children with better developed skills in self-regulation are able to inhibit socially inappropriate responses and choose more appropriate ones (Ingram & Price, 2010, p. 213). Generally in toddlerhood and the preschool years, verbal aggression rises and physical aggression decreases as expressive vocabulary develops, with 70% of two- and three-year-olds hitting others at times but only "20% at ages 4 and 5 and 12% by third grade" (Damon & Lerner, 2008, pp. 438–439); Ulman and Straus (2003) found similar results, with 20% of mothers of three-to-five-year olds reporting being hit in the last year, and 10% of parents of 14-to 17-year-olds.

There appears to be a difference between those children who demonstrate reactive versus proactive aggression; that is, those children who appear to behave aggressively as a way to express or modulate their emotional responses versus those who use violence as a conscious means to an end. It appears that

> reactively aggressive children are more likely to come from physically abusive families, to be temperamentally irritable and dysregulated, to have poor interpersonal problem-solving skills, to misperceive others' motives as hostile, and to be socially rejected than their proactive peers…Proactively aggressive children, in contrast, expect more positive outcomes to their aggression, are less anxious, and are more likely to emerge as delinquents in adolescence. (Kerig & Wenar, 2006, pp. 303–304)

Impulsively reactive children appear to be developmentally immature or have deficits in their emotion regulation. Siegel (1999) proposes that the ability to choose a response rather than reacting impulsively results from a capacity for metacognition about emotions; in other words, the ability to recognize emotional states and their connection to prior similar experiences and choose the meaning and behavior to associate with the feeling. Another way to conceptualize this distinction is as expressive or instrumental; children are more likely to consider using aggression as an expression of strong feeling when they are very young or have impaired maturity due to a disability such as a neurodevelopmental disorder (Gallagher, 2004).

Children with some diagnoses may be more likely to demonstrate aggression. Many of these disorders can be seen as disorders of self-regulation, such as mood disorders, anxiety disorders, and others (Siegel, 1999). Attention Deficit Hyperactivity Disorder (ADHD), bipolar disorders, schizophrenia, intellectual disability, autism spectrum disorders, and oppositional defiant and conduct disorders are also associated with childhood aggression (Nevels, Dehon,

Alexander, & Gontkovsky, 2010). Depression, for instance, is associated with aggressive behaviors such as hitting, possibly in a negative feedback loop between depressed or irritable affect leading to negative behavior which

> alienates parents, peer, and teachers, resulting in more interpersonal conflict and rejection. Further, aggression makes children oppositional and negativistic at home and in the classroom, which leads to learning deficits and poor skill development. Both of these factors result in profound failure experiences in the social and academic realms. (Kerig & Wenar, 2006, p. 267)

These experiences of incompetence and their social consequences increase the likelihood of negative affect. In short, the aggression both results from the atypical development of the child and is reinforced by it by creating negative social interactions and poor self-confidence.

Trauma, such as that caused by neglect or abuse, also appears to have a significant impact on the development of these social-emotional and executive functioning skills from the prenatal period throughout early childhood. In-utero exposure to stressors in the mother may set the stage for problems through changes in brain and nervous system development, leading to, for example, changes in cortisol release in later childhood (Ingram & Price, 2010, p. 212). Early neglect, in particular, appears to disrupt developing regulatory skills through the absence of the attunement from the caregiver; 70 to 100% of children who have experienced maltreatment demonstrate insecure attachment (Kerig & Wenar, 2006, p. 439). Such problematic attachment patterns have been linked to aggressive behavior in kindergarteners and externalizing behavior problems throughout elementary school (Kerig & Wenar, 2006, p. 163). Physical abuse, in particular, can lead to difficulty with development of the self, potentially leading to delayed development of emotion identification as well as difficulty understanding others' emotions and self-regulation of

emotion (Kerig & Wenar, 2006, p. 439). The attachment challenges resulting from abuse and neglect can also lead to social skills deficits, for example, abused toddlers are more likely to react to a peers' distress with fear and physical aggression, and this hostile response is likely to continue throughout the elementary years and beyond into adult relationships (Kerig & Wenar, 2006, p. 440). Putting these factors together, it is easy to imagine a scenario in which a developing child is facing challenges from prenatal exposure to mother's stress, possible genetic loading for mental illness, and exposure to both traumatic events and neglect. These traumas create neurodevelopmental changes and resulting challenges with emotion regulation, poor coping, interpersonal relationships, and frequent negative reinforcement by others due to behaviors. Add in the potential that this child will be removed from the home by child welfare, disrupting what attachment exists and often introducing multiple caregivers during the foster period, and it is easy to see why a child in these circumstances would develop aggressive behaviors.

Ecological models of development emphasize multiple layers of influence on child development. As discussed above, it is clear that individual characteristics of the child in combination with the family environment have a significant impact on the development of aggression in young children. Larger contextual factors influence this behavior, as well; young children who are aggressive are more likely to come from single parent homes, have low socioeconomic status, or parents with mental health or systemic legal problems of their own (Xie, Drabick, & Chen, 2011). Community violence levels also seem to influence aggression levels, at least in adolescents (Bradshaw, Glaser, Calhoun, & Bates, 2006).

Child-on-Parent Violence

CPV remains a poorly understood phenomenon, with more focus on adolescents than younger children. Some adolescent studies include children as young as ten, but most focus on ages 12 and older. Table 1 below presents an overview of the studies which at least partially report on children's aggression towards parents before adolescence; only two focus solely on the younger ages, though they both go include some adolescents up to age 14. There are no studies looking only at children without including adolescents.

Table 1

Studies Examining CPV (at or below age 10)

Author(s)	Age of Children	Focus of Study	Findings
Biehal (2012)	11-16, but mentions incidents starting age 5	Predictors and family characteristics of CPV	CPV was long-standing (prior to age 5); lone mothers were primary risk; parenting, child and parent mental health difficulties prevalent
Charles (1986)	7+	Incidence of CPV	One mention of a 7 year old; mostly white, highly educated parents
Edenborough et al. (2008)	Any age	Qualitative experience of CPV	Parenting is difficult due to fear of danger, isolation, complex emotions (love and resentment both), attempts to manage
Ghanizadeh & Jafari (2010)	5-14 year olds with ADHD	Factors associated with physical, psychological, verbal and financial abuse	Physical abuse and property damage were reported by 50% of parents; multiple forms of abuse co-occur (e.g. financial, verbal, physical)

Nock & Kazdin (2002)	2-14 year olds, clinical sample	Characteristics of children who were physically aggressive towards parents	12.2% prevalence across ages; increased oppositional and generally aggressive behavior increased parent-directed aggression; poor frustration tolerance and high demandingness; high levels of parenting stress; two-parent, higher socioeconomic class increased chances

Nock and Kazdin (2002) is a much-cited work examining a large clinical sample of

children ages two to 14 in an outpatient setting targeting children with conduct problems and

oppositional and aggressive behavior. They found that of this population, 12.2% directed

aggression towards their parents, with the most frequent forms of aggression being pushing or

grabbing, but often including throwing objects, hitting or slapping, kicking, biting, or beating (p.

199). These acts occurred most often in the "5–6 times a year" range, with parents reporting

minor injuries such as bruises or scratches as well as "marked pain" (Nock & Kazdin, 2002, p.

199). Children ranged in age from "2.6 years to 14, and the mean age of reported onset of parent-

directed aggression was 5.0 years" (Nock & Kazdin, 2002, p. 199). There were no gender

differences found in any factors reported, but the children who directed their aggression towards

parents were rated higher on overall aggression and oppositionality than those in control groups

and lower on frustration tolerance and adaptability (Nock & Kazdin, 2002, p. 200). They noted

the "reactive and impulsive (i.e. rather than proactive or callous and unemotional)" nature of the

aggression (Nock & Kazdin, 2002, p. 203). Parents who experienced aggression from their

children reported significantly higher levels of parenting stress than parents who did not, as well

as experiencing a poorer quality relationship with their child; parents of aggressive children were

not more likely to have their own psychopathology than parents of typical children (Nock &

Kazdin, 2002, p. 200). The children were more likely to come from two-parent, higher

socioeconomic class homes, which the researchers theorized was related to more permissive parenting styles in this group (Nock & Kazdin, 2002, p. 203). Witnessing or experiencing aggression in the home did not increase the likelihood that children would direct aggression towards their parents (Nock & Kazdin, 2002, p. 203).

Edenborough et al. (2008) had the most similar study to the research presented in this dissertation, though their mothers also experienced APV which may be confounding. This subset of a larger study examined the qualitative experience of child-to-mother violence in a sample of Australian women retrospectively recalling their children's behavior. They reported that 0.9% of their sample reported CPV or APV and examined the open-ended remarks parents provided on the survey (Edenborough et al., 2008). The incidents occurred from before the age of nine in 17.3% but the experiences were not analyzed separately for the younger versus older children (Edenborough et al., 2008). The primary theme identified was "living in the red zone," describing a constant feeling of danger from their child; the women described "walking on eggshells," and feeling overwhelmed and isolated (Edenborough et al., 2008, p. 468). The women reported constantly feeling in conflict, "torn between nurturing and caring for their child or children and resentment of the offending child or children because of the abusive treatment they received" (Edenborough et al., 2008, p. 468). A second subtheme highlighted the attempts the women made to get their child help, often finding that resources did not offer useful support (Edenborough et al., 2008, p. 479). The authors note that the mothers often "minimized the occurrence of violence, either reframing their child's behavior in a positive light or dismissing the seriousness of the violence in contradiction to their self-reports" (Edenborough et al., 2008, p. 470); they attributed this to the conflict between the roles of victim and protector, as well as fear of social stigma (p. 470). They also highlighted the mothers' emphasis on seeking services

focused on their child rather than on themselves, and the ways in which mothers often felt at odds with or embattled towards service providers (Edenborough et al., 2008, p. 471). The large age range reported on and the retrospective nature of the recollections, sometimes more than a decade into the past, are limitations of this analysis.

Similarly, Biehal (2012) analyzed interviews with parents and youth aged 11 to 16 seeking support from social services in the United Kingdom. While her analysis also focuses on the adolescent age group, she reported that 21% of parents reported that the aggressive incidents began prior to age five, and notes that children who are aggressive in preschool are nearly four times more likely to perpetrate parent abuse in the teen years (Biehal, 2012). Both Biehal (2012) Edenborough et al. (2008) indicate that many parents experience aggression from their children starting well before and continuing into adolescence.

One study examined children with ADHD and their families in a clinic setting in Iran, starting at age five through 14 for boys and six through 14 for girls (Ghanizadeh & Jafari, 2010). More than half of the 74 parents reported some kind of abuse, which was defined as physical, financial, psychological, or verbal abuse (Ghanizadeh & Jafari, 2010, p. 79). They found that both genders equally abuse their parents and that comorbidity of oppositional defiant disorder, tics, and separation anxiety disorder correlated with increased rates of abuse (Ghanizadeh & Jafari, 2010, p. 78). The types of abuse were all correlated with each other, indicating that there is significant overlap in these behaviors (Ghanizadeh & Jafari, 2010, p.79). The high rate of prevalence in this population should be noted but is likely due to the clinical nature of the sample. This study highlights the frequency of CPV in the clinical population but does not address the dynamics involved.

A somewhat older study, Charles (1986) reviewed 300 adult cases from an in- and out-patient clinic, looking for reports of child or adolescent aggression towards parents, either by the now-adult patient to their own parents or towards the patient from their child. Charles' reporting of his data does not allow for illuminating differences that may occur in aggression that began in childhood versus that which began in adolescence. He did note that prior to adolescence, males and females aggressed against their parents in equal measure, while after puberty males were more likely (Charles, 1986, p. 346), but it is unclear how he came to this conclusion. He reports specifically on two incidents involving younger children: a 7-year-old met criteria for parent abuse but was considered not abusive by the parent due to the perception of lack of ability to cause injury (Charles, 1986, p. 346), and a nine-year-old who attempted to stab her mother and broke her hand; this mother noted feeling inadequate and covering up the extent of her daughter's violence towards her out of shame (Charles, 1986, p. 352). The retrospective nature of the reports (which in some cases appear to be from an adult participants' childhood) and the lack of distinction between child and adolescent aggressors limits the value of this study for the purposes of this review.

These few studies barely begin to address the nature and family dynamics of CPV and how it may differ from APV. They may represent a portion of the population in which the aggression continues into adolescence but it is unknown to what extent this is a common trajectory. They also do little to explore the possible family dynamics, understanding of etiologies, or evidence-base for treatment.

Adolescent-to-Parent Violence (APV)

For adolescents, reported prevalence rates vary depending on the populations studied, but it appears to be in the range of 14–20% when considering primarily physically abusive behavior

(Lyons et al., 2015, p. 729); this rate appears to hold true across the Westernized countries, with the United States, the United Kingdom, and Australia providing the bulk of the research found for this review. Some studies consider children as young as 11 or 12 but most examine only adolescents older than 14. Studies report a variety of abusive and aggressive behaviors by teens against their parents. These range from physical assaults with or without weapons, to property destruction, verbal abuse, and other conduct problems such as stealing from parents. The stereotypical adolescent who aggresses against parents is a white male, between the ages of 14 and 17, with highest prevalence between ages 15 and 16 (Hong, Kral, Espelage, Allen-Meares, 2012; Kethineni, 2004); however, studies find considerable variation in child characteristics.

Child, parent, and family characteristics. The major child factors studied have been gender, age, and presence of child psychopathology. Whether male or female children are more likely to perpetrate aggression against their parents is not clear. Studies which identify adolescents in criminal justice-based populations often find that males are more likely to be aggressive (Kethineni, 2004), while studies looking at clinically-based populations find that daughters and sons are equally likely to be violent towards their parents, or, in some cases, that daughters are the more likely aggressors (Walsh & Krienert, 2007). There are mixed results for the relevance of race or ethnicity, with some studies noting white youth are more likely to assault their parents (Agnew & Huguley, 1989; Charles 1986) and others finding no difference (Cottrell & Monk, 2004).

Children with a psychiatric disorder, such as autism, conduct disorder, or attention deficit disorder, are more likely to be physically aggressive with their parents (Laurent & Derry, 1999). Many of these children have characteristics of depression and a poor sense of self-worth, expressed as suicidal ideation, difficulty with emotion regulation, and frustration tolerance

(Ibabe, Jaureguizar, & Bentler, 2003; Laurent & Derry, 1999). Kethineni (2004) found that the youth in a juvenile justice population frequently were reported as being diagnosed with hallucinations, depression, and bipolar disorder, ADHD, or conduct disorders. Similarly, ADHD was also found to be an important factor by Pagani, et al. (2004). Substance abuse was sometimes also a major factor in APV, with youth using alcohol and other drugs being more likely to be aggressive (Kethineni, 2004; Pagani et al., 2004; Walsh & Krienert, 2007). These adolescents sometimes were impaired due to their using, which lead to aggression, but parents also reported that behaviors such as stealing to finance their habit and arguments over limit setting about their use were also triggers for the aggression.

Mothers are more likely to be the target of their child's aggression than fathers are, even when living with a male parent figure (Cottrell & Monk, 2004; Kennair & Mellor, 2007; Kethineni, 2004). They frequently experience injury from the aggression, ranging from "bruises, cuts, and broken bones" to sometimes more serious injury, generally from "a wide range of tactics (kicking, punching, biting, weapons)" (Cottrell & Monk, 2004, pp. 1072–1073). Parents tend to minimize the seriousness of this behavior (Charles, 1986; Cottrell & Monk, 2004). The parents interviewed in Eckstein (2004) articulated a process of escalating verbal then physical and psychological abuse over time; with the three forms generally all occurring and reinforcing each other.

It appears that children exposed to parent-on-parent or parent-on-child violence are much more likely to become aggressive towards their parents themselves (Bradshaw et al., 2006; Cottrell & Monk, 2004; Hong et al., 2012; Selwyn & Meakings, 2016). It is possible that children who witness intimate partner violence (IPV)

learn that controlling behaviours are the way to deal with conflict, they may idealise the

perpetrator of the violence and copy the behaviours, or absorb the messages that

aggression is an acceptable way to treat women or be angry at the mother for not

protecting herself or her children. (Selwyn & Meakings, 2016, p. 1226)

It appears that some children who have been removed from the situation via foster care or

adoption continue to show this aggression; in one study, Maclean (2016) reports that most

adoption failures result from the child's aggression. The aggression is likely the result of their

previous experience of abuse prior to the adoptive or foster placement; for example, girls who

had been sexually abused by their father or stepfather were found to be more likely to be

aggressive, "motivated by a need for self-protection or as an expression of rage against the

offender… or as a means to express the intense anger and resentment that was felt for not having

been protected" by directing the aggression towards the non-offending parent, generally the

mother (Cottrell & Monk, 2004, p. 1083). Hong et al. (2002) instead attributes the higher rates of

violence against mothers to gender role socialization, noting that "aggression towards women is

the product of the socially sanctioned domination and control of females by males" in their social

ecology-based examination of APV (p. 446). Corporal punishment may be correlated with

increased CPV, though Ulman and Straus (2013) note that many studies do not distinguish

between spanking and abuse by parents against the child (p. 46).

Triggers for the aggression are also quite varied. Limit setting by parents often set off the

aggressive behavior (Kethineni, 2004). Often the incidents began as verbal aggression and

escalated as parents attempted to hold boundaries. Cottrell and Monk (2004) noted that a

number of adolescents described abusing parents during times when they felt extremely

vulnerable. Common examples included situations in which parents tried to engage youth

in conversations about sensitive matters, or when parents 'exposed' them for committing various transgressions. Within this dynamic, youth would transform their sense of guilt/shame into rage as an emotional defense. (p. 1093)

However, instances of reactive aggression were also found in some studies (Calvete et al., 2013). Arguments about substance use, as previously noted, also were a common trigger for the violence.

Attachment problems and ineffective parenting practices. There appear to be correlations between attachment style and parenting practices with the increased likelihood of APV. Studies consistently show patterns of poor attachment, with parents who struggle to attune to their child and aggressive youth who feel their parents do not understand them. In addition, researchers consistently report a correlation between youth aggression towards parents and ineffective parenting techniques, often due in part to a dynamic in which the children are in control of the family. It is not always clear whether poor attachment or ineffective parenting led to the development of aggression, or whether the aggression disrupted the attachment thereby creating a sense that setting limits was futile; likely the relationship is bi-directional.

There are various theoretical explanations for the correlation between attachment difficulties with later aggression and other behavioral problems in children. One explanation posits that this occurs through changes in the stress response developed in infancy due to poor attunement, leading to a hypervigilant stress response pattern, difficulty with emotion regulation, and negative attribution of others' motives (Savage, 2014; Selwyn & Meakings, 2016). It is possible that children with poor attachment to their parents have challenges developing empathy, lack good models for the development of perspective taking, or have difficulty with hostile attribution (Savage, 2014). Similarly, attachment insecurity and problems with emotion

regulation have been correlated with challenges managing negative emotionality, contributing to the development of a variety of disorders (Savage, 2014). Bradshaw et al. (2006) noted correlations between high levels of disobedience and violence by children and parents' negative emotions towards the child and feelings of inadequacy as parents, though it is difficult to determine which came first (p. 256–257). High levels of entitlement and low levels of responsibility may create a sense in some children that they can use violence to get what they want (Gallagher, 2004). Parental sensitivity and responsivity were negatively associated with physical aggression or violence throughout a child's lifespan (Savage, 2014). Some studies, however, appeared to find that difficult temperament or behaviors make it difficult for parents to attach to the child resulting in a negative cycle in which parents who deal with child aggression become less responsive, leading to a poorer quality attachment (Savage, 2014). It is possible that deficient parenting in the early years combines with a particularly high-need temperament in the child to create these challenges, leading to aggression. It is clear that there is significant interaction between child and parent factors which lead to aggression towards parents.

The importance of child factors is supported by the increased rates of aggression in children with abuse or neglect histories (Brezina, 1999; Kennair & Mellor, 2007; Selwyn & Meakings, 2016). For example, in children who witness or experienced abuse from or between their parents, rates of CPV and APV increased threefold compared to those who had experienced neither (Ibabe et al., 2013, p. 524). Additionally, adoptive children with trauma histories often become aggressive, with CPV is a primary cause of adoption disruption reported by Selwyn and Meakings (2016); they note 80% of parents report the aggressive behaviors began early in childhood and at times resulting in significant injury to parents, such as a broken nose (p. 1230). Children who have disrupted development due to trauma are often more difficult to parent.

It appears that parenting style also has a significant impact on the development of APV. Laurent and Derry (1999) found that parents in their study struggled either with giving children too much control, through either parentification or a lack of limit setting, or alternatively, being overprotective to the point the child does not learn to manage disappointment. These findings are corroborated by multiple other studies (Cottrell, 2005; Cottrell & Monk, 2004; Eckstein, 2004; Gallagher, 2004; Pagani et al., 2004; Paulson, Coombs, & Landsverk 1990; Robinson, Davidson, & Drebot, 2004). Ibabe et al. (2013) suggest that these parenting styles result in inconsistency or overcontrol, leading children to struggle to develop self-control; their study found that particularly for sons, mothers' ineffective parenting and emotional rejection are predictors, particularly of emotional abuse towards mothers. It is interesting to note, however, that in Eckstein (2004), parents perceived that the decline in their effectiveness occurred slowly as a result of the increased conflict, that they had "lost the power to parent" due to their child's physical size and willingness to use abusive tactics (p. 382); it is impossible to say retrospectively whether poor parenting leads to aggression or aggression leads to powerlessness in parenting. An analysis of discipline style's impact on APV found that high levels of power-assertive discipline, defined as negative consequences for inappropriate behavior without explanation or justification, were predictive of APV but that the model also predicted in the opposite direction, supporting a bidirectionality in this form of family violence (Ibabe & Bentler, 2016). Muravyeda and Toivo (2016) question the veracity of the assumption that changes in parenting styles have influenced the development of CPV and APV, noting that this is a historically recognized phenomenon, and that rates of parricide, at least, have remained relatively constant to those in early modern Europe; they also note that the discourse around the causes of various forms of domestic violence remain quite similar to historic sources.

Silence and stigma. Parents often report feeling significant shame and hopelessness, as well as experiencing either denial or blame, when seeking support. Selwyn and Meakings (2016) noted that parents suffer significant shame, hopelessness, and social isolation as a result of their child's aggressive and controlling behaviors. Condry and Miles (2012) suggest that there is an invisibility about this form of family violence due to

> exclusion from the official definition of domestic violence; a lack of acknowledgement that adolescent to parent violence is a form of family violence in its own right; stigma and shame experienced by parents and reluctance for a variety of reasons to report their own child or to seek help… Adolescents are understood as potential offenders in the public sphere, but not within the home, and it is assumed that parents (and mothers in particular) are able to assert power and control over their children, all of which does not allow for a conceptualization of mothers or fathers as victims who might be controlled or abused by their children. (p. 246)

Holt's (2011) mothers expressed significant hopelessness, feeling that nothing would change. Holt (2011) continues, asking

> indeed, where else can a parent present as a victim of their children's violence [than in an online forum for other parents]? Certainly, from the evidence in these posts, it appears that—in offline arenas—such presentations are met with incredulity, silence or some other harmful response, from both individuals and institutions. (p. 461)

Sporer and Radatz (2017) found that "treatment providers, extended family, and teachers denied problems or suggested things would get better for the mothers," which was perceived by the women as isolating and blaming (p. 689). A sense of stigma and shame were pervasive among the parents interviewed.

Additionally, parents often minimized the experience themselves, either as a result of this internalized stigma or out of a sense of protectiveness towards their child. Cottrell and Monk (2004) note it

> was common for parents to initially deny the problem, and they would often blame themselves for their own victimization. Second, feelings of family loyalty often prevented parents from disclosing the abuse to others, as they feared the possible consequences this entailed for the youth. Finally, some parents were reluctant to disclose their situation because of fear this would incite further incidents of violence against them. (p. 1089)

Parents noted feeling responsible for their child. Multiple researchers remark on parents' reluctance to report the aggression, seek assistance, or remove the child from their home. Mothers "were not prepared to withdraw the nurturing and unconditional love and support that is culturally expected from mothers to their children" and feared intervention would separate them (Jackson, 2003, p. 327). Sporer and Radatz (2017) note multiple studies which find that

> parents provided ongoing care to their child despite extensive violence and victimization, as it was their duty as a parent to do so… participants described their lives as being consumed with the stress of living with and caring for a child with mental illness, and that such stress was compounded by unpredictable yet frequent acute violence and victimization. (p. 684)

The fear of having their child removed from their home forced parents to put aside their own physical and emotional injuries to care for their child; the stigma and shame experienced when talking about it discouraged further support-seeking and isolated them.

Unhelpful help: lack of support or appropriate interventions. Parents also often noted an absence of appropriate intervention or support for the family. There is a lack of clear policy, little evidence base for recommending intervention, and little structured support from mental health providers or agencies. This often leaves families attempting to manage the situation themselves, until it becomes such a large problem that law enforcement, child protective services, or other systems become involved.

A lack of adequate systemic understanding is noted frequently in the literature (Holt, 2016; Selwyn & Meakings, 2016). Holt (2016) makes the case that this lack rises to the level of structural violence, particularly when considering parental responsibility laws which "effectively serves to criminalize the victims of violence by problematizing their behavior and insisting that they must be the transformative agent" which essentially re-traumatizes the parents (p. 492). Under these laws in some jurisdictions, parents are legally responsible for their child's behavior; for example, in England and Wales, in the late 1990s, policies were developed to reduce youth violence which attributed the adolescents' behavior to poor parenting and legislation passed to hold parents responsible for their children's behavior (Condry & Miles, 2012; Selwyn & Meakings, 2016). Children as young as 10 are able to be a prosecuted as a perpetrator (Miles & Condry, 2015, p. 1079); as a result, there is likely to be increase awareness of the CPV problem, placing it firmly in a domestic violence framework (Miles & Condry, 2015). However, doing so highlights the problem of criminalizing young adolescents and goes against the identified aims of parents, who seek support rather than prosecution (Miles & Condry, 2015). Mothers have been particularly judged and held to corrective measures such as parenting classes by the courts (Condry & Miles, 2012, p. 244). This judgment may be partly due to a preponderance of single mothers resulting in more female primary caretakers, but may also be a result of "assumptions of

maternal responsibility and perceptions of mothers as the guardians of family morality (Condry & Miles, 2012, p. 244). Condry and Miles (2012) note that there is so little policy around this form of family violence because of "the fundamental dissonance between responsibilising parents within youth justice and the construction of parents as victims of their children's violent offending" (p. 248). Laws that hold parents responsible for their children's offenses have the unique effect of having the identified victim of the crime be punished for its perpetration (Miles & Condry, 2015, p. 1089). Mothers experience minimization of their experience, internalize it, and then are often blamed for their child's behaviors despite being the targets of the violence. It appears clear that having the justice system as the primary or only route to assistance is not helpful to parents or children.

This parent-blaming, legally and socially, extends to foster and adoptive parents in the child welfare system. Selwyn and Meaking (2016) reviewed cases of failed adoption and found:

> feelings of failure were exacerbated by the response from the agencies that adopters turned to for help. Previous research on APV… has consistently found a very poor response from services with some interventions making the problem worse… the shame and stigma of living with violence in the home meant that many parents did not ask for help until they were desperate but most parents received a poor response… parents felt social workers blamed them for the child's behavior… Professionals did not recognize APV, but instead framed the difficulties in the context of poor (adoptive) parenting and/or saw the child behaviours as a problem of anger management. For the most part, the controlling elements of the behaviours went unrecognized, as did the battle for the "parental space." (p. 1233)

They further described parents with secondary trauma symptoms being accused of a lack of emotional warmth towards their child (Selwyn & Meaking, 2016, p. 1234). These children were likely aggressive due to their trauma histories, but their adoptive parents were still blamed.

Often the mothers noted being so overwhelmed that they did not even know what supports the needed. Sporer and Radatz's (2017) mothers expressed this idea, noting they have experienced so much unhelpful help; upon asking mothers, the researchers found:

in response, they typically paused, sighed, rubbed their temples, shook their heads, threw their hands in the air, or cursed; some cried in despair. Many participants reflected on a tiresome effort to gain access to services, find a hospital bed, advocate for better providers, and pay for treatment. (p. 690)

Parents of violent adolescents are "often exhausted and at a breaking point, and some of the changes demanded by these programmes [such as parenting interventions] require considerable personal resources" (Condry & Miles, 2012, p. 245). By the time these parents are involved in systemic assistance, they are already completely overwhelmed.

Throughout the literature, mothers identify a number of strategies they are already using to attempt to manage the aggression. These include physically retaliating (e.g., slapping the child back), attempting to reason with the child, mental health intervention, leaning on informal supports such as friends and family, and as a last resort, calling the police out of fear of their own safety or as a way to scare the child into compliance; Holt (2011) notes that the parents report that these methods are generally ineffective at best and increase the escalation at worst (p. 459). She also notes that parents describe primarily coping with rather than trying to change the situation, having largely given up hope (Holt, 2011, p. 459). Finding support from others going

through the same thing appeared to be a positive force for her participants, however (Holt, 2011, p. 459). Largely, women are doing the best the can to manage while feeling hopeless and alone.

Once despairing enough to call for crisis assistance, the police minimized parents' experience, which "contributed to their sense of hopelessness and discouraged them from seeking assistance in the future" (Cottrell & Monk, 2004, p. 1089). Eckstein (2004) noted that parents experienced worse consequences from involving the justice system than the adolescent abusers did, including removal of other children in the home by child welfare and significant social stigma (pp. 379–380). Interestingly, in one study, once parents felt supported by the system, "the less inadequate they felt as a parent, the less they enabled, and the less hopeless they felt" (Bradshaw et al., 2006, p. 258). Adolescents have even been noted to use this systemic pressure as an abuse tactic, threatening to call protective services on their parents if they do not get their way (Holt, 2016, p. 493). By this point in the dysfunction, it appears families are significantly struggling to function.

Many studies emphasize the importance of prevention or early intervention. Starting early in the course of the development of aggression via positive parenting strategies, improving attachment, and encouraging pro-social behavior appears to have best outcomes (Hong et al., 2012). Particular attention should be given to mothers who have experienced battering from their partners as a preventative against their revictimization by their children (Hong et al., 2012). Meaningful and supportive social relationships and low levels of media violence may also help prevent APV (Hong et al., 2012). For foster children, prevention by increasing foster parent training, developing better systems for matching foster or adoptive parents with children, and sharing more information ahead of time with caregivers about a child's aggression would go a long way towards helping families; Maclean (2016) notes that most parents with disrupted

adoptions reported that the aggression began early on, but only reached a crisis point once the child was older and more physically risky, indicating that early intervention opportunities have been missed in this population.

For older children already abusing their parents, there are a few interventions being used, though outcome studies are few. An example of such a program, Step-Up, utilizes concepts from the domestic violence literature, including a focus on keeping victims safe and perpetrators accountable, an emphasis on group work and accountability, and focus on power and control (Holt, 2016, p. 494). An alternative program in the United Kingdom, Wish for a Brighter Future, focuses on those youth who are abusive as a result of a trauma history, and emphasizes attachment relationships (Holt, 2016, p. 495). Condry and Miles (2012) identified a lack of specialists in this kind of family problem as a possible cause of lack of policy addressing it as well as a dearth of appropriate interventions.

Constructing youth aggressors. Gallagher (2004) nicely lays out the dilemma facing families in which the children are aggressive towards their parents. He notes that seeing the child as out of control, helpless to react, or as an abuser all create problems for intervening appropriately. He points out that children are often viewed as (or are) victims themselves, either of poor parenting or abuse or trauma; that services designed to help the family are likely to assume the child as a victim; that they are at times diagnosed with a disability or diagnosis such as ADHD or autism and are therefore "excused" from their behavior to some extent (Gallagher, 2004, p. 95). Parents often constructed the child as a "lit fuse" or "ticking time bomb" or "terrorist," which both indicates and creates mother's sense of helplessness and inability to control, but also helps distance the child by presenting him as less culpable and the mother as

less of a victim to the child (Holt, 2011, p. 458). Jackson (2003) also notes the fear mothers express about their children:

> The women described the nature of their relationships with their children shifting from previously affectionate and relatively uncomplicated states to becoming strained, fragile, and fraught with tension. All of the women found this new dimension to their mothering frightening and unexpected… "it was only a matter of time before he hit me. I could feel it building up." (p. 324)

This refusal to hold children accountable reinforces the idea of the parent as the problem. However, seeing the child as the abuser is also problematic, as it may increase parental resistance to seek or utilize help and may lead to a sense of hopelessness over whether the child can change (Gallagher, 2004, pp. 95-96). Miles and Condry (2015) also agree that assigning labels such as "abuser" is not particularly helpful to the complexities involved in APV, arguing that using a criminal justice framework does not serve the family well in this context.

Some women, however, do note an intentionality to their child's aggression, and often construct the child as "Jekyll and Hyde," noting that the aggression is deliberately calculated by a child who

> "turns on the charm when needed"… [The mothers] constructed the perpetrator as pathological 'other' by aligning him/her within a fiction which polarizes 'good' and 'evil' (and consequently "criminality" and "innocence." (Holt, 2011, pp. 458–459)

Generally, older adolescents were more likely to be perceived as acting intentionally, while younger children were regarded as reactive and impulsive, their behavior viewed as more akin to throwing a tantrum.

Some researchers tied this discourse into larger patriarchal ideas, noting that

> Service providers and parents consistently described that among adolescent boys, abusive
>
> behavior was influenced by the role modeling of masculine stereotypes that promote the
>
> use of power and control in relationships. In contrast, aggression by female youth was
>
> noted as a paradoxical response used to create distance from the "feminine ideals" that
>
> were often ascribed to them… Mothers are being victimized not only through a process
>
> of direct patriarchal denigration but also by a paradoxical response in which young
>
> women are redirecting their own sense of social oppression. (Cottrell & Monk, 2004, pp.
>
> 1081, 1092)

Baker (2012) notes, however, that "such theories are problematic for teenage boys because they

presume that all men have a propensity to commit violence simply because they are male, and

that all men unproblematically subscribe to what commentators have termed a 'hegemonic

(version of) masculinity" (p. 269). Baker (2012) continues to note that these theories "perceive

children as without agency to choose how they feel and react to violence… In so doing, they

construct children as mere receptacles for adult behavior, which has been demonstrated to be an

outdated and overly simplistic view of childhood" (p. 269). Holt (2016) notes that constructing

domestic violence in a feminist, gender-based paradigm encourages the emphasize on patterns of

behavior, but also notes that this understanding can silence more isolated incidents as "typical

teenage behavior," fathers as victims, and victims of female aggressors (p. 491). She believes

women are also expressing a conflict between other discourses, with their sense of resignation at

least in part a result of the discourse around children's rights and the expectation that mothers

should be selfless, leading the women to believe their right to protection or safety is not assumed,

while also recognizing that if they did what their child was doing it would be a criminal act

(Holt, 2011, p. 460). They are caught in cultural ideas that are difficult to escape.

As demonstrated above, the social constructions around aggressive adolescents and their parents as well as the conceptualization of family violence all influence understanding of parent abuse. The question of how to understand childhood aggression against parents in younger children remains poorly understood, however. This study aims to formulate an understanding of how women who experience aggression from their children conceptualize the experience, and whether they experience it as abuse, as Ghanizadeh and Jafari (2010) label it. Like Edenborough et al. (2008), Biehal, (2012), and Charles (1986), this study emphasized the phenomenology of mothering aggressive children, but looked at American participants who were largely still experiencing this aggression, or had only recently stopped, rather than looking many years retrospectively and after years of more aggression. It also limited the participants to those with younger children, up to age 10, in order to make clearer the distinction between children and adolescent aggressors.

Methodology

Qualitative approaches best address questions of meaning, the "why" and "how," and explore social processes and dynamics. These techniques have historically been influenced by the constructs of pragmatism and symbolic interactionism as well as the contrasting ideas of positivism and objectivity. It has been said that "quantitative researchers work with a few variables and many cases, whereas qualitative researchers rely on a few cases and many variables" (Creswell, 1998, pp. 16–17).

There are many reasons to choose a qualitative over a quantitative methodology. Creswell (1998) delineates eight reasons: the nature of the question is how or what; the topic needs to be explored, as theories are not yet developed or variables not yet identified; the topic is best served by detail rather than breadth; the topic is best understood by studying "individuals in

their natural setting"; the researcher prefers to write in a "literary style"; the researcher has the resources to spend on a lengthy field investigation; the identified "audiences are receptive"; and to "emphasize the researcher's role as an active learner" (pp. 17–18). This study meets all these criteria, as a topic that is yet to be well-articulated, with participants providing the how or what by describing their personal experience, and as a dissertation-based project by a researcher with a background in the humanities. Grounded Theory specifically was chosen as it represents an attempt to balance the benefits and disadvantages of researcher objectivity vs. participant expertise; structured methodology vs. flexible and responsive techniques that can adapt to the data; and descriptive analysis vs. the explanatory power of theory. Constructivist Grounded Theory additionally is influenced by the social constructivist turn and feminist theory, which matches well with the researcher's philosophical approach to the research.

Constructivist Grounded Theory: Its Historical Roots and Epistemological Stance

Historically, Grounded Theory emerged from trends in sociological studies in the early twentieth century, particularly in the pragmatic and symbolic interactionist Chicago School, where field research was frequently done (Plummer & Young, 2010). Pragmatism's central tenet is that "our actions are based on the practical consequences of that action" and that knowledge requires not just sensory input but interpersonal interaction; it derives from the work of John Dewey and William James (Plummer & Young, 2010, p. 308). Symbolic interaction theory, based on the work of George Herbert Mead, another Chicago school sociologist, holds that:

1. Humans act towards things on the basis of the meanings things have for them.

2. The meaning of things is derived from the social interaction one has with others.

3. Meanings are taken in and modified through an interpretive process" (Plummer & Young, 2010, p. 310).

These two ideas together assert that humans create meaning within the social context, and act with awareness of social consequences for that action. By the mid-1960s, however, research trends were increasingly positivistic, with "beliefs in a unitary method of systematic observation, replicable experiments, operational definitions of concepts, logically deduced hypotheses and confirmed evidence—often taken as *the* scientific method" (Charmaz, 2014, p. 6). The increasing emphasis on the objective observer called into question qualitative investigation, leading to an increasing divide between research and theory (Charmaz, 2014, p. 7).

Barney G. Glaser and Anselm L. Strauss presented *The Discovery of Grounded Theory: Strategies for Qualitative Research* in 1967 as a way to explicate the quantitative process for data collection and analysis, advocating that theory developed from—and grounded in—the data, which produces more substantive explanation of studied processes than the theory verification common at the time. They stated "our basic position is that generating grounded theory is a way of arriving at theory suited to its supposed uses… [rather than] generated by logical deduction from *a priori* assumptions" (Glaser & Strauss in Plummer & Young, 2010, p. 306). This process allows "issues of importance to participants emerge from the stories that they tell about an area of interest that they have in common with the researcher" (Mills, Bonner, & Francis, 2006, pp. 26–27). The systemic analysis process required

> simultaneous involvement in data collection and analysis; constructing analytic codes and categories from data, not preconceived logically deduced hypotheses; using the constant comparison method…; advancing theory development during each step of data collection and analysis; memo-writing to elaborate categories, define relationships between categories, and identify gaps; sampling aimed towards theory construction; conducting the literature review after developing independent analysis. (Charmaz, 2014, pp. 7–8)

Glaser particularly focused on empiricism and methodology, while Strauss emphasized the importance of seeing humans as active agents and of symbolic interactionism, "a theoretical perspective that assumes society, reality, and self are constructed through interaction and thus rely on language and communication," (Charmaz, 2014, p. 9). The theory was created as "a counterpoint to the then dominant structural functionalism of contemporary sociology" (Allen, 2011, p. 29).

Over time, Glaser and Strauss' ideas diverged somewhat. Glaser remained committed to his focus on Grounded Theory as an empirical method of discovery emphasizing analysis of a basic social process (Charmaz, 2014, p. 11). He emphasized that the researcher should not review the literature in the area of study, in order to maintain a minimum of preconceived notions (Mills et al., 2006). In Strauss and Juliet Corbin's publication of *Qualitative Analysis for Social Scientists* in 1988, they move away from objectivity, writing that "a state of complete objectivity is impossible and that in every piece of research—quantitative or qualitative—there is an element of subjectivity" (in Plummer & Young, 2010, p. 307). However, the theory was still known in the 1990s for its own positivist assumptions, despite having been created to push back against overly positivist quantitative research to begin with (Charmaz, 2014, p. 12). Corbin, after Strauss's death, brings her iteration of the theory more towards a subjectivist understanding, noting in 2007 that:

> I agree with the constructivist viewpoint that concepts and theories are constructed by researchers out of stories that are constructed by research participants… I agree with feminists in that we don't separate who we are as persons from the research and analysis we do. (in Plummer & Young, 2010, p. 308)

Constructivist Grounded Theory takes the open-ended, comparative, grounded-in-the-data emphasis and adds the understanding, based on social constructionism, that the researcher is not, and cannot be, an objective or neutral observer, but is in fact a co-creator of the data with the participant. This approach is articulated by Kathy Charmaz, in *Constructing Grounded Theory* (2006, 2014), who argues that one can use the methodology without having to accept the positivistic and objectivistic aspects of its epistemology. She stands on symbolic interactionism as a basis, believing that knowledge is socially constructed and intersubjective (Plummer & Young, 2010). Constructivist grounded theory attempts to adjust the previously discussed balance, between structuralism and postmodernism, subjectivity and theory. This critical realism can "bridge the divide," by accepting that "social constructions themselves can constitute what we know as the reality of our social worlds" (Oliver, 2011, p. 372); in fact, holding the dialectic can be the most valuable aspect of this approach by breaking theoretical assumptions which may lead to new ideas and perspectives. This capacity for placing the individual's experience inside the larger structural means of the social milieu makes it an ideal fit for contributing to social justice research (Allen, 2011, p. 30).

This perspective also aligns with feminist approaches, which are often positioned from a postmodern stance (Allen, 2011). The researcher is both part of and witness to the participants' "social-historical-bodily experience—itself always constituted through fraught, non-innocent, discursive, material collective practices" (Haraway, in Allen, 2011, p. 25). Feminism itself if not a homogeneous movement, but for the purposes of understanding here, as Plummer and Young (2010) note:

> A review of the contemporary feminist literature reveals a shared set of common epistemological features, including valuing women's lived experiences as a legitimate

source of knowledge, appreciating the influence of context in the production of knowledge, respecting the role of reflexivity in the research process, rejecting traditional subject–object dualisms, and attending to gender, power, and transformative social action. (p. 307)

Applying Grounded Theory to Child-on-Parent Aggression

Given the limited prior literature regarding specifically CPV, an exploratory approach was appropriate. Focus on the phenomenology allows for the mothers' experience to provide the language, highlight the important topics, and articulate the dynamics. Individual interviews allowed women the space to speak openly without fear of judgment, and allowed for privacy while discussing this very vulnerable experience. Fundamentally, this research sought to answer three primary questions. One, what is this experience like for mothers?; two, what meaning to do they make of this experience?; and three, how does this understand fit into larger cultural and clinical theoretical constructs?

Grounded theory was chosen to allow that exploration of the phenomenon while still tying the developing theory to known understandings about intimate violence, aggression in children, and the cultural context of mothering. Constructionist grounded theory as elucidated by Kathy Charmaz was chosen, as it allows development of the "why" and "so what" as well as the phenomenology of the experience. Unlike traditional Glaserian grounded theory principles, Charmaz (2014) argues the researcher is inherently subjective, and that multiple meanings are possible from the data. Her emphasis on retaining the voice of the participant also fits nicely with feminist traditions of research, which seemed particularly important given the invisibility of this experience in the literature and the cultural context of violence against women in general (Allen, 2011; Mills et al., 2006). I am further influenced by critical realist approaches to grounded

theory, which recognize that our understanding of reality is always mediated by language and meaning-making. I appreciate the emphasis on emancipatory goals and on systemic mechanisms, as well as the hermeneutic process of going from the individual to the system, from agency to structure, found in this approach (Oliver, 2011).

Epistemologically, I come to this research as a feminist and as a social constructionist, and do not believe I can "bracket off" those philosophical positions. Perhaps more importantly, I also come to this research as a mother who has experienced the phenomenon in question, which I believe makes it impossible for me to be unbiased in an objectivist sense. These philosophical positions and the exploratory nature of the topic make the choice of methodology appropriate. The proposal for this study was approved by Antioch University Seattle's Institutional Review Board in June, 2015.

Procedures. Participants were invited for interview via a variety of methods over a three-year period. Solicitation proved to be a challenging process, with multiple women expressing interest and then backing out, at times stating it was too difficult to discuss. Recruitment methods included advertisement on parenting online forums and listservs as well as to special needs parenting groups and schools and doctor's offices locally; word-of-mouth recruitment with professional colleagues also proved effective.

The majority of recruitment success came from the online parent groups, and then word-of-mouth from participants who encouraged others to be interviewed. Participants were invited to meet with the researcher for an approximately hour-long interview discussing their child's aggression. Participants responded to the flyer by email or phone, and were provided with consent forms to review before being asked if they would like to participate. These meetings occurred in the researcher's office or a private meeting space at a public library, as the

participant agreed, and were audio recorded once consent paperwork was completed. Participants were advised that they could stop the interview at any time and offered access to resources should they become distressed by the discussion. After the interviews, the audio was transcribed for analysis. Both original interview recordings and the transcriptions are saved in a password-protected, de-identified manner. Interviews were between one and two hours long.

Participants were asked to introduce themselves and describe their families, and then prompted to describe their experience of an episode(s) of physical aggression from their child which resulted in bodily harm. The researcher then encouraged the participant to go into detail in their narrative, using "intensive interviewing" skills as described in Charmaz (2014). These questions focused on "going beneath" the surface of stories, noticing what is not mentioned, exploring dynamics of power and systems, and asking about the participants' feelings or meaning-making around an aspect of the discussion; reflective listening was also used to encourage the participants' to expand and clarify the researcher's understanding (Charmaz, 2014). This technique fits well with grounded theory as both "are open-ended yet directed, shaped yet emergent, and paced yet unrestricted" (Charmaz, 2006, p. 28). Questions included asking what led participants to choose a particular word when describing an incident; asking for expansion and clarification on comments made with particular attention to internal states of the mother, social relations, and meaning-making; and explicitly asking about meaning-making and sources of belief.

Eight participants were interviewed before data saturation was reached. The women were not specifically asked for demographic information such as age or race/ethnicity. They were all from the greater Seattle area. In the course of the interviews, it was revealed that all but one was married or in a long-term, live-together relationship; the one was previously divorced but in a

long-term relationship, but did not live with her partner. Discussion also indicated that there was

a range of socio-economic status from low to upper-middle class. In five cases, the aggressive

child was biological; one was adopted at birth, one adopted from foster, and one foster only.

Four of the children were diagnosed with autism, one with an alcohol-related

neurodevelopmental disorder (ARND), and three with trauma. All of the children with autism

were biologically related to their mother. The children who had been in the foster system were

diagnosed with trauma, as was one biological child. The child with ARND was adopted at birth.

Six of the eight children discussed were male.

Table 2

Demographics of Participants and Their Families

Participant	Child's Age	Family Type	Child's Gender	Child's Diagnosis
Abigail	7	Biological	M	Autism
Becky	9	Foster	F	Trauma
Carolyn	10	Biological	M	Autism
Danelle	5	Biological	M	Trauma
Eleanor	8	Biological	M	Autism
Fiona	6	Adopted later	M	Trauma
Giselle	7	Adopted at birth	M	ARND
Helen	9.5	Biological	F	Autism

Analysis included transcription and coding of interviews, followed by axial coding of

initial codes, and then development of categories and a model from the axial codes, always

referring back to the data in an iterative process. As each interview was collected and transcribed, a continuous process of analysis continued, with new data being constantly compared with emerging codes and new codes resulting in a re-analysis of previous data. These codes were developed via line-by-line analysis of the transcribed interviews using the software package *Dedoose* ™, when sensible using the participant's own words to define the initial code. After initial coding of all the interviews, a refining process began of grouping codes that went together conceptually, reviewing the data to ensure no nuance was lost, and when possible collapsing or restating codes into a clearer conceptualization. As this process continued, codes were grouped into axial codes, larger categories which reflected the smaller concepts detailed in the initial codes. The researcher looked for gaps in the data, social processes and conflicts, and participants' meanings and assumptions.

 Throughout this process, the researcher wrote memos regarding observations, thoughts, and feelings about the data, the analysis process, and challenges to preconceptions and personal experiences in an effort to keep the codes close to the data.

As data accumulated, axial coding began to formulate the categories those codes connected to, the "when, where, why, who, how, and with what consequences" of the data (Corbin and Strauss in Charmaz, 2006, p. 60). Axial coding "aims to link categories with subcategories, and asks how they are related" (Charmaz, 2006, p. 61). Interviews and coding continued through data saturation, or the finding that new codes or constructs are not coming up in new data, which was complete with eight interviews. After interviews were completed, a final theoretical coding pass was completed. These codes and categories were then developed into a larger theory, by considering the relationships between the codes and utilizing researcher memos. At this point a literature review was completed, which expanded on prior research looking at

CPV and APV as well as examining resources on women's embodiment and intensive parenting. The theory was further developed by relating the initial theoretical ideas back to this existing literature and larger cultural perspectives.

Results

Analysis of the interview data resulted in two major categories. These categories explored the phenomenology of the experience, entitled About the Experience, and the larger construction of women's conceptions of themselves and their influences, called Defining Motherhood. The first section expands on the lived experience of the mothers, with all the emotional and social consequences they raised, and explicates the languaging of the experience. The second section discusses these experiences in the larger context of defining motherhood and articulates a variety of roles that the mothers identified as key to mothering the aggressive child.

These categories were then placed into the larger theoretical concept of Embodying the Good Mother. As the data below shows, women who experience aggression from their children are profoundly impacted, physically, psychologically, and socially. The interplay of child factors such as their diagnosis, the social implications of parenting an aggressive child, cultural ideas about mother, and the mother's internal state transactionally shape the mother's experience. Interactions with others in their world—partner, friends and family, professionals of various kinds—also influence these self-conceptions. Through their cultural understanding of what good mothers do, they internalize and rationalize the experience of the aggression, enacting the various roles they feel are expected of them. Taken together, these three influences strongly shape the mothers' understanding, resulting in literal embodiment of the expectations of good mothering. Figure 1 shows the relationship of these factors, using the codes and categories

developed, to the larger concept of Embodying the Good Mother, as a roadmap to the data

presented below.
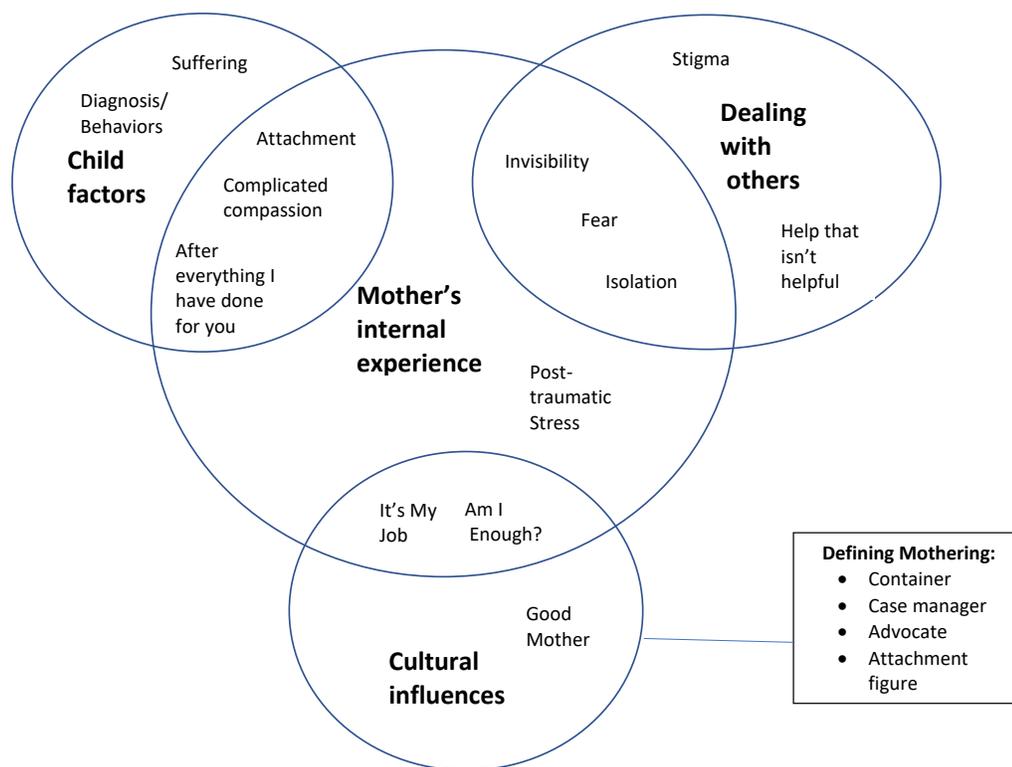
Figure 1. The mother's experience of aggression from her child is influenced by various factors, illustrated here to highlight the three major factors identified: child factors, dealing with others, and cultural influences. The various codes which make up these factors are also illustrated.

About the Experience

A primary goal of this research was to answer the question: What is this experience like

for the mother? The section below addresses the phenomenology as described by the mothers. It

articulates the basic facts about the aggressive episodes—how often, what kind, how intense—as

well as the emotional experience. This section also addresses the language that women use to

describe it and the ways they feel it is similar and different to other experiences of aggression or abuse they have experienced.

Phenomenology. "How can he touch you, and do these things that sound like a violent man, and be like a child?" (Carolyn)

The mothers described many kinds of aggressive actions directed at them from their children, including but not limited to hitting, biting, scratching, kicking, shoving, choking, and hair pulling. Their descriptions evoked significant violence, including injury at times, and strong emotion; all participants were in or close to tears at some point in their interview, as was the interviewer at times. For ease of reading, participants were given pseudonyms, based on their interview order (e.g., Abigail represents Participant 1, Becky Participant 2, etc.). The following are examples of aggressive episodes recounted in the course of the interviews, in their own words:

> Abigail: I have never felt pain like that in my entire, like, much more than childbirth. There's like flooding, like nausea, almost blacked out, intense… He and I had been in his bed, we were reading stories, it was dark and we were having the sweetest little moment, just talking and laughing. He was getting tired and then all of a sudden, he just rears his head back and slams it into mine. And like, I kind of just jumped out of bed and was like oh my God, oh my God. And my husband came running in and the first thing I said to my husband is "make sure he is okay and that he's not scared."

> Becky: Like many foster kids, when she gets triggered by something she has her kind of flight-or-fight mode, and her go-to reaction is very much to lash out. The third night she was with us, she took like a table knife and said she was going to stab us with this. And we were like "AAAHH, what do we do with this?"

> Carolyn: When we got home and he just wouldn't leave that spot alone on my face…. And I was like, you've got to stop, and it was like… trying to put his hands down, trying to give him something else to hold, anything, to deter him. But he just would not deter…. it turned into hair pulling. He was like, got ahold of the hair, and then he was trying to choke me… and then out of nowhere he just punched me across the face. And I was like seeing stars, and I couldn't, like, get up from it. And I got, I just crawled up and he punched me again, and he punched me again, and he kept punching me [cries] until I ran into the bathroom and I locked myself in the bathroom. And he was trying to beat down the door of the bathroom … And ironically my phone started ringing, the phone started

ringing, and I knew that it had to be [my husband]. And I said, [son's name], Papa's calling, can you get the phone. And so he got the phone, [laughs] in the midst of all this, see this is how it's such a disconnect. He got the phone, and he answered it, and they were talking, and [my husband] said let me talk to your mother. So I said ok, so I opened the bathroom door, and he hands me the phone, and I close the door quickly and I start talking to [my husband] and he bursts in on my while I was on the phone. And so we wrestle, and the phone was still there, I grab the phone and I go to our bedroom and I lock it. And he starts in again…. I just start calling people… he was still in a rage. And they came in, and as soon as they came in, he stopped…. our friend, he stayed, he stayed with me, and they brought another friend [rueful laugh], and said "do we need to take you to the hospital?" and I said "I don't know, I don't know if my cheekbone is cracked or broken," and you know I was just in this state of, I didn't know. Bruised, my face was swollen, my eye was swollen shut.

Danelle: I would drop him off at his preschool and I would spend sometimes up to an hour just trying to get him into the classroom. I'd have to hold him, and he would, you know he's left bruises on me many times and like bit me, thrown things at my face, punched me, spit in my face, which woo, that one. That's one of my deal breakers.

Eleanor: So, the head goes down, and then the uuuuhhh starts, and he would push his head into me as hard as he could, if I was standing, he'd headbutt my hip… he wants the deep pressure so he pushes into me, and we'll do bear hugs, and he'll grab me and I'll grab him and he scratches my back. Or he'll punch my back, or if I have to restrain him because he's hitting himself, because he punches himself in the head… then he'd headbutt me to his back, and he's got my arms, and so he'll scratch my arms…. From that pressure and bear hug and, and, whatever, he will eventually calm down and that will turn into hugs, and then turns into crying, and then we kind of come out of it from that. But it was always me. I was the only, as soon as a meltdown starts then he is coming to me and then I am getting hurt and he is getting hurt every single time.

Giselle: There was a little snub nose hammer, like that big… I knew [my son] was behind me because I could see his shadow, and I saw [my son] raise his arm, and I ducked right at that moment… and thank god I did because then it hit me on my neck, like, the back of my neck here, instead of the back of my head. Otherwise, the back of my head. Granted it still hurt like a mother. Um, but he hit me and I screamed because it hurt, because I thought he was just going to hit me with his hand, because I didn't see the hammer…. I cried, because it hurt! I just sat there and cried in the front yard.

Helen: We had this plan that if she started raging, I needed to get everyone into a safe place, which was behind a door, and that meant being in my bedroom, holding the door closed while she threw her body against it repeatedly. Usually for about 15-20 minutes… screaming and yelling. [sniffles] … it hurt, actually. She was big enough that it really actually hurt to sit against the door.

These descriptions paint a vivid picture of how severe and distressing the aggression attacks can be, and some of the consequences of them for the women, physically and emotionally.

Multiple women described their child as flipping a switch and being "suddenly blinded by rage" (Carolyn) or appearing out of control when the episodes occur. Abigail described her son as a "feral child… he would kind of have this look on his face that like he didn't even know why his body is doing this.… I always envision it like he was going along and then somehow he is getting sucked into… a tornado. It's just this magnet pull, he had no control over it. I would see him get sucked in and things would escalate immediately." Fiona described an episode when her son was "a completely out-of-control kiddo, who didn't feel he would be able to keep himself safe… He's scratching, biting, pinching, anything he can do to, to get me away from him so he can destroy or pull things down on him." Becky distinguished these attacks from typical tantrums, stating, "a tantrum is just, like, a normal child's response to not getting their way. But the rage is much more like, a visceral response, a kind of literal, I've lost all my cognitive functioning and I'm simply reacting to you right now… which is much more of like a trauma response thing." Carolyn summed it up, saying, "it was like my son has been kidnapped." Most of the participants noted that their child appeared to be unintentional about their aggression much of the time, noting he or she looked "surprised" or "like what just happened" and even at times having a particular, disconnected look on their face (Abigail).

Multiple participants also described their child as having little or no recollection of the event after it occurred, or appearing to be in an altered consciousness during it. For instance, Eleanor recounted,

> He always feels better in the bathtub and… he would lose his mind and be scratching at my arms and clawing at me and I would put him in the bathtub with clothes on… and I'm sitting there with my head in my hands and he loves the water, and even though he didn't want to get in, and he's like, "what's the matter?" [laughs] Are you fucking kidding me,

we just spent two hours screaming and clawing and headbutting and, and you know, and then he's in the bath and he's happy and he's like "why are my clothes on?" [laughs] And I'm like "Jesus Christ."

Giselle described her seven-year-old son as having

these patented phrases that he says, that he's heard from movies or from other kids. You are, you are going to pay for what you said, you are going to regret that … You are going to pay for that. It's this mean evil awful voice … He threatens to kill me all the time [laughs], he stabbed me, tried to stab me with a knife. … Completely devoid of emotion, like a little tiny psychopath … and you can look into his eyes, and he says are you going to cry now? Are you going to cry yet?

The mothers overall noted this lack of awareness as evidence of their child's lack of control or intention.

Episodes often occurred daily, or multiple times a day, during difficult periods and lasted anywhere from a few minutes to several hours; Becky described one episode that lasted twelve hours, with varying intensity over the course of that day, though most incidents lasted approximately 20–60 minutes. Eleanor noted that it was not uncommon to have 8–9 episodes in the afterschool to bedtime period, or 15–20 times on a weekend day. All the women described being scared by their children during these episodes and used words such as "unleashed" and "chaotic" to describe them. Fiona described her son as "all out raw" when he is raging. All but two of the mothers noted that the worst period of frequent episodes was past them at the time of interview; this intense stage was described as lasting up to two or three years, though most of the children showed signs of unusual aggression even in toddlerhood (when history was known). They attributed this decline in episodes partly due to increased maturity and self-control, partly due to the multiple and significant interventions provided to the child, and partly due to increased attachment to the family (in the case of the foster children).

Most of the mothers reported injury from their child, ranging from bruises and scratches to black eyes and broken noses. None reported long-term consequences from these injuries. One

mother reported considering going to seek medical attention but chose not to; none of the other mothers sought immediate help for their injuries. Head-butting and using an implement as a weapon were reported to have the most serious consequences for the mothers in terms of physical harm. They also as a whole noted that the emotional consequences of the aggression, namely the wearing nature of the unpredictability, were more damaging to them than the physical consequences.

     Complicated compassion. "It's hard to hold both realities, right? That this is a child whom you love and is in distress, and the experience of feeling victimized and abused." (Helen)

     Many of the women expressed a sense that their child had multiple sides, was two people in one, or was somehow Other when in the aggressive state. Carolyn stated, "And so it seems like a whole other person that this happens, there is such a disconnect… Who is this, what is this not even a person?" Becky uses the trauma her foster daughter has experienced as an explanation, saying, "I guess I view it as this is not the real child. This is a child that has been traumatized, and they are having a flight-or-fight response to a trigger. So, it is not directed at me, kind of thing. I mean I'm not the real, I'm the target right now but not the real target." Carolyn stated, "I have to remember when I see the violent side come out, where's my sweet child? [laughs] Sometimes I've said that to him, 'where's my sweet child?' And I know he's in there, I know he's in there," as her way of managing the dialectic of nurturance and conflict. She continued, "I just didn't want, want whoever this person was [laughs ruefully] that he has become, I didn't want that person around. I was just angry, but it was like my son has been kidnapped." This sense of not-my-child was exacerbated by the understanding of the child being in an altered consciousness discussed above. By othering the violent parts of their child, they are able to keep their affection and recognition that their child is a child.

All the women held tremendous compassion for their children, viewing the aggressive episodes as a demonstration of suffering, even as they were aware of how awful their own experience felt. What developed was the idea of "complicated compassion," a strong holding of both realities, the aggressive child and the loveable child. Becky expressed some guilt over the difficulty holding this dual reality, describing this dialectic as "a conflict of belief versus feelings. Belief that they are all equally beautiful and valuable humans, but I don't feel the same way about all of [my children]," because of the aggression of one. Carolyn saw her child's remorse, and that helped her maintain her compassion: "I think because I have seen it so many times after he's had a violent episode, how absolutely destroying it is to him, and you just want to help him. You just want to help him any way you can. And then the rest of the time he is extremely sweet, extremely loving. He's one that needs lots of hugs and reassurance, and physical touch and squeezes and hugs and kisses, he craves that. And you see that side of him." Giselle agreed, saying "You have to [have compassion]. Otherwise you would leave them on the street. [laughs] Left him with a free sign. But no… I think you have to have the compassion otherwise you wouldn't want to love him. Because they are super unloveable. And sometimes I don't. That sounds awful. But sometimes I don't love him, sometimes I am just like 'could you just NOT?!'" Somehow, despite experiencing extremely difficult and violent behavior and sometimes personal injury, these women persisted in understanding these behaviors as evidence of suffering.

There was also a consensus that the aggressive outbursts were part of a new normal for the family. Multiple participants commented that they had not really thought about what the experience was like for them prior to being invited to interview; they were simply "managing" or getting on with it as the experience came (Carolyn & Eleanor). Danelle stated,

>Our level of normalcy just moves to a whole different realm… it's not so much in the moment when it happens, but like four days later, when I'm washing dishes and then I see the bruise, it's like "oh my god, this is really serious. This is not, we all shouldn't have it this hard," it's kind of what it is. And it's like, definitely shifts your perspective. [laughs]

Danelle also described a cyclical pattern to the aggression:

>With my kids it's like clockwork every couple of months. They go up, they come down, they will be, you know, even for awhile, but it's always up and down. It's never like we've been doing so great and I don't know what happened.

Becky noted that her child's aggression has changed her idea of what normal would be for her family, because "it's made me reevaluate like how much I can do. Because in my head I picture being able to juggle more things. But it's like, if someone gets into one of these aggressive episodes, that's like an all-in. That's all you are doing. You can't be like dealing with that and cooking dinner at the same time… maybe we won't have as many kids as I was picturing us having, or maybe we will eat frozen meals more than I was picturing us having, or just letting go of a lot of the idealism stuff because that's just not going to be." Giselle wondered how to know what normal is, asking "Are you being sassy because you are six, or are you being sassy because you are being a jerk? Is it your brain, or are you being a butthead? You know, like what is this line?" All the women were resigned to the outbursts as a fact of life for their family, at least at that time.

       Invisibility: "I wanted someone to see it too." (Abigail) "It seems like the moms I talk to, it's like, we always have a long story that we start with, and then has anyone experienced this. Because there is no, there is no name, there's no name for this, no blah blah blah syndrome or whatever [laughs]. But, there are some similarities it seems like, that we talk about. In the story, you're reading the story, you are like oh yeah, I've had that situation, or I've had something very

similar to that. You recognize it. And yet you are right, there is very, very little written about it."
(Carolyn)

All the mothers reported that the violence seemed invisible to others outside the family, including professionals; to the extent that anyone paid attention, they were focused on the child and the behaviors, rather than the impact on the mother or family. They reported experiencing significant loneliness and isolation and a lack of support from others, feeling that they could not talk about the experience, or if they could, others did not understand. This invisibility often extended to their own sense of themselves, leading to a lack of self-care and in some cases even a lack of sense of self.

Some women connected their isolation to the lack of recognition that mothers get generally, but all of the women talked about how limited they are by their child's behavior and how it ostracizes them from their communities. Abigail noted, "You're isolated anyway as a stay-at-home mom a lot of the times, and then you have a stay-at-home mom with a kid with special needs and behavioral stuff, and you're even more isolated because you can't get out and do this other stuff. You could go to the park and stuff like that, but you can't just get out to do stuff, like even going to the grocery store, you're not even interacting with other adults, and it's just all about this kid." Danelle remarked on how difficult it was to maintain social networks when her children were so often unable to manage appropriate social behavior, saying,

> There is like scheduling things, or if the kid is having a bad day they might not go, but for us it's the opposite, it's few and far between when I feel like, ok, we might be able to handle this event, you know, all of us, together. So, yeah, usually I just pass. And then feel like it makes me look flaky or like I don't care.

Danelle also expressed frustration that she cannot spend time with other adults, because her children's demanding behaviors make it so difficult to leave them or even get a break while with them, saying,

That's something that any parent needs, to recharge yourself and to have time outside of your kids. My whole day is planned around them, my whole week… to have some time here and there to just check out? It is healthy and I don't always get that when I need it or would like it.

Similarly, Eleanor articulated well how the child's behaviors get in the way of typical social interaction and limit the family's choices:

People don't want to hear about it… this particular friend, she's never told me not to talk to her about it but it's like, "oh hey how was your day." Word vomit. This is, this is how our day looks like. And if you are a friend, then you are genuinely interested, you want to know how our day actually went. And if you have neurotypical kids, and you just came home from baseball, me explaining to you, "oh our [Individualized Education Plan] meeting went south really fast, and this principal said he was going to do all these things and he didn't, and argh this awful teacher," who she loves, you know, and "what are your plans for summer?" People are talking about going on vacation. We can't, can you imagine us at fucking Disney? He'd pull my shoulder out of the socket. There's no way we can go to Disneyland. Um, you know, or even maybe get on a plane. How would that go? Jesus, being on a plane, trapped with 20 or 30 or 50 other people.

Helen also had a similar response, expressing that her daughter's aggressive outbursts made social planning impossible:

We had gotten more and more isolated from everybody, because [cries] I'm sorry, my daughter may spontaneously decide that something is horrible and go off the radar in behavior and I have no way to explain it and no way to know when it's going to happen and so, yeah, let's get together [laughs].

Danelle agreed, noting that "People do not understand. So, it's exhausting trying to get them to see your kids as little kids and not these… you know, assholes that choose to act this way." Abigail also found "the ones that did understand even got to the point of 'I'm tired of hearing this, every time we see you, it's all this stuff that is going on with the kid.'" All the mothers reported social isolation of this kind at one point or another.

Even more than just social isolation, all the mothers raised invisibility as a primary theme; they universally felt that their need for support with the violence was great but quite unseen. Helen described being in a group while her child was hurting her:

I remember feeling like just so alone? Like, that no one else even noticed that I was getting pinched, even though I was like, part of me like didn't want people to notice, at the same time I was like how can you guys be so unobservant that you don't notice that this kid is sitting here pinching me? Like really, how can you, like? [laughs] and if you do notice, why don't you just say, "can we help you?"… mostly I just remember thinking that I am surrounded by people and completely alone.

Abigail described,

At this time, it's like I didn't really know anyone, I had no friends who have ever had to deal with this, no family members who have ever had to deal with this, no friends or family members who know people who were dealing with this. Are we just the only ones?… I had no one to ask. It made me feel—I just felt like I was kind of walking through life, just, I don't know. I just felt invisible from the rest of the world.

Helen felt that the message she got from others was often

"I don't want to deal with your crap so I am going to pretend there's no problem".… [Some people would say] "she'll be fine, she'll be fine, she'll be fine." Like, I hate that phrase. Like people, when they say someone will be fine, I just want to scream at them. It's like, the biggest cop out ever.

Who precisely would be in a role to ask about the mothers' experience, however, was not clear; Eleanor pointed out that it would feel very odd to have, for example, school staff ask her about herself, because "the focus is on the kids" and should be.

Some of the mothers acknowledged that even their aggressive child could not acknowledge what had happened to them, because of their impaired recall of the experience discussed above; Carolyn noted,

to be fought and beaten and bitten, I mean to where you have got scars, or bleeding, and to have him just walk away and have [my son] not be able to say anything about it. That's I think that's the most depressed I've ever felt.

This ignoring and minimization was experienced as very invalidating; Abigail summed it up, saying "I think I just wanted someone to see it too."

This invisibility and lack of understanding carried into professional resources as well. Becky expressed frustration on the lack of focus on the parent in the available resources:

I've read hundreds of books about like parenting traumatized children, and foster care, and adoption, and I've never read one that is about the experience as a parent. It is always like, this is as a parent what you need to do as a parent to heal this kid, which is great, I'm glad for that. But then I guess I never really noticed that there was a total lack, I've never even seen a book about what this is like and maintaining your own mental health and stuff when you are parenting.

Abigail also expressed a desire for more information, wishing

there was more out there on, you know, about the toll it takes on the whole family. Because, I mean, my husband watching me or getting seven phone calls a day at work because you know I'm crying and hiding and being hit, it's everyone involved, it's a tough, you know, a tough thing to go through. And if there was just more understanding, and more, and even in some of the research, they don't talk a lot about the aggression.

This lack of understanding and information led the women to feel alone, isolated, and invisible.

An interesting finding is that universally, when asked about their own experience, the participants all began speaking about what the incident was like for their child; it was as invisible to themselves as to others. When the interviewer noticed this to them, there was generally rueful laughter, an attempt to speak about their own experience, and then a quick return to the child's understanding. All the women found it very difficult to stay with their own experience, often noting that they had not thought about it before. Several became very emotional as they noted that no one had ever asked them about the experience before and thanked the interviewer for asking. Fiona related this to the role of mothering in general, stating,

I think from nursing to doing this trauma care, it's all kind of, you are in the position of giving and giving and giving and giving. And it's easy to lose yourself in that, and maybe that's why it keeps bringing me back to the child's need, the child's experience, the child's emotions, you know… that's what I do all day long, is assess who needs what, where are they coming from, and then prioritizing it.

Eleanor commented that even when she did her own therapy that "it's still about them." Becky noted that she had to be able to set aside her own feelings, as she is the adult, and felt that was part of her job as a mother. Similarly, Abigail felt she put her needs "on the back burner—I wasn't even on a burner." Danelle described her experience:

> The things that are happening are immediate, right now, in this moment. And if there is not an episode happening, my focus is on preventing the next one. With two kids. So, there's not a lot of time or space to even think about like do I need to go to the bathroom? Am I hungry? What do I want to eat for dinner? Stuff like that. I'm thirsty and I have been thirsty all day. So, I think, in the last year or two I have been working on just like, being aware of my physical body.

They reported habitually sacrificed their own perspective to serve their children's needs, to the point of rending their own feelings invisible to themselves.

Help that isn't helpful. "[Working with a psychologist,] that was a year… trying to slap band-aids over a gushing wound, basically." (Helen)

All the mothers identified unmet needs throughout the interview; they wished most for logistical and informational support. A theme that emerged reflects the struggle these mothers have to find resources that actually help with the situation rather than become just another burden. Many of the women identified ways in which institutions and systems constrain actually accessing help instead of providing it.

The foster and adoptive parents all noted the lack of helpful resources available to the family. Giselle expressed frustration that because they adopted their child before the full extent of his needs was known, that they do not receive the kinds of services that he would have as a former foster child; she cited respite care as a particular need that she had. Becky shared that the foster parent training she was provided was inadequate, and that ongoing support once she could connect better to the experiences they were describing would have been more helpful; however, she found some support from the system, noting, "I've always felt that even with our least responsive social workers, that there's other people to back us up kind of thing." Overall, the foster parents identified more sources of potential help than the biological parents, but still felt there was significant need for more specialized help.

The biological parents also decried the lack of information about child aggression and the lack of knowledge from professionals meant to help them. Carolyn noted that she had been trained in de-escalation and restraint of aggressive behavior and that "Sometimes it helps [laughs], depends on the day. Sometimes it helps a lot, and sometimes it doesn't help at all. I'd say a year ago, it wouldn't have helped. It wasn't helping. We really, really, really were searching for something new"; she also noted, "oh, boy we've gone to a couple of child psychologists, we've gone to, we go to a psychiatrist currently, a child psychiatrist… And then in our ABA training.… So yeah, we've just gathered information over the years. Yeah. And also, we've also looked up some things ourselves. There's videos, there's blogs online, there's people that write about this stuff." Danelle agreed that therapists, particularly, do not always know what to do about the aggression:

> When I am working with somebody who is there to specifically there to give us solutions, or help us like get to a better place, and they are intimidated by our family, I just feel like are we really that big of a burden? And like, if its more stressful to work with you to get this help, then why am I coming here?… I think that therapists in particular have their little training manual or rulebook of this is the way that you get success with a client, and it seems like it's on a linear thought process instead of understanding [laughs] that nothing is linear, especially trauma in kids!

Helen complained that professionals often would make her discuss her daughter in front of her daughter, "because I can't do like that to my daughter, sit here and tell her how horrible she is when she feels like she's horrible already because basically every time she'd have a meltdown, she'd rage, she'd hurt people, and then she'd be in despair and self-loathing." Eleanor noted going to her doctor for a therapy referral and feeling "it was never like 'let's wrap about [Eleanor] and help her feel cared for,' it was 'oh you are doing kinda shitty, I guess we should do something about that, all right off you go.' It was very practical, 'here, take these kind of steps to

go through things.'" Many of the mothers described the professionals they saw for help as not

knowing how to manage the aggression either.

Sometimes, the systemic barriers are as in basics such as our nomenclature for the

experience and lack of physical support. Giselle describes trying to get support for her son, who

has a fetal alcohol syndrome disorder:

> I don't have anything. And there's not, like and especially for ARND kids, there is not, I
> feel like we can't, this is going to sound really bitchy and I apologize, I preemptively
> apologize for this. There are so many resources with kids for autism and so many grants
> and so, playgroups and such for kids with autism and I don't, I mean I begrudge them a
> little bit, but I don't begrudge them, because they need them, but our kids have a lot of
> similar issues and there is nothing. It's like this wasteland of things and people don't…
> some of the stuff that works for kids with autism does not work for kids with fetal
> alcohol, so you can't lump them all under the same group. [sighs] And at the same time,
> it's like well I'd like to get my kid into this playgroup, well do they have autism, no but
> they have something similar, well sorry. Like, gggrrr, ugh. Or they don't, they don't
> qualify for stuff because the DSM doesn't recognize this or that or you know, other
> things. So I'd really like to get the DSM changed, that would be great.

Other parents wished for logistical assistance during the difficult hours of bedtime, such as

someone else to be the one to deal with the aggression and similar in-home reliefs. Many of the

wishes amounted to a wish for more normality; for instance, Abigail stated, "I would love to be

able to take him and go to the grocery store, it sure would be easier than waiting to do it at ten

o'clock at night, when he's in bed." A plaintive request came from Giselle, who said, "Can we

just have an easy day? Can we just do normal things together as a family? And we can't. And it

sucks."

Logistical and practical systemic barriers also were identified. Carolyn noted: "you can't

put them in the psychiatric unit unless they are in a rage, unless they are being violent. And I'm

like, to get him there? I don't even know how I would do it at this point." Danelle identified that

> When we were in the shelter… [and in] transitional housing… everybody wanted to help
> us. And as soon as we got into permanent housing, we were magically cured. And that's
> when stuff started getting really hard for us, because we have a home now, we're safe

from [her ex-partner], he can't find us, so everything we didn't get to deal with or work through comes out now…. And so that's the hard part, this mentality that oh yeah, that happened to the kid but that was two years ago, but not understanding that maybe they haven't ever had a space or a time to even understand that this thing happened to me and I'm not ok from it, and so it just comes out as, in really extreme ways.

Eleanor asked, "There is no cultural anything to support parents in that regard. Where are the people to help them calm down?" However, she also noted not knowing what that framework could look like, noting that Child Protective Services was viewed as punitive rather than supportive. She summed up her sense of structural concerns, saying "there aren't spaces for us in the world. They are not at school, they are not in the park, they are not at the grocery store, they are not in the therapist's office. They are not, they don't exist." Though overall, the mothers reported significant systemic and practical challenges, there was a consensus ass that some practical supports such as learning restraint holds and using medication for their child were somewhat helpful.

Other mothers with special needs children were the only source of connection many of the biological and adoptive mothers found, because they "got it." Abigail described the process of feeling out other special-needs parents:

I'd never tell anybody [about the aggression] until maybe they reveal a little snippet and you're like "oh my gosh that happens at our house too" and they're just like "wow, what do you do? Oh my God" and they say the same thing. "I can't believe I am letting my kid use me as a punching bag" and I'd be like "I know."

Some of them found significant support in online communities, particularly those for special needs or foster children, or via texting with another mother. Eleanor and Helen both noted that their online communities were particularly helpful because they did not have to attempt to bring the children with and it was available at any time. Eleanor stated:

Good or bad, you are able to go in and say my kid was an asshole today and everybody laughs and says my kid is an asshole too… but so much of what parents talk about is about being isolated and feeling isolated. And so, an online support group is great

because you can do it without bringing the kids anywhere and you can do it whenever you want… but that parent-to-parent support doesn't exist unless you facilitate it yourself. That's just one more thing to do. And getting your autistic kid together with their autistic kid? Like, that's really hard, because your kid has challenging behaviors and then you are just adding more challenging behaviors into that mix and you are never going to have a conversation because your kids are biting each other or whatever it is that they are doing. Or, you're tending to your own kids' needs so it's hard to have a conversation with somebody else. And yeah, it would be lovely to get together and have a mom's night out or a dad's night out or whatever it is, um but then you need a childcare and there is no childcare because there aren't babysitters that will come to your house and work with your autistic kids because you have to hire special educators like we do … It's never going to be less than $100 for us to go just be able to leave the house, and most families can't do that. Or necessarily have the skill set, either the skill set to be able to go out and find someone they can bring into their world, and that took us a year to even find somebody or the resources to be able to do that.

Danelle finds a parent support group very helpful, as

you don't have to explain anything, you walk in with a look on your face and they are like yup, they already know… and you know, we are not all worn out at the same time, so some days I come in and I am able to be that person that's like "we got you" and other days they are able to be that for me.

Giselle worried that even the sources of support she has feel insecure, wondering what will happen if her son hurts his friend or his friend's younger sibling, while Carolyn worried her community would be reduced to only "autism moms." All the mothers agreed that the people who understand are a crucial sanity-saving resource.

Partners were an uneven source of support for the women. Some described their spouse as knowing when they needed a break, just as in the line of fire as they were, or otherwise as a major source of assistance. Becky described her husband as "my biggest support." Others were described as not really understanding, slow to understand, or as actively unhelpful. Helen, for example, described her partner as less skilled in managing the aggression:

I learned not to react and he always reacted, overreacted usually… it's been hard, it's been really hard. Because he wants me protected… but at the same time, he knows that I can't feel well if I don't take care of her, so there's stress there… for a long time he had this idea that he wanted to intuitively parent, and there, you can't just intuitively parent with her, you have to follow plans… I kept trying to get him to listen to me and do things

the way I knew they needed to be done, and he wouldn't… [until] he was finally like, I accept.

Eleanor described the struggle for both partners when

your buckets are empty and you can't fill up someone else's bucket if your bucket is empty, and then how do you refill your own bucket? And you just get to a point where you don't have anything left for the other person, because if you are giving everything you have to your children, your child or whatever, and then you're, can't get anything from your partner because they have been listening to screaming all day, and they've been at the appointments, and … their bucket is as empty as yours and then, how do you fix that problem?

Fiona agreed, saying "The marriage is affected, the everything within the marriage is affected. I mean, when you are holding a raging child all day long, just like a newborn child, you are probably not very physically receptive at night." All the women reported significant negative effects on the partner relationship, at least sometimes.

Stigma and fear. "We went on a field trip… and he had this huge meltdown and the parents are staring at us. And the kids are staring at us.… I don't bother to look up, because I'm helping him through his thing and we are going through our routine and we're getting out of it, and then we leave. And some of that is just avoiding eye contact. Because I know we are getting stared at and I don't need to know we are getting stared at. I don't need to know who is looking. And then if I make eye contact, then it's like do I explain that to them and do I do this, you know… like do I have to deal with you AND this, like let's just not. But I know that those parents are talking about it now." (Eleanor)

All of the women expressed significant amounts of fear as a factor in their isolating themselves—fear of judgment from others in the community and from the system and its helping professionals, fear of the future, and physical fear of being injured or seeing their other children injured. These fears were significant, debilitating at times, and were identified by many women

as the worst part of the aggression. For all the women, possibly the only thing worse than being invisible was being seen, because this gaze inevitably felt tinged with blame and judgment.

Dealing with others in public was a consistent problem when their children were acting aggressively in the community. Eleanor noted, "we get stared at a lot." Giselle described an incident with her son, expressing a common worry that people will call Child Protective Services on her because of her son's reactions:

> So, basically you have to ignore him [when he's escalated], which I'm sure the neighbors love because he's screaming at the top of his lungs "don't hurt me" and you're like "Nobody is near you, we're not touching you, please stop making it seem like we're trying to kill you." Or "ow, ow, stop!" And I'm like "Honey, can you not?" I want to stand out in the front yard and shout "I promise I'm not hurting him! I'm not even touching him!" [laughs].

Eleanor also expressed this worry, stating "What happens when we are in public, and he's melting down, and I go to restrain him and he screams 'please don't hurt me.' The police are coming to my house, right?… I talk to everybody about this, even for my own, my own safety, because the police might come to my house. CPS might come to my house. And say a parent on the field trip called us because your kid screamed 'please don't hurt me.'" This fear of legal intervention was pervasive and led to worry that their child would be removed from their home as a result.

The lack of understanding from others also made some of the mothers feel they could not depend on others to give them a break or show compassion for their child; for instance, Danelle stated, "having to trust other people to pick up on [his signs he is about to become aggressive] is really scary. Because if they don't, then he suffers from it." Giselle experienced direct shaming from her son's teacher, who "used his history against him, she said … if we couldn't get him under control … he would end up just like his birth mom.… I wanted to slap her. I never wanted to physically hurt someone else before." Giselle also noted,

I get a lot of those looks, because he's running up and down because I cannot, I cannot always make him stand next to me… there's a lot of like, "well what are you doing? What are you doing at home? Well what are you feeding him?" Speed and crank, what do you think I am feeding him!… There's always that initial suss out of me, which I find kind of annoying.

Danelle also wished she could get understanding without having to explain so much; she stated,

It's also conflicting because telling people why he can't do these things… once I say specifics, they are like "oh my gosh, I had no idea it was like that." And so that's good, but it's like constantly cutting open the wound, every time, and it's like I don't want to always have to do this for you to then choose, ok, now, I have some compassion. When before, if I say we can't do it, I just would like compassion then. So, that's, that gets exhausting, like constantly going through, reliving the same thing and like having the same experiences over and over, when its new to the person that I am talking to, but for me it's like, I just did this yesterday at the school. Or I did this last weekend, with my other friend. You know. That gets exhausting.

These judgments from others were experienced as invalidating and isolating across the board.

Even friends and family were a source of judgment at times. Abigail remarked,
Most of my friends, because his stuff just looked like behavioral stuff, typical like you need to give him time-outs or you need to be firmer with him or you need to do this. And they were like, "why aren't you dealing with this?"… I lost some good friends over that.

Carolyn expressed significant worry about relating to "normal people":

I have to find safe people to talk to… because I'm out in the community and I am, I am with a variety of people and sometimes its "why do you have those bruises?" and why, you know? Comes up and sometimes I just say it's an accident. But occasionally I, you know, I just needed to say something, and I get really mixed reactions of, a lot of times that we should put him away, we should do this or that, and I'm like, he's my son. Would you do that for your child? Would you do that to your child? [I feel] anger, a lot of sadness, a lot of sadness because, they just, jealousy, I think, not just sadness. It's a mixture of jealousy, of course you haven't had to deal with this, and good for you, and no. I wish I didn't have to.

Danelle noted that people assume

that for [my children] to not always be able to function at the same level as [other] kids, it presents like I am a bad mom, or at least that's how it feels, like people are like "you need to get your kids together."

Eleanor angrily noted the ways in which friends tried to be helpful and were not:

you have all these fucking idiots who write you to say "have you tried fish oil? I knew somebody and their kid had fish, have you tried cranial-sacral therapy? And have you hooked them up to a car battery yet? Or maybe it's like, red dye number six?" And you are just like, holy shit. You and your stupid ideas need to fuck right off.

Sarah also noted that some people tried too hard to be helpful, so that "either they are not helpful or they are too helpful." Fiona holds back from her family, in particular, to prevent judgment:

I don't think I ever share the whole enchilada, you know like how bad it can get. Because there is always this little piece like, I don't want them to feel, like, there's concern about having us over for Easter, or you know, I want to protect their impression of my son.

There appears to be a cycle of feeling or being judged, holding back due to fear of further judgment, and feeling unseen or unvalidated experienced by all of the women.

The women also expressed significant concerns about the future and what that might look like for their families in the long and short term. Abigail expressed concern that her son would continue to be aggressive as he got older, saying "How long is this going to last, is this going to be the rest of my life? Am I going to be dealing with a 180-pound teenager, and like how am I going to deal with that?" Many of the women worried for their child's future, like Giselle:

Because I worry, I worry about him hurting somebody, I worry about him drinking and doing drugs, and I worry about him going to jail. All four—I mean they are all four kind of connected, but I worry about all of those [sighs].

Overall, there was significant worry, anxiety, and fear about every aspect of life for all the women.

Post-traumatic stress symptoms. "That's when you are on eggshells. Because when they are the sweet, loving, cute, you're just like, I don't know how long this is going to last so you're just not ever wanting to rock the boat, so making things easy for him.… So just like waiting on him hand and foot just to see if that will prolong the good, happy moment you know kid. Even though you are in those happy moments, I mean your body is just this tight ball of

stress just kind of waiting for the other side to show itself. So, you're never relaxed, and you're never really let down, to just unwind." (Abigail)

Many of the women described, sometimes naming it as such explicitly, experiencing symptoms of post-traumatic stress disorder (PTSD). Abigail stated, "I equate it to like shell shock or PTSD… like my nerves or my stress, they go from zero to ten because it could be happening now." They expressed significant levels of hypervigilance, constantly monitoring their child in order to try to prepare for another attack, and also described feeling unable to react and at times re-experiencing some of the attacks. They also expressed high levels of hopelessness and helplessness at times.

The feeling of hypervigilance was universal. Like Abigail in the quote introducing this section, Carolyn also expressed this sense of struggle between enjoying the good times and watching for things to go wrong; she described the aggression as "it touches those places that are so raw and so, so hard. That you, when times are good like this, I'd like to really put those way behind. [sighs] It's like a roller coaster, constant ups and downs." Danelle described the feeling this way:

> Like when I go to other people's houses, or I see other people with their kids, and they like if we're playing at the park, is like a really simple example. And I can see an issue coming from a mile away, so I am like five steps ahead of my kids all the time. And when I see other parents not hypervigilant, like me, or not even… they don't even know that its coming, to me, my first thought is like "how the fuck do you not see this?" And then, like, its usually later on like that evening when the kids are in bed and I'm like replaying the whole day, it's like it makes me feel really lucky to be able to see that far ahead for my kids… And it's also like, it feels really unfortunate that I have to do that. Like I just, I find myself thinking like, "I wonder what it would be like to do what the other mom did." Cause it's like so far from my reality. And I'm just kind of accepted that this is our life and this is our norm and we will probably never be like that.

Constant monitoring of their child's mood appears to be a universal and exhausting experience for these women.

Fear of physical injury was also a focus of that hypervigilance. Giselle's description sums up the sentiment of the mothers well; she stated,

> academically I know that a six-year-old doesn't really know that if they hit you in the head with a hammer you're going to die.… But at the same time, "I want to kill you. And I've tried to." [laughs]… it's definitely more intense… terrifying. Excuse me, because I've had dreams that [my son] has killed me before. And he's six.

Carolyn said it simply: *"I want to feel safe. I don't want to be afraid in my own house."* This extended to siblings, who were sometimes identified as collateral damage, or targets of aggression in and of themselves. For example, Helen identified letting her daughter hurt her partly "in order that she wouldn't hurt her sister." All of the women were acutely aware of the child's capacity to cause injury.

Hopelessness, another common symptom of PTSD, was also a significant topic of discussion in the interviews. Most of the women, particularly the biological and adoptive mothers, expressed a sense of hopelessness either explicitly or in the way they talked about the aggression. For instance, Carolyn remarked,

> I really wish I could believe in him growing out of it, I do. I don't anymore. Growing up, growing better, getting more tools to deal with life. I have hope still. I hope that never dies. [laughs] But growing out of it completely? No. And I wonder what that is going to bring, for all of us.

Danelle stated, "We've worked so hard together, we've gotten so much help outside of our family, like why is it still so hard for him?"; she also said, "I feel hopeless a lot of the time." Helen related,

> I couldn't like respond in the moment at all, emotionally, or it just would have been even worse, so I went after her, grabbed the scissors, I don't know even know what happened really, except that I got her calmed down and then like, four days later just totally broke down at work, [cries] cried for, I don't know, an hour and a half? You know, and then just kept going. Because what do you do? … It took up three months [for the therapist] to even convince me that I had to [cries] stop letting her hurt me. Like, I couldn't like see any way out of it. I couldn't believe anything would work.… I just couldn't fathom like being able to say "you can't hurt me" and having it work.

Abigail noted,

> for a period, it really broke me. I didn't even know, like I just, I didn't even know, like even my husband would be like "what do you need, like what do you need from me," and I would just be like "I don't even know."

Overall, the foster parents generally had a more positive outlook, feeling as though being in a safe home and having treatment for their charges' trauma would be effective in the long-term, while the biological parents were more resigned to their child having life-long challenges.

Helplessness often accompanied this hopelessness. Becky noted feeling helpless to help her foster child, to protect the other children in the home, and to protect herself; Becky continued,

> I would say that I have some PTSD from that, because then later we got another kid after she had left… and I would like, my body was reacting like it was the nine-year-old in front of me… rapid heart rate, sweating, like going into like a, like a, kind of like a panic mode.

Carolyn noted having flashbacks which recur when "times are bad." Many participants felt at least at times that there was little they could do to prevent the aggression.

Most of the mothers also acknowledged experiencing their own mental health concerns as at least partly a result of the aggression they experienced. Many of the women mentioned their own therapy or other treatment, and that they experienced difficulties such as trouble sleeping, trouble concentrating, and feelings of being overwhelmed by the demands. Giselle remarked, "Where do I work again? That's the other thing, my brain is just totally fried. Because all my stress and energy go into this one project [of my son]." Helen noted that she goes to therapy, but that it was inadequate as a resource: "yeah, I go to people for an hour once a week. That's like, it barely, barely scratches the surface." Becky stated,

> the aftermath feels more like a depressive episode, where I just can't be around anybody right now… I think mostly it's just more the cumulative effect of it. I feel like I could handle [one episode], but it's like the cumulative effect of like this happening over and

over again, and then starting to expect it, it becomes a lot more difficult to see the positive things… It takes a lot, it's kind of exhausting to try to find the good things.

Fiona noted having a similar sense of dissociation about the experience compared to her childhood abuse, stating,

part of living in a home where there was both physical and sexual abuse happening, it's a survival skill to be able to say "hey, this is my body but I have, I am staying intact, and things can happen to me but they aren't going to affect me," and it's kind of where I found my strength.

These symptoms raise one of the primary questions raised by this research: is what these mothers are experiencing abuse?

Comparison to abuse. "I would tell my husband I feel like I'm an abused spouse or something, but it's my kid. Like, you can leave your partner if they are doing that, but you can't leave your kid." (Abigail)

I know that I am helping him.… when you are a kid and your dad does this that and the other thing, you are not helping anybody. You are not. I never felt that was a responsibility for me to get hit one way or the other by my dad.… I knew that was him, and his shit and his issues and… I knew all along that that was not ok and that I was the child and that was not my responsibility to participate in this. With [my son], arguably, its institutionally my responsibility to participate in this because what's the alternative? (Eleanor)

Participants were somewhat divided on whether to perceive the aggression as abusive. Some of the women shared experiences of either childhood abuse or intimate partner violence and noted a significant difference in intentionality shaping their difference in perception. Others felt that children were not developmental capable of being abusive, though they agreed that they were violent. Other women struggled with the word abuse but described feeling victimized. Some women resonated with the word abuse, but still qualified it as different than abuse from another adult. Overall, it was clear that there are similarities in behavior and consequences, but

that there was a qualitative difference between this experience and adult-on-adult or adult-on-child aggression.

Many of the women argued that developmentally, children are not capable of perpetrating abuse, though noting the actions that they were doing would be perceived so if done by an adult. Carolyn pointed out that her child was developmentally behind in many areas, and wasn't capable of being abusive: "it wasn't even a year ago, that's he's finally, what I would say fully potty trained. [laughs]" The foster and adoptive parents frequently cited the trauma their children had experienced as an etiology for the reactivity, while the biological parents generally cited it as part of their diagnosis. Even in the face of others' judgment of the aggression as abuse, Carolyn refuted this idea:

> I would describe some of these things to some of my friends and they would be like, one lady went off because she was abused by a husband, and she was like, "this sounds like that, blah blah blah, you need to get him out of there," and I'm like "He's 10 years old! He's 10 years old and can hardly take care of himself at times. You don't get the whole picture. You don't get it."

Fiona cited the idea that children with trauma need to re-experience old developmental stages to rework them, saying "he's not really an eight-year-old right now, he really is kind of at his three years old… so your expectations change, and you have to constantly remind yourself, this isn't your typical" child. Giselle poignantly described, "you suddenly then just—[very quietly] you see he's a baby." None felt that their child had the capacity to be deliberate about using aggression as a tool for power.

This distinction between the aggressive behaviors and the purpose of the behavior informed their understanding. All the mothers characterized the aggression as unintentional and reactive rather than planned or manipulative. Carolyn shared that she had been previously abused by a partner, but she experienced her son's aggression differently, because "there was an

intentional, kind of like, intentional planning, plotting side to it [from the partner]. My son, it's just reaction. It's not—there's no planning, there's no plotting, its simple stimuli and reaction." Fiona stated,

> there's no connect for me in my brain from a child who is out of control, and has legitimate reasons to be, and is confused and untrusting. That's way more easier to be compassionate to a child and understanding than towards an adult who in my eyes should feel a responsibility.

The participants were all able to place blame either on their child's experience of trauma or on their neurodevelopmental diagnosis, and thereby place it outside of the child or themselves.

Explicit discussion of language prompted interesting discussion about the language of abuse, victimization, violence, and aggression. Fiona identified the capacity to get help as a source of power for her in this situation versus her childhood abuse; she also wondered if her own experience of being unprotected during her childhood abuse has led to her to be more protective of the children in her care. Eleanor flat-out stated, "I don't feel victimized by [my son]." Becky agreed, saying,

> I don't think I would view myself as a victim, because I feel like, and I don't think I would call it abuse either, I don't know. I guess in my mind, abuse is a more powerful person hurting a weaker person, and so with a child I don't feel like that… on some level, I still have the upper hand.

Carolyn attributed her continuing to get help, "looking for new paths… trying to keep the communication open" with her son as a mark that she "has power over being a victim."

However, at times the women did acknowledge some similarities as well. Carolyn summed it up well, saying, "You have days where you feel a little bit like a punching bag. [laughs] Like a recipient of all of other people's garbage." Abigail was the only participant who characterized her child as abusive throughout the interview, though she also recognized the difference in intentionality; she stated, "It was almost like this abused person, you know, well

you are. You were being… I was being abused, you know, and it was my own kid"; she

continued, "You can leave your partner if they are doing that, but you can't leave your kid."

Eleanor, despite having denied being victimized or abused, articulated that this was something of

a semantic difference:

> The easiest comparison that I think that I can make having had lots of therapy is not having control over your body and that's, I think, anyone that's experienced any abuse, whether it's from your child – and it doesn't necessarily feel like, I don't feel like he's abusing me, I don't, even though I know that technically that's what is happening – but it's still that … I don't get to decide if I'm hurt or not, I don't get to decide if I participate in this situation, I don't get to decide what part of me is being touched, I don't get to decide if it hurts or not. So not having, you don't have any autonomy over your body and I'm a, you know, almost a literal whipping post to—this is my responsibility in this moment and so this is what I'm here for.

The "lack of responsibility" taken on by both her abuser and her child was also noted as a

similarity by Fiona. Giselle noted her own childhood abuse and explained her understanding:

> Even with my childhood stuff the most powerful thing I did was to kind of reframe that, and look at times when I did, as an older child, did have opportunities to get help, receive help, because if you believe yourself as having that power, then you are a powerful choice maker today and I won't be a victim again. So some of that is the work that I have done, I just never felt that way, just more of a container.

Carolyn felt it was similar

> because you are physically beaten and so you bear the scars on your body and your heart and your soul… And a victim, ugh, that word, I think, I guess you are a victim in a way, because you're, you don't ask for it, and so it's done to you. You are held hostage…. It's just got such a reputation as a word, victim. I try not to see myself as a victim because I don't want to go down that rabbit hole.

Danelle made the connection between the hypervigilance she experienced in an abusive

relationship with the feeling of "having to make sure everything is ok because if it's not ok, then

people get hurt." Helen stated

> I'd say I was a victim of abuse… I feel like I have PTSD from it… because of how strong my emotional reaction is to it. If she starts to have aggression towards me again I just flip to like, total reactive state very quickly… just thinking about it brings up this well of

emotion like, and I was like, never an anxious person until going through all this with her.

Overall, the women overwhelmingly agreed that their experience had some commonalities with other kinds of family violence but struggled with the words abuse and victim. They noted that they had some forms of power, especially intellectual understanding of the situation, but have lost bodily autonomy and control over their time. They struggled with the idea of being a victim while accepting how they could be seen as such. They accepted the terms aggression and violence much more easily, and traumatic with some reluctance.

Coping. "I started noticing how good it felt to take those breaks or do something nice for myself. Or, you know, say no to [my son] about something… And just kind of be able to set more of my boundaries and realize that's a form of self-preservation." (Abigail)

The women all described a variety of ways they managed the consequences of the aggression towards them. Some noted that over time, self-care became so necessary that they were forced to learn to put themselves first at least some of the time, and that as they did so, the situation improved. Abigail described understanding that she had a limited amount of energy in a day, and that it was a conscious choice how to "spend" it. Becky had to overcome a sense that "healthy people doing the right thing don't need this type of support," referring to therapy. Fiona remarked, "I think I have a right to set boundaries and I feel like I do it really well. I definitely do not put myself in the position to be a punching bag and say 'this is ok.'" Giselle, on the other hand, noted, "telling us to do self-care is bullshit [laughs]. That's my only thing, 'go and practice self-care.' Yeah, great… We are doing our best." Helen described her method of coping: "I learned to walk out of the house, that's what, instead of going, like, if the weather was nice, I would walk out of the house and just keep walking, and she would run after me screaming," but

would calm faster than in the house. Finding ways to keep themselves safe and recharge after difficult incidents was a struggle for all the women.

Many of the women described using research as a form of obsessional coping. They expressed a feeling that if they just learned enough or understood well enough, that they would be able to help their child better. Abigail described this strategy: "I just wanted to understand, you know, kind of how his mind worked, because I felt that the more I understood, then the better I could become at helping him, which would then ultimately fix all this." Giselle laughingly stated, "It's how I calm my fears, by learning about more fears!" To some extent this was a form of coping, but it often became just another manifestation of the advocacy and emotional labor the women felt was part of the job. This advocacy role is discussed in more depth as part of the women's discussion about the nature of motherhood and the roles they must play in mothering their aggressive child.

Summarizing the experience. The mothers have clearly articulated the profound physical and emotional impacts the aggression has on them. They describe physical injuries, constant stress, and deep ambivalence, complicated by their overwhelming compassion for the suffering of their child. They note social isolation, lack of helpful support, and at times active stigma and judgment against them due to their child's behaviors. Many endorse high levels of post-traumatic stress symptoms, including hopelessness, helplessness, and withdrawal. However, they also are very clear that what they are experience, while violent and scary, is not abuse; while they recognize their lack of bodily autonomy, they do have other forms of power, as well as understanding their child's behavior as stemming from their own suffering rather than as an intentional manipulation.

Defining Motherhood

Throughout the interviews, the idea that a certain task was a role of the mother emerged. Tolerating the violent behavior was often described as "part of the job" even as participants acknowledged the resentment that emerged at times as a result. Other tasks identified were providing advocacy and education to strangers, family and friends, and professional helpers and system representatives such as teachers and social workers; and performing as an attachment figure for their child. The mothers also identified significant anxiety about doing these tasks well and struggles with resentment. By defining motherhood, the women were creating meaning about their experiences and highlighted sociocultural influences which shaped these understandings.

"It's my job." "Especially a mom with like a special needs kid. You just, it's like, it's beyond a mission. It's an instinctual animalistic power that comes over you to want to help your kid, understand your kid, you know? I mean I know all parents feel that way, but there is just something very different… between the relationship between of the mom and a special needs kid… once I had him, I felt like my heart was outside my body, not the figurative part but the literal organ. And you've got everything attached to it, and how delicate it is, you don't want anything bumping into it, you don't want dust on it, this organ is out of your body. So, anything that happens to him, or what, you just feel it on such a physical level that it, it scares you. You are responsible for this thing, and you know any little bump… it was like oh my God like this should not be out of the body. This needs to be in here, behind the rib cage, like protected." (Abigail)

This idea of being a holder for their child's rage was expressed by multiple women when discussing their role as a mother. This was expressed in a variety of ways: as being a container,

as absorption, as a safe space, and as a conduit. All the women identified taking the aggression as

what a good mother does, and that they were responsible for accepting that. Often, this was

paired with a sense of guilt about feeling resentful or overwhelmed about it and led to worries

about being up to the task. Fiona used the word "container" to describe her role in the aggressive

interaction. Abigail identified as being uniquely positioned to help her son, saying,

> I mean at one point, I'm like, okay, I know I am his safe person, to where he can let all
> that out. But yet it's like, can you spread it around a little bit, where I am not the only
> one? So, it was frustrating and kind of annoying that you know it was just me, not [his
> father].

She described hiding her injury and pain from her child after he hurt her, because it was her duty

to protect him despite her injury, and despite the injury being caused by his behavior. Fiona

agreed, stating,

> To me, that's what being a mom is. Not to be emptying out, to nothing, and being mean,
> but that to me is what mothering is. And at the same time, encouraging them to learn how
> and giving them the tools to take care of themselves. You know? I don't always want to
> be the one in control of taking [my son] to an in-control place. I want to give him the
> tools.

Helen described her role as "absorbing" the violence, and that by taking it her child was relieved

of her rage. Eleanor stated, "I hate to describe [subjecting myself to the aggression] as

therapeutic," but that her role was to be

> the person that needs to alleviate his suffering. And he's coming to me for help, even
> though he's hurting me, and so I have a responsibility to not feel angry and to be
> compassionate and to keep calm and to not join the storm.

Sarah described being her son's "external emotional processing system. All of his emotions. That

also means when things don't go his way, I am the immediate target." Overall, there was a sense

of themselves as a healing tool, removing the suffering of their children through a process of

absorbing or drawing off emotion by accepting the aggression.

Most of the women specifically used the phrase "it's my job" in their interview. Eleanor stated,

> I have a responsibility on one hand to help him through his thing, because nobody else is going to do it and he doesn't have the skills to do it himself, and that's what being a, the best mom would do that, and then there comes a point where I can't, I can't do that anymore.

For Becky, this feeling went further into a "calling" to "help traumatized kids heal." Abigail described her sense of responsibility as the mother, saying, "I think you feel even more sense of, well, I have got to be responsible to fix this, I've got to help the situation. And that's almost more of a natural reaction than taking care of yourself." This self-abnegation was pervasive throughout all the interviews.

Some of the women connected this expectation to the parenting trope that children are always worst-behaved for their mothers. Giselle noted, "We are the safest. You are always meanest to the people you know are not going to stop loving you... please, beat the crap out of me, I love you most." Eleanor agreed, saying, "the kid's behavior is terrible and out of control and ... we are the safe space for them to be dysregulated with, which is supposed to somehow make us feel better." They identified this as a message given by cultural ideas, parenting literature, and professionals, and acknowledged both their belief in it and the invalidation inherent in the concept.

Some of the women connected these concepts to larger systemic or cultural constructs, such as the devaluation of women. Eleanor compared it to the social changes that occurred around other kinds of violence against women:

> I cried when you [the interviewer] asked me [what this was like for me]! [laughs] because it was [laughs], now I'm crying again! The fact that you are doing this is so important. Because nobody else cares. Nobody cares. And I don't know if that's just because we're women. And especially talking about, women being hurt, that's not—I mean, sure we'll all going to rally around people beating their wives now, which is fantastic. But 50 years

ago, that, nobody cared. And so, and I don't want to equate those two things, because they are not the same, but if we are going to put these two in the same kind of bucket of women being hurt, whether its intentionally or not, is you know, I don't view [my son] as intentionally hurting me, but I think it falls into that same category as we did women 50 years ago when nobody cared. This, this is just your role in the family, and this is my role currently in the family, and if your role in the 1920s or '30s or '40s included your husband hitting you, then that was just part of your role in the family. And again, I don't want to equate them, I do separate them very, very much. But I do think that our response to it is probably from the same type of cause. Where, it's the kind of that same old story. You know? People are not interested in hearing what your voice is.… It's women, it's women in the home. Nobody really gives a shit, you know? And you gotta convince people why they should give a shit. And that's not on me. So. Thank you for doing it, because my bucket is full.

Fiona described the larger societal expectations as well, remarking,

I think there's a piece of the vision of motherhood, and I don't know if its cultural or if it just is, but from the moment you receive a child, in any way shape or form, it is, it is kind of like the acceptance of being used, really sounds really cold, but being a conduit for like, giving and giving and giving. The trick is, what are you giving from, you know? I think, am I replenishing you know, enough and if I am not, then that's where I start to get resentful.

Abigail agreed, and stated, "I think it happens so gradually that I don't even know if I can say how it really happens, or even if we are aware of it until it's gone too far." Carolyn stated that her son "picks up from society that I am a woman and I am weaker, that I am supposed to be all these things. And so I think he targets me first… he knows there is even more, a bigger vulnerability with me." Helen noted, "I was raised in the '90s, when we were told we can do it all. That was the female ideal of the '90s and I bought it hook, line, and sinker… and then I started unravelling [laughs]." Once again, the women are describing holding two realities, in this case of their ideal of mothering and their own resentment about the consequences of that ideal.

Case management and advocacy. "I often joke, I often tell friends I spend 98% of my time in advocacy mode, and I spend 2% of my time crying in the bathtub." (Eleanor)

Many participants described working with professionals, such as social workers, school staff, and therapists of various disciplines as part of their job and noted that this aspect of their role as mother also puts their own needs in the background. Carolyn noted,

> I try to interpret his perspective all the time, as a parent, as a mom. And I think because I talk to professionals all the time and that's what we are doing, is we are putting him under a microscope and looking at things from his perspective. You need to look at things from his perspective all the time. And so I, my perspective is in the background.

Eleanor also described her role as "case manager" and added,

> There's a lot of conversations that I think [my husband] and I have gotten good at, when we are talking about—let's call it the stuff. The stuff is like all the things, the OT and the speech and the IEPs and the like all the stuff, all the stuff... But I was always the one at the IEP and teacher meetings and all this other stuff.

Abigail agreed that mothering an aggressive child required her not to just to be mother, but play multiple roles:

> It's my job, along with the other professionals we did find, to take on the role, but not
>
> only are you mom, but you're also occupational therapist at home, you're a teacher at
>
> home, you're all these different things... It is just this constant learning and being ten
>
> steps ahead, and making sure you have your bag of all your tricks... I'm keeping files on
>
> him, information on him, and, and, and.

Case management was a major role for all the mothers.

Advocacy for their children, or their children's diagnosis, was also identified as an important role of the mother. Advocacy tasks included educating others on their child's diagnosis or behavior management, working with schools and other environments to be sure their child would be appropriately treated or cared for, and working to get services. Mothers identified needing to be proactive, act as case manager, and at times being "that parent" in order to get the help they needed; Danelle described it as "hard because I know a lot of times, I am that parent,

that when [school staff] see coming they are like 'oh shit' … but I also don't give a fuck!" They also identified a conflict between their and their child's privacy, and the need for others to understand, particularly in public. They also expressed frustration with having to take on an educating role with professionals they perceived as the person who should be the expert. They described their roles as interpreter, liaison, translator, and educator.

This advocacy often takes a substantial amount of time for the mother. They described attending meetings for IEPs, Wraparound or similar support services, multiple therapeutic appointments such as psychotherapy and occupational therapy, and for some parents, meetings with social workers for their foster children. These meetings often require substantial planning time as well as communicating frequently with team members. Danelle described having "wraparound services so we have meetings every month, plus IEP meetings, plus I email them to check in or to like 'hey, he had a really hard morning.'" Danelle also expressed feeling the need to take charge of many meetings, because her experience was that school officials in particular were not willing to provide the services she felt her son needed:

> If it's not a school that's going to, and I don't want to say do it the way that I want to, but definitely let me lead the process, then it's not a school that I am going to put my kid to because if they don't respect me as the head of our family and that I know my kid and at least what to ask for even if I don't know what that solution is, if they can't like recognize that and work as a team then it's not the best place for them.

The foster parents had the most commitments with team members and the most systemic involvement, but all the children were described as having involvements with outside resources.

The mothers expressed mixed feelings about taking on this role. In some ways, it was a source of pride, of validation of their expertise on their child, of enacting social change. However, it was also described as exhausting. Some mothers noted that professionals such as

school staff and judges often did not acknowledge them as experts on their child, identifying this

as a systemic problem within the culture of those organizations. Danelle noted,

> Unfortunately, sometimes as a parent I say something and it's like I didn't say it, but their therapist or the principal or whoever could say the same exact thing and then all of a sudden its… this epiphany that's like this is the greatest!

The parents who were involved in the child welfare system unanimously agreed that despite their

daily caretaking, the system did not give them a voice; Becky noted,

> Anger [at the system] usually stems from the disrespect. Like, we had our meeting about visits, and one of the visitation supervisors was like, "well I think we would know what is best for this kid because we are with them every week." And I was like, "I think I know what is best for this kid because I'm with them every day." I was just like, "I can't believe you said that." As though living with them was less valid than being with them for a visit twice a week.… Why is what I'm saying not even important?

Fiona echoed this sentiment, describing,

> Constantly feeling that you have to do ten times better than the birth parents are ever asked to. And there are times where that sassy little attitude in me is like, are you kidding me? Do you know what I've been through with this little guy?

This ignoring of the mother's experience was perceived as a further invalidation.

Many of the mothers struggled with how much, if anything, to tell others about their

child's special needs. Giselle, whose son is adopted and has a fetal alcohol-related diagnosis,

stated that she struggled with sharing his story, "which is nobody's business. And it brings up

this whole 'and how did you adopt him' and blah blah blah blah and you have to become an

ambassador for adoption and an ambassador for fetal alcohol." Fiona remarked,

> There are times where I feel like I kind of bring the doom and gloom because [laughs] that is part of the reality that we all would like to, in our society, that we'd like to have our head in the sand and not think about the kids that need homes and what's happening to children in general and the impact of it and the reality of that, but I also share the celebrations and the growths.

Eleanor was very clear that simply taking her child out in the world was "awareness work" she sometimes felt pressured to do, as a way to educate the public about special needs, but also noted that "I don't have that in me right now." She continued to express her struggle:

> How much information do I need to spread out in the world, to his class, to his other you know, like "oh hey, let's have this autism talk with all the moms"' yay.… It's exhausting to perpetually have to explain to people what autism is, what it looks like for our family, and also trying to have the right political approach as we discuss these things.… person-first vs. identity-first language, and how much am I respecting his privacy by sharing all this… if I'm going to be the face of autism by educating somebody else, even in these moments where he is melting down and I don't feel like sharing all this. I'm having to educate our friends and family about what autism looks like for us but also the caveat that if you have met one autistic person you have met one autistic person and everybody's different and argh, it's just such a long conversation every single time. Like, I know some moms who carry cards for like when their kids are melting down. And they just hand it to stranger, like, "here, you have a question? Just read this card." And it's one of those "my child has autism, sometimes he has blah blah blah," all the things you'd like to say if you had a well-thought script that you would have. So, here's my autism script I'm going to hand out to strangers and I was like, really, do I need to go on Vistaprint and carry these around with me, and have them readily available in my jeans pocket so I can like, manage him and restrain him AND hand out cards to strangers?! Like, how about we just not leave the house. That's a lot easier.… But it the like, oh my god your eight-year-old is doing this. Like there's a whole lot of judgment about an older kid doing it versus a younger kid doing it. (Eleanor)

Danelle described this conflict as

> putting all your shit out there [laughs] and it's like, your most personal deepest like most intimate things, you know? And it's like, if somebody… if my sister gets in a fight with her husband, she's not going to broadcast it to everybody, and I feel like that's on the same level. And so, but I also feel like… I have to tell it, or else my kids will get treated differently. And so, trying to figure out which one is needed or is it worth it, is sometimes is hard and sometimes afterward, like if I'm like here is everything, and later I'm like I didn't really need to do all that [laughs] you know, but it's, it's exhausting, processing it every time that sometimes I just word vomit [laughs].

The conflict between privacy and advocacy was a real struggle for many of the women.

The roles of case manager and advocate were both a source of strength and a significant burden on the women's time. Much of this work was identified as being a parent to a special needs child in general but that the aggressive behavior makes the need more urgent and help

more difficult to access. They were unanimously resolute that they were the experts on their child, despite the professionals who invalidated this belief.

Attachment. "I love him so much [cries] but I don't love this! [laughs through tears]." (Carolyn) "Certainly, it's harder to love someone who beats you up, regardless of who they are." (Becky)

Many of the mothers expressed the importance of mothers as attachment figures. This focus was equally true for the biological, adoptive, and foster parents, though there were some differences in how this idea was articulated. Biological parents worried about their adequacy as attachment figures, while the foster and adoptive parents recognized that their children come with significant attachment challenges. They too worry if they are an adequate attachment figure but acknowledge that there was already trauma impacting and often, in their perception, underlying the aggression.

Strong attachment was a key theme for the biological mothers, with all of them feeling that their strong bond with their children is an asset, but also expressing fear that attachment problems contribute to the aggressive behavior. For instance, Helen believes her attachment parenting style is a resiliency for her daughter, while also acknowledging that to some extent her choice to parent in that way is the result of her own insecurities. She stated:

> I was like if I can just make sure that this baby is held and loved and is close to me enough, maybe I can help with this like potential we have in our society… And I intentionally was a very, I guess that is called attachment parenting, model of parenting from the very beginning with all of my kids.… that is about as external as my motivation gets, but then it's still very much grounded in the internal motivation to selfishly have that bond with my child.… I do think it makes a difference. Especially even [my aggressive daughter], she always has trusted me. Like, I am her voice, I am her person, she always comes back to me as her like… touchstone foundation. Like she will tell me everything. Which is pretty amazing for a kid with autism who won't communicate with most people. Granted, it's been very helpful in getting her what she needs. (Helen)

Both Eleanor and Danelle related that their child's attachment to them as a comfort object helped

with preventing or calming aggressive episodes; for instance, Danelle described "holding him,

being like right here on me, is the strongest way for him to, like regulate himself." Danelle

acknowledged the importance of her attunement and also how problematic that dynamic had

become:

> So him getting physically violent with me always guaranteed that I would wrap myself around him and stay with him and I would rock him, and you know, it would guarantee that comfort for him, and so, that's what made it really sad when I started understanding that, his like, he's hurting me and that's his way of saying I'm scared because I'm not okay and I need you… I would feel really thankful that I could understand that … and it's also sad and scary that that is the way he asks for help because when he's not with me, 99% of the time people won't understand it that way.

Their positive attachment was overwhelming interpreted as healing to their aggressive children.

The foster and adoptive parents were also focused on attachment, but they accepted this

challenge as part of the foster or adoptive process. Unlike the biological mothers, they did not

feel like their parenting was a cause of the aggression, but still expressed worry that they were up

to the task of parenting such a challenging child. Fiona summed it up nicely, stating:

> I think it's that attachment piece, you kinda become one a little bit. Labor and delivery and pregnancy isn't always easy, I didn't have, you know, that wasn't a lovely time [with my biological children], some women love to be pregnant and all of that. Even getting my little teeny, they were tiny birthweight babies and it was hard to get them to latch on, all of that is a little bit of hardship. I guess I view [the aggressive episodes] as sort of our attachment process, and, and, it's the labor and the delivery [laughs] of my adopted son, has been all of that turmoil. So with that it kinda does become one to me. I can't, I have a hard time separating and making it about me, you know.… There are very few occasions that it's been about me, and that's kind of one of my mantras. This is not about me, that's kind of a saving grace. I did not do this to this child. I didn't. Not that my [biological] kids don't rage at me, I mean they get mad too [laughs]."

She also connected her adopted son's increasing attachment to her as a protective factor, noting,

> from five until now almost eight, it's a lot less physical towards me. Probably because, with attachment comes more responsibility in caring for that other person and the impact of their violence towards them… And that attachment is more insecure than secure at times, so when you are feeling out of control and raging my impression was that he

would rather destroy something else and get in trouble for that. Or be responsible for that is probably a better way to word it, than hurt a person because now he realizes that he loves and cares about his family that he calls his own.

Giselle also believes that her love has a protective effect, though her worry is greater; she stated:

One of the things I tell [my son]. I love you no matter what. Even when he's angry, I will sit there and sob, and tell him that I love you no matter what. Even if I kill somebody? He'll ask me that. Even if you kill somebody. What if I killed [grandmother]? I will still love you. I won't like what you have done, but I will still love you. Cause I, I worry that he won't feel loved. [laughs, sniffles] And like maybe, that love will keep him from making a really bad decision at some point [tears].… And somehow, I know it's not true. I know that I can't love him enough to keep him from making poor choices. But if I just love him hard enough, I will keep him doing drugs, and I will keep him from going to jail… Some of it I wonder is… the feeling inadequate on my part, and if I can just show him I love him enough it will make up for the fact that I'm not his biological mom [tears].

Becky summed it up, saying,

I think all of them have attachment issues, so they are not acting loveable, so loving them is like, and that's like a choice and action, I am choosing to stick it out with you, even though I don't really want to be with you right now because you know, you just punched me in the face, and that doesn't make me want to hang out with you. [laughs] So I think that a lot of the aggression stuff is coming from the attachment, like, from the lack of attachment [in their biological family] or what they witnessed and all that.

All four women seemed to strongly believe in the healing power of their love for their traumatized children.

Am I enough? "I think it's a process of constantly questioning if what you're doing is the right thing, if it's enough—am I enough?" (Fiona)

Participants across the board reported wondering if they were not just doing enough but if they themselves were enough to meet their child's needs. These worries presented as profound self-doubt about being the "right mom," about strategies they were using to cope with the behavior, about whether they were a good parent. It also raised intense feelings of guilt, overwhelm, and self-judgment. Speaking about these feelings often led to tears. Participants

connected these thoughts to a variety of sources, including larger cultural messages of what

mothers should be, family beliefs, and internal aspirations.

This self-doubt was acknowledged as a standard part of mothering by many of the

mothers, but the aggressive behavior intensified the sense that they were doing it wrong. Giselle

summed it up as "I'm not doing enough, I'm not smart enough, I'm not good enough, I don't

care enough. [tears] I'm just not enough, period." Helen stated, "there must be some way I can

do it better," while Carolyn tearfully described her experience of mothering as "just really, really

hard. [cries] I kept thinking it's not supposed to be this hard, is it?" Fiona jokingly questioned

whether she was the right parent for her child: "Surely there must be a mistake, I don't have the

skills to deal with this." Danelle expressed guilt that she could not solve the problem: "Your kid

is struggling and you feel like you are struggling as a mom because you can't fix it. And we're

told that we are supposed to be able to fix everything." She attributed this idea to "the

patriarchy!… A mom plays a certain role and family has to be a certain way… and our society

does not get, they don't even acknowledge trauma." Eleanor expressed this guilt by stating,

> I turn around and get angry at him and then feel guilty that I'm angry at him like, oh you
> just yelled at your autistic kid because he needed a hug. It was a hurty hug, it was an ouch
> hug [laughs], but it was… he was trying to get something he was needing from me and
> then, and then I get angry at him for it.… that doesn't feel good, there's a lot of guilt that
> comes in to that.

Helen expressed guilt that she initially "didn't understand her" daughter and believes "we paid

for it, with a lot of behavior." Giselle also expressed worry that she was to blame for her son's

aggression:

> I think if he wasn't, if [my son] wasn't physically aggressive, I wouldn't doubt myself
> quite as much. Because at least in our society there is that piece of physical violence is a
> huge step. You know? Because I can remember as a kid being like "I hate you mom…
> Mom, you're the worst," you know? And my mom being like "ok," you know? You're
> 13, everything is the worst to you, fine whatever. But when you get stabbed with a fork or
> hit with a hammer or rocks thrown at your face or things like that, those are physical acts

of violence and that is one, like a step above to where when someone, I mean even a child looks in your face and says "I want to kill you," and then says "I want to slash your neck with a knife," and even if they are six, if they have tried to hit you with a knife, or tried to stab you with a fork, before, you have that like history of physical act to go along with that threat. So, it kinda ties into each other to where it's like, if I was a better parent, my kid wouldn't be so physical, and my kid wouldn't want to kill me when they are angry.

This self-doubt pervaded all of the mothers' interviews.

Comparisons to other mothers also led to feelings of guilt and incompetence. Becky stated,

I have to constantly like fight the guilt over like all these other people, they are doing just fine… And I, every time I talk to any other mom, there is some level of mom guilt of like I am somehow, not doing enough or being enough.

For some participants, this led to a perceived over-response, where they felt if they just made the perfect tool or tried the perfect strategy, that it would solve the problem. Abigail described making visual charts and sensory tools off of the social media site Pinterest as a way to gain some feeling of control over the situation, while Fiona described feeling, "You're never enough, so you kind of overdo it… so there's a sense of my own importance, or of my own sense of worth, or whatever, attached to that." Overall, there was a strong sense of worry that they were not living up to their own and others' expectations of themselves as mothers.

The messages they receive about mothers as secure attachment figures prominently influence the women's choices about parenting and what they expect of themselves as assume others expect of them. Again, there is duality to the experience, a sense of importance and validation from these expectations that sits uncomfortably with a sense of the impossibility of the task and the judgment that they are not doing it adequately. They desperately hope to be up to the task of loving their child enough while fearing that they cannot do so well enough.

After everything I have done for you. "It's really easy to get depleted and tired, and your resources are down, and it's easy to get into that state where you are like "Are you kidding me, after everything I did for you or have done for you?" (Fiona)

Many of the mothers also expressed feeling frustration that all their efforts are not recognized, particularly by their child. Feelings of disrespect, anger, resignation, and resentment were universal. There was significant conflict between feelings of responsibility to take care of themselves and a sense of impossibility of finding the time or energy to do so.

All the mothers discussed feeling extremely depleted by the experience of aggression, and that this led to feelings of resentment and less-than-ideal responses to their child, which further led to guilt. Fiona stated, "it was kind of that feeling of ugh, after everything I put in, you know, [laughs] this is coming at me as an attack, and, and, it's, it is hard to not take it personally sometimes." Eleanor described the exhaustion:

> I think at that point when your bucket is so empty you are not even processing that [you are getting attacked]. It's just this, this is my life and this is what's happening and I'm just here for the ride. It's that, you know, when your bucket is empty and you can't refill it and you have no control and you are just resigned to it.

Fiona agreed, saying,

> I do get resentful when I get emptied out. But I also, when I sit with that, and I see myself being cranky, regardless of who it is that, you know—'Are you kidding me, you aren't picking up again,' or whatever it is, like, that constant kind of taking and taking and taking, that I put myself in as the parent, I definitely look at the fact that I have let myself get depleted. And I see that as my responsibility, not my family's, to replenish.

Giselle described that resentment:

> My attachment to him, and he's my son, and I was like I can't believe you are doing—I mean, there is attachment to your own self sense of self with your kids, and once you have that happen with an adoptive child too, there's beauty in that but it's also challenging, because you attach your own ego to it I think. And I'm like, I can't believe you are doing this!

The resentment of doing everything they do for their child, only to receive aggression in response, was universal among the women.

Many of the women expressed anger at their child, even to the point of wishing to be able to be aggressive back. Carolyn admitted, "I would want to hurt him, because he was hurting me, but actually I could override for the most part. Sometimes I'd swat him on the butt or whatever." Abigail confessed:

> I thought, he's driving me to [hitting him back]. Honestly it is a miracle that I didn't ever. Because there were days where… I even had visions of it in my head. Of just like, I'm just going to closed-fist pop him in the face. Or call him some horrible name. Or be like, what's wrong with you? And how I managed to not do that on some of those days, I don't even know. Honestly, I don't even know. But I think those are the days I went in the bathroom. And that was the only thing saving me from that. And I also just, I would never have wanted to hurt him, I could not imagine, you know, and I don't know if I could ever recover from that, had I, if I had done that to him. And then that would have started its own, you know, can of worms, and guilt, all of this. But sometimes it was like, oh my god, it's going to happen. Today's the day that I'm going to cross that line. And you know, I've seen it happen to friends and they have crossed that line and it was horrible for everyone involved. They were just like, it was out of my, it was almost like an out of body thing and they just snapped. And, you know, I could see why. You can only put up with so much.

Helen also volunteered an incident in which she was "pushed to being physically, physically violent in retaliation… I literally picked her up and threw her onto a bed once, like I just, it totally freaked me out. Afterwards, I was like, I can't believe I just did that." Danelle admitted getting angry but was able to reframe that anger as anger at the situation rather than her child, by remembering the trauma he had experienced: "Sometimes he does make me angry and then those feelings always come back even in the midst of me being angry and its more anger of 'why does this have to be so hard for him?'" Becky stated,

> Certainly, it's harder to love someone who beats you up, regardless of who they are… more recently, I think I've had more of like an anger response to that. I don't, I don't think I really had an emotional response to it before, other than kind of the after the fact very drained… more recently it's been like a "you did not just do that," and then a kind of like, "I'll fight you!"

These feelings of anger, resentment, and aggression were throughout the interviews, accompanied with significant feelings of guilt.

Defining motherhood. This section addressed a primary research question, asking how the women make meaning of the experience of aggression from their children. The women defined motherhood by articulating the multiple roles they play in an effort to be a good mother: advocate, case manager, but more importantly, as an attachment figure and a container for their child's rage. They recognize the cultural messages that good mothers provide secure attachment, and that children act out against the person they feel most secure with, as important rationales for "taking" the aggression as part of "my job." At times they feel resentful or inadequate to the job, but overall, they find empowerment by becoming experts on their child and their needs and by understanding their sacrifices as healing to their child.

Embodying the Good Mother

This study set out to provide an understanding of the impact children's aggression has on women, their relationships, and their conception of themselves as mothers, based on women's lived experience, and to place that understanding in a larger cultural and theoretical framework. As shown, the data suggests that women are profoundly impacted by the experience of aggression from their children, with negative implications for their physical and mental health, their ability to participate in typical social activities and relationships, and the development of their sense of competence and confidence in themselves as mothers. The women's internal experience develops from the interplay of their self with child factors, such as their diagnosis-related behaviors; stresses from dealing with others; and the impact of larger cultural influences. As shown, the codes reflect both the phenomenological aspects of the experience and the ways in which women utilize their understandings of what good mothers do to understand it.

The women's descriptions of the aggression are evocative, powerful, and moving, at times even scary and shocking. Yet, the women note significant compassion for their children, even while recognizing the harm that the aggression does to themselves. The ways in which help isn't helpful and the social stigma the women experience create feelings of invisibility, even from themselves, isolation, and fear of the future and of losing their child; post-traumatic stress symptoms demonstrates the severity of the impact on the mothers, psychologically and physiologically.

The category Defining Motherhood reflects the ways in which the women conceptualized themselves as mothers. As the codes reflect, they see themselves as containers or tools to manage their child's rage, as case managers, as advocates, and as attachment figures. They also worry a great deal about their capacity to live up to their understanding of what good mothers do, and report that self-doubt about their own capacity and resentment for having to be in this position are significant feelings. The emphasis on the cultural ideas of attachment as a healing force and the mother as safe space were presented as both significant sources of meaning-making, but also guilt.

Throughout, the data shows they find themselves caught in multiple dialectics without resolution. These dialectics include:

- The dual nature of their child: the "sweet" vs. the "feral," combined with the uncertainty in knowing which child will show up at any time

- Nurturing vs. resentment: Good mothers "take" it, but the women also secretly resent the aggression and the resulting distresses

- The conflict between their needs and their child's needs and belief in the impossibility of both being met

- Empowerment vs. victimhood

The women struggle with feeling overwhelmed, hypervigilant, and afraid for their physical safety while at the same time feeling loving, nurturing, and skilled in managing their child's emotions and behaviors. They experience significant dissonance between these competing beliefs and demands.

The last conflict, empowerment vs. victimhood, demonstrates most significantly the primary findings of this study. The mothers in the study largely declared that their experience of CPV is that it is not "abuse." However, much like women abused by their partners, they do note experiencing a loss of some of the powers that adults generally enjoy, such as bodily autonomy, the ability to set household rules and develop family cultural norms in harmony with larger social norms, and to freely participate in activities that are enriching. They do not feel safe in their own homes. The mothers are able to rationalize this by noting their children were either developmentally incapable or so traumatized that they were incapable of being intentional about hurting them, and were also not capable of anticipating the consequences of their behavior in the moment. They frequently understood their child as dual-natured, Othering the aggressive side in order to maintain their affection and protectiveness of their children. By understanding the violence as reactivity, impulsivity, or otherwise outside the child's control, they placed the aggression outside the context of manipulative power and control seeking characteristic of abuse and into a mental health framework.

That said, all of the women also reported feeling victimized, injured, and at the mercy of their child's behavior. They isolated themselves, experienced stigma and blame, and changed their patterns of behavior in an attempt to avoid another attack. They experience similar behaviors from their children, including hitting, kicking, punching, threatening, and being struck

by items being used as a weapon, as women victimized by a partner. They lack control of what happens to their body—a fundamental, essential loss of autonomy—and have physical and emotional scars to show for it. They describe the invisibility of their victimization and in some cases explicitly compared it to other forms of intimate violence they have experienced and the cultural messages they have received about it.

For many of the women, their hypervigilance, hopelessness, helplessness, and difficulty functioning indicate post-traumatic stress. They report experiencing high levels of distress as a result of the aggression, fear another incident, and experience all the physical signs of a flight-fight-freeze response. They all endorsed experiencing "trauma" even if they struggled with the words "victim" and "abuse," while continuing to foreground their child's suffering. This complicated compassion, in which mothers hold both their awareness of the child's suffering and the experience of themselves as scarred by the experience, is a difficult dialectic to manage.

Good Mothers, they state, accept that their role is to "take" their child's behavior, both logistically/physically and in the sense of feeling responsible in some way for it. They feel that it is their job to be a container for their child's anger, to be a safe person to express that anger with, even if it means a risk of physical injury to them. By doing so, they believe they alleviate this suffering they see in their child. This self-objectification, the subjugating of self to the role of mother-container, both invalidates their self and uplifts their mother-ness.

For the mothers of children with a neurodevelopmental disorder, this dissonance is accentuated by the significant levels of stigma and blame that the women experience from others. The implication from family, friends, and a variety of healthcare and educational professionals is that they are both responsible for their child's behavior and in charge of "fixing" it, and their own experience of injury, fear, and suffering is, if not deserved, is certainly to be set

aside in the interest of their child. Others, both family and friends and professionals, reinforce the discourse and create significant levels of distress and internalized blame in the mothers. This "unhelpful help" inadvertently reinforces the pattern, leaving mothers feeling they have few or no other options to managing the aggression by themselves, and discourages seeking other resources, prolonging the pattern.

For the foster and adopt-from-foster parents, the experience is somewhat different. The blame is placed elsewhere, on the children's biological parents and/or the foster system, rather than on the foster mother. However, at the same time, the discourse is reinforced as they experience praise and honor for being so strong as to love the child despite the aggression. They are the heroes, coming in to save this child from the Bad Mother who traumatized them by reparenting them as a Good Mother. Even with the additional supports supposedly afforded by the foster system, however, these mothers experience similar isolation and silencing about their own experience of the aggression and are left without tools to manage it.

This invisibility is evident in both groups of mothers in this research. There is no discourse they can refer to about children's aggression, no resource which feels useful, other than other mothers who have been there. It is interesting to note, that even as I was proposing this study, there was a good deal of feedback from psychologists questioning whether this experience occurs, whether children can be violent, and in general disbelieving the premise; these are professionals in the field who see individuals and families clinically as well as should be regularly involved with the research literature as faculty. This invisibility compounds their isolation, their difficulty in getting out of the aggressive pattern, and increases their feelings of losing self. This was especially apparent when women continually returned to their child's experience when asked about their own, demonstrating how deeply they have internalized this

silence; conversations about language also made it clear. There was so little vocabulary that felt acceptable to women; they generally denied or had a very mixed response in connecting to words like abuse or victim, even while describing experiences that were extremely intense, fear-provoking, and traumatizing.

The mothers universally have instrumentalized themselves in the service of their children, literally using their bodies to become tools, containers, sponges. This objectifying of themselves serves multiple purposes, but primarily allows them to find some empowerment in what is clearly an awful but repeated experience.

They see themselves as the experts in their child. By constructing themselves in this way, they also feel they prevent further harm to their child or others, find themselves and have others find them to be Good Mothers, and maintain the space to hold their child's suffering. The expectation that they be case managers and advocates for their child reinforces this sense of themselves as having expertise and competence.

The mothers appear aware of their many intersectionalities. In some areas, they do have power: they access services, they advocate with schools and their families and the public. They recognize that they have parental authority, even if at times it feels elusive in the moment. They recognize that their position as mothers, as women, places them both in a place of privilege and a position of powerlessness, which is a familiar one. They accept suffering as a woman's job, while also finding strength and power in the capacity for profound understanding. They value attunement, compassion, and empathy and experience their enactment as power, as feminine strength. This strategy is often one that women employ in order to manage their own marginalization as the minority in a patriarchal structure.

Table 3

Summary of Primary Findings

Women report significant trauma from their experiences of aggression from their children, with post-traumatic symptoms of hypervigiliance, disturbed sleep and mood, and hopelessness. However, they do not consider their experiences abuse, due to the lack of intentionality from their child.

Relationships with others are significantly disrupted due to the practical difficulties in taking their child around others, but also because of social censure and lack of understanding from others. Even partners and other family members are only sometimes helpful; professionals generally not very helpful at all.

There are differences in the experiences of women who are biological mothers vs. foster or adoptive parents in their understandings of their child's behavior and in their experience of social censure.

Mothers endorse a belief in the narrative of the Good Mother, literally embodying this role. They believe they heal through attachment and by becoming a tool to contain their child's rage.

Discussion

The Good Mother narrative these women endorse is not a new one, and comes from a long history in the United States defining mothering as selfless, valorous, and child-centered, at least for middle-class white women. Fundamentally, these ideas stem from the social construct of innocent childhood being nurtured into continued moral goodness, which began in the late 1800s and early 1900s out of the child hygiene movement (Hays, 1996; Kinser, 2010). It also has roots in the Cartesian mind/body split, which encouraged the dualism that men are the intellectuals while women are of the body, and in the dualism of the public (male, economic) and private (female, moral home) spheres (Hays, 1996; Kinser, 2010).

The finding that women see themselves as literally embodying Good Mothering through their containing of their child's rage is crucial to understanding the meaning they make. This belief connects to the other ways that women have historically been expected to use their bodies

for others, as in childbirth/breastfeeding, sex, and home labor. Their use of the metaphor of a tool also relates to other ways in which female embodied experience is technicized and presented as a disembodied skill to be mastered (e.g., Regan and Ball [2013], discussing the ways breastfeeding is "learned" and "managed"). From the early child hygiene publications in the 1920s, to the "expert manuals" of Dr. Spock in the 1950s, to the more current parenting manuals of Brazelton, Sears, and Leach, women are told that through technical application of the right parenting techniques, they will maximize their child's potentials using their bodies. Hays (1996) addresses this idea:

> For these writers, maternal love and affection are not only vital, they also come naturally. Leach writes, 'Whatever your mind and the deeply entrenched habits of your previous life may be telling you, your body is ready and waiting for him. Your skin thrills to his. His small frame fits perfectly against your belly, breast, and shoulder' (1986: 34). For Leach, then, a mother is naturally thrilled to cuddle her child, even if her mind seems to tell her otherwise. Spock also consistently refers to parental instincts toward loving nurture, and Brazelton, as I have noted, explicitly claims that 'mothering is instinctive.' In fact, he writes, parents are "programmed with a whole set of 'reflex' responses" that leave them "geared to lavish affection on the child" (1983a: 42, 11, 2)." (p. 57)

These writers do not acknowledge for centuries prior, there was little concept of childhood let alone an idea of "instinctive" and "lavish affection" (Hays, 1996). This cultural construction of mothering is so deeply rooted as to be unquestioned by the mothers in this study, even while their children behave in ways that seem likely to undermine such beliefs. Instead, the women internalize a deep sense of inadequacy in their mothering.

The pressures of these dualisms and belief in the essential nature of mothering appear in the social construction of modern mothering as Intensive Mothering, a belief that "mothering necessarily should be time and labor intensive, child centered, emotionally draining, expensive, and guided by experts. Many women [are], as a result, exhausted, demoralized, and convinced of their failure at being 'good' mothers" (Kinser, 2010, p. 121). For the women being physically threatened by their children, they are caught not only in the dualisms of mind and body, public and private, and feminist and traditional, but also in the reality that their child challenges the very notions of these beliefs. If her child is innocent and good, how can he attack her? If he attacks her, is not her mothering at fault? If her mothering is at fault, she must not be devoting enough of her energy and intellect, not listening to the right experts, and/or have her own moral failing. This pressure to constantly improve her parenting to allow her child to be his pure, innocently-good self forces the women to continually give more of themselves in the service of their child, and yet it is never enough.

This understanding of the way the Good Mother discourse impacts the experience of women whose children are aggressive towards them is a new and critical finding. However, some of the results found in this study are similar to research on APV. In addition, the clinical implications of the mothers' experience of stigma and blame will be highlighted, and suggestions for further research considered.

Child-on-Parent Violence and Adolescent-on-Parent Violence: Similarities and Differences

There appears to be significant overlap between the experience of aggression from a child, whether pre-teen or adolescent, as shown in Table 3. Despite their smaller size, younger children appear to be capable of similar types of aggressive acts, including hitting, biting, slapping, punching, kicking, and using items as weapons, as teens. Their parent targets, who are

most often the mother in both cases, report similar kinds of injury, ranging from bruises and scratches to more significant injury such as broken bones. The mothers are often socially isolated, and find there is little help available when they seek it. They experience similar patterns of blame about their parenting from professionals, family or friends, and acquaintances they interact with. They also frequently blame themselves, questioning where they went wrong.

However, there are some differences apparent as well. Younger children's aggression is most often perceived as a reactive rather than intentional act and is therefore characterized more as a "tantrum" than as a manipulative attempt at power and control. This perception appears to reflect an understanding of children as developmentally incapable of conscious use of instrumental aggression, particularly for those with a diagnosis of a neurodevelopmental disorder such as autism. For the children who experienced trauma, the mothers attributed this behavior to a trauma response and still considered it reactive.

Table 4

Similarities and Differences Between CPV and APV

Similarities in CPV and APV

Types of aggression: hitting, kicking, beating as well as verbal threats
Demographics: higher class, white children more likely
Mother is more often the victim
Similar physical and emotional consequences for parent being targeted
Isolation and withdrawal
Re-traumatization by the system
Victim-blaming is common
Influence of discourse around "being a good mother"
Child is more likely to be diagnosed with a mental health or neurodevelopmental disorder

Differences in CPV from APV

Generally reactive vs. more intentional
Developmental considerations; e.g. capacity for intentional power seeking
Lack of policy or evidence base for treatment
Different legal and social consequences for the child

In this study, there were two main trajectories identified for the development of violent behavior. The children identified as diagnosed with a neurodevelopmental disorder were all noted to be aggressive prior to age five with this behavior continuing into the study period of five to ten years old, and their mothers perceived it as an extension of the age-normative temper tantrums their child exhibited as a toddler or preschooler. The children seem to be delayed in the development of self-soothing and impulsive control. The mothers noted that the aggression has decreased over time with a peak intensity occurring early in the elementary years and then diminishing in frequency and intensity.

For the children with a trauma history, the pattern appears somewhat different. In many of the cases, it was unknown when or if the child was aggressive prior to the current foster placement or the trauma experiences which led to their placement in foster care. Most of the women noted a honeymoon period in which the child did not demonstrate aggression immediately upon placement but had it present over time as they grew more comfortable with their attachment. All the parents believed that their child was dissociative at the time of the incidents. These children were considered by their mothers to have a longer-lasting pattern of outbursts at older ages as a result.

It should be noted that most of the mothers in the study were already past the peak period of aggression; it is possible that those still actively dealing with the issue at a high level of intensity are less likely to participate in a study such as this one, given the low emotional and logistical resources available during those times. It is also possible that children who are older and still aggressive represent another trajectory which was not reflected here.

Clinical Implications

The overwhelming result that all the mothers experienced at best helplessness and at worst blame and shame from clinical providers highlights a significant finding relevant for providers of therapeutic services. Typical behavior management recommendations generally fail to acknowledge or underestimate the contribution of the child to the parenting dynamic and make the assumption that parents are in control and have the emotional resources to assert that control, a paradigm which clearly has often failed for the women interviewed. Clinicians are in a difficult position; if they assert that the women should not simply accept this behavior, they risk being perceived as blaming the women for doing so. It is very clear that providers, often unwittingly, contribute to and reinforce the mothering discourse that leads these women to be isolated with behavior from their children that is highly damaging. Clinicians are placed into the center of the uncomfortable dissonance the women experience of the "abuse that is not abuse" and, in the absence of clear evidence-based practice recommendations or policy guidelines, must find their way.

How can a clinician honor the experience of the mother who insists this is not abuse, while also being ethically and therapeutically obligated to acknowledge the traumatic stress symptoms that these women are demonstrating? It could be argued, perhaps, that the mothers are wrong, that they are experiencing abuse—after all, they are being injured, there is a pattern of injurious violence, they are afraid, their children hold significant power in the family. Perhaps their denial is just that, denial. But it is also clear that at least for the women interviewed here, many had experienced other forms of intimate violence and were still adamant that this experience is different. Typical strategies involving a perpetrator of violence and a victim generally require either separation of the two, generally for good, a solution that is unacceptable

to the mothers who desperately fear losing their child. In APV, restorative justice strategies have been implemented in some programs (e.g., Step-Up, as discussed earlier) but these approaches are not always developmentally appropriate at this age, particularly in children with developmental differences or a history of dissociation. Treating the child as a perpetrator also goes against the stated understanding of the mothers and as such is likely cause rejection of the strategy outright. Maintaining the position that it is abuse risks creating additional vulnerability and harm to the mother, and fundamentally reinforces the stigma and the dissonance that "this isn't abuse because it is caused by a child, but it feels like abuse, but we can't talk about it that way because it's caused by a child." The cultural messages that mothers are responsible for their child's behaviors and that children are not capable of violence undermine genuine assistance and treatment efficacy.

Placing CPV in a family violence framework, as has often been done in the APV literature, may be a way to reduce stigma, promote understanding, and offer a language to discuss the experience, but rejects the assertion of the mothers that it does not belong there. Placing it in a mental health context, where it has generally been treated so far, has unfortunately reinforced the discourse that parents are to blame and felt unhelpful, resulting in an unwillingness to continue to seek help and reinforcing helplessness, hopelessness, and isolation as well as seeming to be largely ineffective, from participants' report. It is noticeable though that despite being perceived as less helpful than desired, that all of the families were involved in treatment at least at some point, whether through psychotherapy, occupational therapy, or other services. Parents are seeking the help under this framework, it just isn't helping enough.

It is also clear that large systemic changes need to occur in order to help these families. There is a clearly a need for dedicated child crisis teams to help protect women in immediate

need, with specific training for law enforcement. Additionally, education for health care

providers and various other professionals that may interact with these families, and perhaps most

importantly, and in the development of policy and evidence-based practices that would allow

families to come out from isolation and receive help that actually helps.

Limitations and Directions for Future Study

As an early exploration, this study is limited in scope. The women represented here were

not screened for particular demographics, and may not be representative of other populations,

particularly those which come from traditions other than the middle-class ideals endorsed. While

they were recruited from a range of sources, they also self-selected and had the resources to meet

with the interviewer on their own time. They also identified largely as being "past the worst of

it," which means their reports are largely retrospective, which may alter their memories of the

experience. It is possible that those in other circumstances (still actively in the aggressive phase,

those who are not managing as well, etc.) may have different results; if there is a spectrum of

processes at work, it is possible that this study only captured a portion of that range.

Additionally, there appear to be some clear differences between foster and biological parents,

which warrant additional investigation. It is unclear how generalizable these results may be.

These results, however, provide some preliminary theoretical understandings to guide future

research.

It is clear that not enough is known about CPV. Even basic quantitative questions remain:

How often is this happening? At what ages? Are there diagnoses which are associated? Other

demographic factors? Understanding how this pattern of aggression begins in the family, what

reinforces it, and what treatments reduce or eliminate it would also be very helpful clinically and

theoretically. Further theoretical questions arise as well, particularly around the formation of this

mothering discourse and its impacts on women and the family.

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