

'I'm his safe space': Mothers' Experiences of Physical Violence From Their Neurodivergent Children—Gender, Conflict and the Ethics of Care

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Drawing on recent criminological scholarship on child to parent violence (CPV), this article applies a feminist 'ethics of care' framework to understand how mothers of neurodivergent children understand the violence they experience from them. Examining data from in-depth interviews with 15 mothers who experience CPV, this article explores how mothers construct themselves as a 'safe space' through which their child can manage their distress. The tensions and emotional conflicts this produces for mothers, as well as the harms that result, are highlighted. Discussion focusses on the usefulness of understanding family violence from an 'ethics of care' framework, and the implications for violence prevention through broader social change.

KEY WORDS: ethics of care, neurodiversity, child to parent violence (CPV), motherhood, gender

INTRODUCTION

Violence towards parents is a complex problem that can include physical violence (e.g. hitting, shoving, kicking), psychological abuse (e.g. humiliation, degradation, coercion), economic abuse (e.g. theft) and, on occasion, harmful sexual behaviour. In cases where it continues over time, it shapes the dynamic of the family home such that parents and other family members unhealthily adjust their own behaviour in an attempt to manage the violence. The harms caused by child to parent violence (CPV) can be wide ranging and include damage to the physical and psychological health of both the parent and the child involved. It can also negatively impact on family relationships, parental employment, household finances and the social and community life of family members (see [Miles and Condry 2015](#); [Holt and Lewis 2021](#)). Violence towards parents is often theorized as a gendered form of violence (e.g. [Holt 2016](#); [Meyer et al. 2021](#)), with both criminal justice data (e.g. [Brennan et al. 2022](#)) and community surveys (e.g. [McCloud 2017](#)) indicating that mothers and female carers are much more likely to be targeted than fathers

and male carers. There are a number of explanations for this: at a micro level, parental labour is organized in households in such a way that mothers spend more time with their children than do fathers, thus providing more opportunity for mothers to be targeted; at a more macro level, the ways in which violence towards women is normalized throughout contemporary westernized societies means that such violence can be seen as more acceptable.

Despite this issue receiving increased attention from researchers over the past decade, there has been little research into the experiences of families with neurodivergent children. This is particularly surprising because evidence suggests that a disproportionate number of families with neurodivergent children are seeking help for what is often referred to as ‘child to parent violence’ (CPV). For example, in their annual survey of parents and carers receiving support for CPV from across the United Kingdom, [PEGS \(2022\)](#) reports that over 50 per cent of the children are neurodivergent. Similarly, in a survey of practitioners across London who undertake CPV intervention work with families, neurodivergent children are reported as making up the majority of their caseloads ([Brennan et al. 2022](#)).¹ Traditionally, neurodivergence has been constructed within a pathologizing medical framework, underpinned by assumptions that conditions such as autism and attention deficit (hyperactivity) disorder (AD(H)D) derive from biological ‘deficits’ which produce ‘faulty’ styles of thinking and communicating. However, contemporary research highlights that neurodivergence produces its own style of communicating, sensing and interpreting the world that is just as valid and valuable as more ‘typical’ styles. In this context, the challenges experienced by neurodivergent people are the consequence of having to operate in a social world that is set up for the neurotypical majority. As a result, neurodivergent people are structurally disadvantaged throughout their lives—in school, in the workplace and in social interactions. Furthermore, behavioural differences related to neurodivergence are stigmatized, with many neurodivergent people experiencing significant discrimination and bullying, particularly during childhood ([Humphrey and Hebron 2015](#); [Maiano et al. 2016](#)). Consequently, many neurodivergent people try to hide or ‘mask’ their differences, and this takes a huge toll on their mental health ([Miller et al. 2021](#)). In particular, neurodivergent adolescents and young adults experience disproportionately high levels of trauma ([Kerns et al. 2015](#)), mental health problems ([Mochrie et al. 2020](#)), self-harm ([Blanchard et al. 2021](#); [Mulraney et al. 2021](#); [Ward and Curran 2021](#)) and suicide ideation ([Eddy et al. 2020](#); [Cassidy et al. 2022](#)).

The mothers of neurodivergent children experience significant stigma as a result of their child’s differences ([Broady et al. 2017](#)). Some of this is due to the cultural legacy of theories about how neurodivergent conditions such as autism and ADHD are caused by inadequate mothering.² Mothers also shoulder the burden of caring responsibilities within the family and consequently experience greater strain in caring for neurodivergent children ([Nealy et al. 2012](#)). Research suggests that mothers spend 50 per cent more time with their neurodivergent child compared with mothers of neurotypical children ([Tunali and Power 2002](#)). Much of this time is spent developing parenting strategies to accommodate the needs of their neurodivergent child, such as providing occupational support for routine tasks (e.g. dressing and bathing) ([Schaaf et al. 2011](#)), and engaging in learning activities to stimulate their child’s development ([Maljaars et al. 2014](#)). High levels of stress have been identified in mothers of neurodivergent children, with mothers experiencing poorer mental health, poorer physical health and lower quality of life than mothers of neurotypical children (see [Fairthorne et al. 2015](#) for a review). These additional stresses experienced by mothers are arguably related to the limited state support for neurodivergent children who, in a neurotypical world, have additional care needs that are not

1 It is estimated that approximately 1.2 per cent of 5- to 19-year olds in England have an autism diagnosis and 1.6 per cent of 5- to 19-year olds have a hyperactivity disorder diagnosis ([NHS Digital 2018](#)).

2 For example, the concept of ‘refrigerator mothers’ blamed maternal ‘emotional frigidity’ for their autistic child’s social withdrawal (see [Douglas 2014](#); [Cleary et al. 2023](#)).

accommodated (see [Crane et al. 2016](#); [Legg and Tickle 2019](#)). As such, the greater challenges experienced by mothers, and the greater distress experienced by neurodivergent children and young people, are the result of a lack of support, rather than by the neurodivergence per se. Some research has specifically examined how parents manage what is often referred to as ‘challenging behaviour’ in the context of specific neurodivergent conditions such as autism (see [O’Nions et al. 2018](#)) and ADHD (see [Ringer et al. 2020](#)). Parental strategies include modifying the environment, providing structure and routine and managing their child’s distress ([O’Nions et al. 2018](#)). However, ‘challenging behaviour’ tends to be broadly defined in such research and may or may not include violence: indeed, the term is often used as a catch-all to include disruption, repetitive behaviours and self-injury, as well as challenges around food, toileting and abscondment. Such research also tends to focus on ‘parents’ or ‘caregivers’, despite overwhelming evidence that CPV predominantly targets mothers. To address this research gap, this study aimed to explore how mothers whose neurodivergent children are violent towards them manage the violence within the broader context of maternal caring practices.

Theoretical framework: an ‘ethics of care’

The caring responsibilities that are primarily taken on by mothers have been theorized within an ‘ethics of care’ framework. Carol [Gilligan \(1993\)](#) first identified an ‘ethics of care’ to understand the moral framework upon which we base difficult decisions. It was developed as an alternative ethical orientation to an ‘ethics of justice’ that was conceptualized by [Kohlberg \(1981\)](#) in his cognitivist theory of moral development as the apex of moral thinking and which prioritizes the values of autonomy, individualism and clarity about right and wrong. While assumed to be universal, an ‘ethics of justice’ was seen as an ethical orientation predominantly practised by men, with women and children less frequently reaching the ‘highest stage’ of moral thinking. In contrast, an ‘ethics of care’ orientation foregrounds the private intimate contexts in which decisions are often made and recognizes the role that emotions such as sympathy, concern and compassion play in such decision-making—particularly within relationships that are unequal and dependent ([Held 2006](#)). While ‘care’ can be a rather nebulous term, [Engster \(2007\)](#) defines the core aims of care as meeting basic biological needs, developing and maintaining capabilities and alleviating suffering. This definition is reflected in Gilligan’s description of an ‘ethics of care’ as ‘...an activity of relationship, of seeing and responding to need, taking care of the world by sustaining the web of connection so that no one is left alone’ ([1993: 62](#)). As many feminist ethicists have noted, women have been socialized to prioritize caring relationships and as such they operate according to a different (and de-valued) moral framework compared with men, often prioritizing care for others at the expense of their own personal wellbeing. Furthermore, an ‘ethics of care’ forms the central tenet of non-violent conflict resolution by reflecting a ‘...belief in the restorative activity of care’ ([Gilligan 1993: 30](#)). As such, it represents a departure from the ‘ethics of justice’ that underpins most westernized criminal justice systems which emphasize individual responsibility, objective standards and penalty.

An ‘ethics of care’ framework has been applied to make sense of a range of women’s experiences, including experiences of mothering (see [Rogers 2012, 2019](#); [McCloskey et al. 2021](#)). This is perhaps not surprising given the extent to which values that conform to an ‘ethics of care’, such as selflessness, attentiveness and responsiveness ([Tronto 1993](#)) underpin modern westernized constructions of ‘ideal motherhood’. Indeed, some feminists have suggested that caring is the central process through which gender is defined and through which a woman’s identity emerges ([Graham 1983](#)). Cultural expectations of these idealized standards of motherhood include being child-centred, self-sacrificing and emotionally involved ([Hays 1996](#); [Burman 2008](#)) and mothers who feel that they fall short of such exacting standards report feeling guilt, shame, psychological distress and internalized stigma ([Liss et al. 2013](#); [Henderson et al. 2016](#)).

The inclusion of *neuroculture* into discourses of idealized motherhood has further extended the demands placed on mothers, which now includes responsibility for their child's brain development (Lowe *et al.* 2015). This is something which mothers of neurodivergent children are likely to experience particularly acutely in their 'relentless, devoted efforts to resolve their children's complex, partially neurochemically based troubles' (Blum 2007: 222–3).

An 'ethics of care' framework offers a useful theoretical starting point to understand the complex emotional terrain faced by mothers who experience physical violence from their neurodivergent children as they navigate their intersecting and gendered roles of (1) being a victim of CPV, and (2) parenting a neurodivergent child. Thus, this article examines mothers' experiences within an 'ethics of care' framework to elucidate how mothers make sense of their neurodivergent child's violence towards them, and the caring practices they engage in to manage such violence.

METHODS

This study involved in-depth individual interviews with 15 mothers from across the United Kingdom whose child was aged 10 years or older and who had a diagnosis of autism, AD(H)D and or foetal alcohol spectrum disorder (FASD). They were recruited through social networks that support parents whose child is neurodivergent. The call for research participation requested parents whose child demonstrated 'aggressive and/or violent behaviour towards you'. Despite the gender-neutral call for participants, only mothers chose to participate. The 15 mothers ranged in age from their mid-30s to mid-50s and two were adoptive mothers. Eleven mothers worked in full- or part-time jobs, and four were currently not in employment. Thirteen mothers were White British, one was White Irish and one was British Pakistani Muslim. Ten mothers were living with husbands/male partners (one was separated but co-habiting), one mother was in a same-sex relationship, two mothers were separated, one mother was widowed and one mother was a lone parent.

The mothers spoke about 17 children (i.e. two mothers were experiencing violence from two children). The children they spoke about comprised 10 boys and 7 girls, ranging in age from 10 to 20 years. Eight children had a diagnosis of autism spectrum condition (ASC), four children had diagnoses of attention deficit hyperactivity disorder/attention deficit disorder (ADHD/ADD), four children had a dual diagnosis of ASC and ADHD/ADD and one child had a diagnosis of FASD. Three of the children had an additional neurodivergent condition diagnosed (such as dyspraxia, sensory processing disorder and alexithymia) and four of the children were either waiting for further assessments for an additional neurodivergent condition or had a suspected additional neurodivergent condition. Six of the children had either received an additional mental health diagnosis (such as obsessive compulsive disorder (OCD), anxiety disorder, anorexia, pica and post-traumatic stress disorder (PTSD)) or were on a waiting list for a mental health assessment. Some of the children who had a diagnosis of ADHD had been prescribed medication (e.g. *Elvanse*) though some children chose not to take it.

The interviews were conducted remotely, with participants given the choice to be interviewed via telephone or video-conference. With consent, the interviews were audio-recorded and the audio data were transcribed verbatim. Participants were asked questions about the nature of the violence they experienced, its impact, their strategies for managing the violence, and the responses of others to the violence. The interviews lasted approximately 1 hour. The data were analysed thematically: two researchers read each of the transcripts several times and then met to develop a loose idea of key categories and themes for organizing the data. Each researcher then independently coded each interview transcript line-by-line, using *Nvivo* software to manage the data. The over-arching coding framework was guided by the project's key research questions, which were to explore and understand the nature, meaning, management of and responses to

the violence. During analysis, key themes were identified whilst also attending to the gendered aspects of the participants' lived experiences. Once the researchers completed the coding, the codes were compared and discussed, and the coding framework was refined to ensure both analytic consensus and methodological rigour.

Ethical considerations

A number of ethical safeguards were built into the project to protect the participants and the researchers from potential harm. All participants were informed about the project through the recruitment methods outlined above and chose to 'opt-in' by contacting the researchers directly. Participants were provided with information about the project via an information sheet (detailing project aims, what participation entailed and how data would be protected) and a consent form. Written and verbal informed consent was willingly given by the participants. If the participants showed distress during the interviews, the interview was paused and they were asked if they wanted to continue, either then or at a later date. Signposting to support services was provided. To ensure confidentiality, pseudonyms are used throughout and identifying details about the participants' location and families have been removed. The management and storage of all data complied with legal requirements, and the project received institutional ethical approval prior to the commencement of fieldwork.

FINDINGS

The findings section examines how the mothers made sense of the physical violence they experienced from their neurodivergent child. The first section provides a broad context to the mothers' experiences, in terms of the emergence of the violence, how it manifests, and its triggers. The second section examines how the mothers understood the violence by drawing on an 'ethics of care' framework to elucidate their sense-making practices. The third section explores how the child's use of self-directed violence shapes the mothers' responses to the violence towards them, and the final section examines the conflicts and tensions experienced by the mothers as they attempt to practice an 'ethics of care' in the context of violence from their neurodivergent child.

(1) Violence towards mothers in a neurodivergent context

The violent behaviours that the mothers typically described included being punched, shoved, kicked, pinched, slapped and scratched—often on a daily basis. The violent behaviour often started in the child's early years, and gradually escalated over time. Indeed, the violence was often seen as an indicator that something was 'different' about their child and its presence often contributed to the mothers' motivation for seeking a diagnostic assessment, as Shirley explained:

Since he was little, there was always difficulties and that was mainly the behaviour and a lot of that is with violence towards me or his brother. You know, explosive outbursts – that was the main indication of difficulties before any anxiety became visible or other difficulties surfaced. And then we had a long journey of him not being able to manage in school, having a lot of sensory difficulties and wondering what was causing it. And then we went down the whole assessment pathway and that took a long time. So his autism diagnosis was only accepted finally and officially by the local authority and CAMHS two years ago. But the challenging behaviour has been present since he was very little (Shirley, mother of autistic son, 13)

Shirley's account illuminates the wider context of mothering a neurodivergent child. For most participants, the journey to diagnosis was long and complicated: referrals for assessment were

difficult to obtain, with agencies sometimes denying that there was an issue ('they were adamant he was just an attention-seeker'). Often, the mothers raised concerns over a number of years with different agencies (including nurseries, schools, general practitioners and health visitors) before a referral for assessment was eventually made, and years-long waiting lists were common. Importantly, it was mothers (rather than fathers or other male carers) who undertook the emotional and administrative labour involved in seeking an assessment, something which has been found in other research (Crane *et al.* 2016; Legg and Tickle 2019).

The children who were engaging in violent behaviours were aged between 10 and 20 years, and the nature of the daily violence is illustrated in the following extracts, which draw on the accounts of mothers of children at different ages:

He kicks off and screams and shouts. So I'm on the edge of my nerves all the time. When he's lost it, he's kicking the house, kicking the walls, shouting he's going to kill me in various gruesome ways, and then if I go near him he'll start kicking and pushing me. So when I took the iPad off him yesterday, after that he just went mad, and then he went and got one of the big knives (Frances, mother of autistic son, 11)

If I asked her to do something and she didn't want to do it, then she would become really angry really quickly and then it would become physical, and it was usually that she would hit me or that she would push me, sort of pushing and shoving. She would get to the point where she was often trying to pin me in corners and not let me out of the corner and she would hit me and pull my hair. And I didn't want to retaliate, I didn't want to lash out and hit her, so I would just be trying to cover my face and my head. But she wouldn't really stop and obviously my husband would try and get her off me (Heather, mother of autistic daughter, 17)

He will smash up his room. It would often be at the weekends when my husband wasn't around because he was busy with his family in London, and my daughter and I would cower away from him in another room because if you got in his way he would take your head off, he was so angry. You know, he punched through the panels in his bedroom door, wrecked his wardrobes and ... he will try and punch the walls and damage his knuckles and they'd be bloody and bruised. So it's kind of violence against himself, and if you got in the way of it, you would get injured too (Alice, mother of ADHD son, 19)

A number of observations can be made from the mothers' accounts, of which these three extracts are typical. First, the physical assaults were almost always accompanied by property damage as well as verbal abuse, which often involved threats to hurt or kill the parent. Second, the violence often caused significant injuries to the child themselves, particularly in cases involving older children. Third, the mothers interpreted their child's over-riding emotion as *anger*. Sometimes, the mothers felt that the anger was directed at them, but at other times they sensed a more generalized anger—perhaps towards the world, perhaps towards the child themselves. Fourth, the mothers identified a range of triggers, which included a mothers' request for something, the presence of a distressing sensory stimulus (e.g. feeling too hot/cold, feeling pain or a sudden noise), or something that was happening at school which was causing the child to feel overwhelmed. The commonality across all the triggers they identified was that they caused their child to feel particularly anxious or stressed. Fifth, there was very little support available from the state agencies who had been involved in the diagnosis to help the mothers cope with the violence, as Allie explained:

I just feel quite lonely and lost because every avenue you look at, there's either massive waiting lists or nobody can help you or nobody's got any ideas (Allie, mother of autistic daughter, 13).

As Allie's extract illustrates, the absence of professional support was identified as a significant challenge for all the mothers—in terms of both lack of personnel and lack of strategies to prevent the violence. This exacerbated the mothers' feelings of social isolation which, as existing research has found, is commonly felt by parents of neurodivergent children (see Wong and Shorey 2022) and by parents experiencing CPV (see Miles and Condry 2015). Such isolation is likely fuelled by the 'double stigma' of parenting a neurodivergent child (e.g. see Broady *et al.* 2017) and of experiencing CPV (e.g. see Brule and Eckstein 2016).

(2) '*Im his safe space*': mothering through children's violence and the 'ethics of care'

Other family members—including fathers and siblings—were hurt during violent encounters, both directly and indirectly. However, all of the mothers explained that they were *specifically* targeted by their child, as Chrissy recounted:

When he started attacking me, it was noticeable that he wouldn't attack my husband. He still hasn't. He's threatened to quite a few times, but he's never actually done anything to my husband (Chrissy, mother of autistic son, 10)

This aligns with the existing literature that most CPV targets mothers (see Introduction). However, it was notable how many mothers made sense of being targeted by constructing themselves as their child's only 'safe space', as Nina and Chrissy explained:

When push comes to shove and he's heightened, that's the first thing he'll do – he'll come for me. And I get that that's because he *can* come to me, he can let all his emotions out and I won't hit him back. I'm his safe place, aren't I? Whether I want to be or not, that's who I am (Nina, mother of autistic and ADHD son, 11)

If we're out and about with other people and something happens, then he will run. Because he thinks *Oh God, I don't want to hit them*, so he'll run off because then he thinks *Well, I can't hit them because I'm too far away from them* and he's taught himself to do that... The fact that he doesn't manage it with me in the same way, I've always felt quite proud of that fact. It's almost like *Well I'm his safe space* ... and he's about to be exactly who he needs to be at that moment, and that's fine (Chrissy, mother of autistic son, 10)

The concept of a 'safe space' has a long pedigree in the field of education. Although a contested construct, it broadly refers to a psychosocial and experiential space that is '... free from self-doubt, hostility and non-affirmation' (Stengel and Weems 2010: 505). In the context of this study, the 'safe space' is constructed as a *maternal vessel* through which their child manages their own distress. The mothers' construction of their giving their *selves* as a 'safe space' speaks to what Gilligan (1993) and other feminist ethicists have described as an 'ethics of care': that is, an orientation towards others, self-sacrifice, and the prioritization of another's wellbeing over their own. For example, Nina's account highlights how providing an outlet for her child's distress (manifest through violence) is part of her maternal identity ('that's who I am')—a central tenet of which (as Gilligan explained) is *non-violence* ('I won't hit him back'). Chrissy's account highlights the pride she takes in this role ('I felt quite proud of that fact'). That is, by enabling her son 'to be exactly who he needs to be', the violence she experiences is conceptualized as a marker of ideal motherhood.

What was also evident in the narratives was the extent to which this sense-making practice was reinforced by others, as Rachel explained:

People keep saying to me that it's because he's comfortable at home and he knows you and he knows you're Mum, and its safe surroundings (Rachel, mother of autistic son, 15)

Thus, the collective idealization of being their child's 'safe space', as a specific component of the maternal role, effectively serves to socially sanction the violence that the mothers experience. However implicitly, this serves to reproduce a broader 'ethics of care' orientation which may not be in the interests of either the mother or her child. The question about the reproduction of an 'ethics of care' is picked up again below.

(3) The co-presentation of self-directed violence: the imperative towards an 'ethics of care'

The violence towards the mothers was often accompanied by the child's self-directed violence: in this study, nine of the 15 mothers reported that their child was also engaging in practices of self-harm. Self-harm is a contested term, but it generally refers to 'deliberate, self-inflicted destruction of body tissue' which might involve cutting, burning or hitting of one's own body (Muehlenkamp *et al.* 2012: 1). In this study, the mothers described self-harming behaviours in terms of their child deliberately hurting themselves with objects such as scissors or broken glass, or by using the property to damage their body: as one mother explained, '... sometimes he likes to bang his head against the wall or to roll down the stairs'. While the CPV literature often refers to 'property damage' as a type of violence, these findings suggest that, in many cases, it may be more accurately referred to as 'using property in acts of self-directed violence'.

Self-harm is a complex behaviour for which there are a range of motivations, but to provide relief from psychological pain (Rasmussen *et al.* 2016), and to communicate that 'unseen and inexpressible pain' to others (Chandler 2013: 723) is how it is commonly understood. In this study, the mothers understood their child's self-harming behaviour in similar terms, as Lucy explained:

When she was very little, I think she was year 2 [i.e. 6–7 years old], I had to have surgery on my foot, and she smashed her head against her wardrobe twice. And her logic of it was *Well, Mum got hurt to get better, so if I hurt myself, I'm going to get better*. And I think it was the most heart-breaking thing at that age group I'd ever heard but it made ... it was a bit of a logic of how she was thinking. (Lucy, mother of ADD daughter, 20)

Furthermore, while self-harm is often conceptualized as distinct from suicide/attempted suicide, there is nevertheless a strong correlation between the two (Muehlenkamp *et al.* 2012). In this study, some children told their mother that they wanted to take their own life during a violent encounter ('he was saying he wanted to die'). In some cases, the child had attempted to take their own life, sometimes on more than one occasion. Thus, the presentation of self-directed violence alongside the violence towards their mothers suggests that both forms of violence have the same root: extreme distress.

The co-presentation of self-directed violence with violence towards mothers had a number of consequences. First, during some violent encounters, the mothers did not know whether the violence was about to be directed towards them or self-directed, producing confusion about how best to respond, as Chrissy explained:

He was smashing the glass in this frame and I honestly don't know whether he was going to do self-harm with it or whether he was going to come after me. I still don't know to this day (Chrissy, mother of autistic son, 10)

Second, it meant that the mothers' attempts to prevent their child from self-harming led directly to the mothers being injured. As a result, the mothers were unable to prevent the self-harming behaviour, as Ava explained:

She had been self-harming and I'd walked into her bedroom one evening and she had a big pair of scissors in her bed with her, a sharp pair, and I just didn't want to leave her with them.

I didn't know whether that was what she was going to use them for or whatever, but I wanted to take them just to keep her safe really. And I just went to take them, I didn't say anything, they were on her bed and she literally just started kicking out, telling me to fuck off and all the rest of it. So I couldn't take the scissors without getting into a physical altercation with her. I ended up having to leave the scissors with her because it would just escalate to that point. And this is why I was speaking with Social Services about how am I meant to keep her safe if I can't physically take ... you know? (Ava, mother of ADHD daughter, 13)

Third, such an extreme manifestation of the child's own distress was a significant factor in the mothers prioritizing their child's wellbeing over their own injuries, as Clara explained:

The physical pain doesn't bother me at all, it's much more ... what's more upsetting for me is that my child feels so out of control (Clara, mother of autistic and ADHD son, 13)

Thus, the intensity of their child's distress, coupled with the need to keep their child safe from themselves, produced a context where drawing on an 'ethics of care' was not only necessary, but imperative. For example, Lucy's daughter had self-harmed in the past but was no longer doing so, and this shift meant that Lucy could 'make acceptable' her daughter's continuing violence towards her:

I'd much rather be on the receiving end than her harming herself. ...To deal with that, than having to pick up the pieces of a cut arm that's caught a vein it shouldn't have caught. (Lucy, mother of ADD daughter, 20)

As this extract illustrates, Lucy conceptualized the violence she experienced from her daughter as a worthwhile sacrifice because, for Lucy, the alternative would be Lucy's daughter harming herself. Lucy concluded that it was better for her to be the recipient of the violence than her daughter. This perhaps illustrates the maternal practice of an 'ethics of care' in its most extreme form: a sacrifice of the physical self to save her child.

From a criminological perspective, the close relationship between young people's self-directed violence and violence towards others has been identified in correlational research (e.g. Swahn *et al.* 2010), as have the links between both forms of violence and poor mental health (Harford *et al.* 2013). While such research is important in terms of understanding the aetiology of violence and for developing appropriate interventions, the findings presented here demonstrate how such contexts also shapes how those who are the target of such violence understand its *meaning*. Such sense-making practices are particularly salient in the context of family violence, when violence can sometimes be targeted towards those who have caring responsibilities towards those engaging in violence. Thus, there are broader implications here not only for our understanding of how such contexts shape practices of care, but also for how such contexts shape victim responses to violence.

(4) The aftermath of violence: the limits of an 'ethics of care'

The findings discussed so far highlight that the children were often injured by the violence they engaged in. However, the violence also caused *emotional harm* to the children. As a consequence, the mothers' role extended beyond being their child's 'safe space' to supporting their child to come to terms with their use of violence, as Frances explained:

He feels terrible about himself, so the more he does it, the worse his self-esteem gets, and it's a vicious cycle ... sorry (upset). Some days, straightaway after a meltdown, he will hug me and... he won't say "I didn't mean to do that" or "I really wish I hadn't done that", but he'll

hold me in such a frantic kind of ... like, you know it's there. He wants to say 'sorry'... And I'll say to him, "you're feeling upset about that now, aren't you? You're wishing you hadn't done it?" and he'll just kind of agree with me (Frances, mother of autistic son, 11)

Frances's extract illustrates how, in the aftermath of violence, the mothers sacrificed their own personal needs to instead prioritize their child's needs by supporting their child's emotional and cognitive development. For Frances, this meant physically comforting her son and helping him to reflect on and process his feelings of regret following a violent incident. As explained in the Introduction, the cognitive and emotional support needs of neurodivergent children are often greater than those for neurotypical children, and mothers undertake most of the work to meet these needs. In the context of family violence, this represents a further example of the gendered and unequal distribution of caring labour.

Furthermore, the maternal guilt felt when their child is distressed, and the burden of responsibility on mothers to 'make things better' for their child, has been recognized as a central moral component of an 'ethics of care' (O'Brien *et al.* 2014). The weight of this maternal responsibility, and the profound emotional impact it had, was articulated by many of the mothers in this study. For example, Talia explained the significant toll taken on her mental health from the responsibility to 'fix' her child in a context where she was assaulted every day:

Initially you're a bit like Mary Poppins, *Ooh we'll try this, we'll try that ...* But when you're being attacked on a daily basis and it's just the same old, same old ... it's really disheartening. I'd never had suicidal tendencies, I'd never thought *I want to be dead*. But for the first time, the thought crept into my head: *If I wasn't here anymore, none of this would be my responsibility*. Do you know what I mean? (Talia, mother of autistic son, 11)

It is evident that engaging in an 'ethics of care'—primarily by supporting their child's needs in the aftermath of violence—often conflicted with the mothers' own needs following an assault. In particular, the need to also engage in practices of self-care (which may involve finding a 'safe space' away from their child, at least temporarily). This was difficult for the mothers to cognitively reconcile, as Shirley explained:

It's very hard to get away from. Obviously you love him, would do anything for him, and want to support him. But you're giving so much and then you have this sense of being physically abused, being verbally abused and it's happening constantly and I know it's not OK... so sometimes it's made it difficult to then ... once the outburst is over, that normally requires a high degree of support and attention because he directs a lot of hate ... so he becomes very suicidal and he talks about wanting to end his own life. So you have to support him through that and by the end of it he'll end up sitting next to me, and you're right next to someone who you're thinking *this is just awful* because these really awful things were said and shouted at me, and physically and whatever ... but yet I've been the one to then give him the comfort, and that's really hard. And it's not that I wouldn't do that, but I guess it's like an ongoing feeling of ... *this isn't right, it can't continue, it shouldn't happen*. But I'm the only person who's dealing with it and I don't know what I can do to move it forward and to change it. (Shirley, mother of autistic son, 13)

Shirley's account illustrates the emotional conflict produced by being located in the seemingly irreconcilable roles of 'mother' (which demands an 'ethics of care') and 'victim' (which does not), and the unsustainability of this tension. Furthermore, there is a further conflict in her account in her identification of the competing maternal imperatives to comfort her son (*its ok*)

and to support her son's moral and cognitive development by teaching him about the unacceptability of assaulting another person, particularly a woman (*its not ok*). These emotional conflicts are difficult to navigate and Shirley's reference to her ongoing feelings that 'this isn't right' highlights the limits of practising an 'ethics of care' when mothering in the context of CPV.

Further limits to an 'ethics of care' were evident when examining how CPV impacts on broader family dynamics within the household. While little research has focussed on the how CPV impacts on siblings, we do know that growing up in households where there is violence can cause a range of harms (Walker-Descartes *et al.* 2021). In this study, most of the mothers were also parenting other children in the family home, and many discussed their concerns about how the violence might become normalized for their other children. For example, as Rachel explained:

My daughter is twenty, she finds it extremely difficult. She'll say to me sometimes, "Mum you've known life without it, all I've known is life with him. I don't know any different". It's had an enormous impact on her... you know, she thinks that's [the violence] normal (Rachel, also mother of neurotypical daughter, 20)

A central component of such concerns involves the conflicting caring responsibilities the mothers had for each of their children. That is, practising an 'ethics of care' towards one child may not equate to an 'ethics of care' towards another child. For example, Frances explained how everyone else in the family was 'walking on eggshells' to reduce potential triggers for violence from her neurodivergent child:

My daughter is learning to tolerate things in ways that she shouldn't have to. I want to teach her that she should be able to stand up for herself and be free to express herself. She has to be quiet all the time so he doesn't get triggered (Frances, also mother of neurotypical daughter, 7)

This example also illustrates how Frances' younger daughter was learning to engage in an 'ethics of care' by inhibiting her self-expression and compromising her own wellbeing in order to manage her brothers' wellbeing. The *intergenerational transmission of violence* is a concept that is frequently drawn on when attempting to make sense of how family violence is passed down through the generations, in terms of both its perpetration and victimization (Widom and Wilson 2015). However, what has not been discussed in the criminological literature is how an 'ethics of care' might also be transmitted within families through the generations as a by-product of such violence, and the ways in which such practices are likely to be highly gendered.

DISCUSSION

The findings presented in this article highlight the difficulties mothers face as they navigate through the experience of parenting their neurodivergent child while also being the victim of their child's violence. In particular, the findings identify some of the ways in which an orientation towards an 'ethics of care' underpins how mothers of neurodivergent children understand the violence they experience. This is achieved most notably by framing their victimization as a practice of 'ideal motherhood' by constructing their selves as a 'safe space' through which their child can manage their distress and, in the aftermath of violence, by focussing on their child's cognitive and emotional development and on alleviating their child's suffering. As discussed in the Introduction, an 'ethics of care' framework provides an alternative model to the culturally dominant 'ethics of justice' which is frequently critiqued for being male-centric and for failing to recognize women's ways of managing challenging situations which, as Gilligan (1993) notes,

prioritizes the welfare of others over oneself. However, while all of the mothers evoked an ‘ethics of care’ to make sense of their violence and their responses to it, this was not without an emotional conflict which reflected deeper divergences in the moral frameworks underpinning practices of motherhood and practices of victimhood.

The mothers’ accounts of violence are obviously concerning: mothers should not be kicked, punched and shoved on a daily basis by their child, and the evocation of an ‘ethics of care’ allows their victimization to become, at least to some extent, acceptable. Such findings raise important questions about whether mothers would position themselves as their child’s ‘safe space’ if they knew that their neurodivergent child had other safe spaces in the world where they could demonstrate their distress? Or indeed, if the world was sufficiently safe as to not distress their child in the first place? While it is likely that many mothers who experience CPV operate within an ‘ethics of care’ framework, the neurodivergent context is significant: the frequent refrain of *It’s his safe space* found in the data only makes sense in a context where neurodivergent children grow up in otherwise ‘care-less spaces’ (Rogers 2016) which disadvantage them at every turn. Ultimately, the imperative to practice an ‘ethics of care’ in such a way is understandable when one looks outwards to how contemporary Britain responds to neurodiversity. That is, it is organized in a way that discriminates against neurodivergent children (see Kusters *et al.* 2021) who fall through the gaps of fragmented and underfunded services (see Hasson *et al.* 2022) and whose parents—primarily mothers—are left to pick up the pieces (see Crane *et al.* 2016; Legg and Tickle 2019).

Many feminists have argued that adopting an ‘ethics of care’ orientation can harm women’s agency because it encourages women ‘...to put others’ needs consistently ahead of her own and to doubt her own judgment’ (Card 1996: 80), potentially exposing women to exploitation, manipulation and abuse. However, the findings presented here suggest that the mothers were well aware of these risks: concerns about their own safety and wellbeing as victims of assault, as well as concerns about how ‘justice’ was being played out within the family home, were ever-present. The findings suggest that the mothers were continually conflicted by their mutually exclusive subject positions of *victim*, which traditionally demands an ‘ethics of justice’ orientation through the mobilization of victim rights, perpetrator responsibility, and a demand for reparation, and of *mother*, which demands an ‘ethics of care’ orientation in the prioritization of her child’s cognitive, moral and emotional development and wellbeing. As many feminists have argued (e.g. Day 2000), not all women (and not all men) rely on one orientation to the exclusion of others, and while this study showed that an ‘ethics of care’ prevailed, the mothers nevertheless experienced profound discomfort about engaging in its practice as it appeared to produce a number of problematic outcomes both for her own safety and wellbeing, and for her children’s emerging understanding about family violence and its acceptability.

The implications of the research

This research has important implications. First, the study highlights how an ‘ethics of care’ plays out in day-to-day family experiences that operate at the intersection of motherhood, violence and neurodivergence. Criminological research that has explored how an ‘ethics of care’ shapes decision-making has predominantly focussed on professional practice.³ In contrast, there has been relatively little focus on how an ‘ethics of care’ shapes experiences of victimization, particularly in the context of family violence. However, it is exactly these kinds of contexts that are most likely to feature an orientation towards an ‘ethics of care’: that is, contexts which involve a relationship with someone known to the victim, where the persons involved are viewed in relational

3 For example, see Hadjimatheou’s (2022) study of how police officers manage competing demands in relation to Domestic Violence Disclosure Schemes, or Ward and Salmon’s (2011) analysis of how clinicians work with sex offenders.

terms (rather than as autonomous beings), where emotions play a significant role in motivation, and where relationships are unequal and are often involuntary (Held 2006).

Interestingly, family violence is one area of criminal justice where an orientation towards an ‘ethics of justice’ has become increasingly dominant over the past 50 years, with a significant increase in formal sanctions against offences related to domestic and family violence through both criminal law and civil law. Yet much evidence shows that the solution to family violence, particularly when children engage in it, is not necessarily through the criminal justice system and certainly not without an accompanying package of support for those involved (Hester *et al.* 2003). Indeed, in cases of family violence that involve children and young people, as well as cases that involve those who are neurodivergent, evidence suggests that services outside of the criminal justice system are likely to be more effective in ending the violence than services within it (Day 2022). Huge progress has made over the past decade in the development of support programmes to address CPV, both inside and outside of the criminal justice system (see Holt 2015; Toole-Anstey *et al.* 2023). However, most of these programmes still operate within a ‘neurotypical framework’ that often excludes neurodivergent children and their (potentially neurodivergent) parents by failing to recognize different sensory needs, different ways of relating to others and different modes of learning. As we have learned from research into adult family violence intervention programmes, delays in diagnosis can exacerbate these issues and can contribute to neurodivergent people in attendance instead being labelled as ‘belligerent or disruptive’ for failing to conform to neurotypical expectations (Renehan and Fitz-Gibbon 2022: 5). Thus, we need to be mindful that such programmes do not produce further ‘care-less spaces’, producing further distress for the child(ren) who, in turn, require further ‘safe spaces’ from their mother(s).

Second, this study suggests how an ‘ethics of care’ might be reproduced within families, such that daughters learn from their mothers to prioritize others to the detriment of their own well-being. This is an area which has not thus far been explored in research and suggests that applying a developmental approach to understanding how ethical orientations become practised (and gendered) over time might be fruitful, since an ‘ethics of care’ is not ‘innate’ to womanhood but is a social practice that is learned (Noddings 1984). The gendered nature of CPV victimization has been reported elsewhere in the literature, but so far there is little explanation as to *why* this might be—particularly in cases where both male and female carers are present during a violent encounter. This study offers some insights into this by elucidating the ethical dynamics involved in violent encounters between family members.

Finally, this study highlights how an ‘ethics of care’ is not untethered from its social and political context, and that the compunction to engage in such practices, despite the harms they can cause, is shaped by a broader political and institutional context. If we can re-imagine a world which is not organized to prioritize the needs of the neurotypical majority, and a world which does not rely on the gendered, unequal distribution of caring labour, then perhaps this might change the dynamics within the family home, including those that involve violence.

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