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Living in Misery: Child to Parent and Grandparent Violence and Abuse

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This article investigates the hidden and under-researched phenomenon of child/adolescent-to-parent violence and abuse (CAPVA). Despite the attention given to spousal and child abuse, very little is known about why children abuse their parents or what can be done to prevent it. This article explores how this issue is explained, its effects on parents and carers and the different interventions that have emerged to tackle it. Based on in-depth focus groups with parents, grandparents and practitioners participating in a 'Who's in Charge' intervention in the United Kingdom, this article explores the complex intersection of parenting skills, intergenerational violence, gender, neurodiversity and the associated response (or lack thereof) from education and law enforcement. The article concludes with important new recommendations on 1) the need for better referral routes, 2) greater emphasis on neurodiversity, 3) very early intervention, and 4) the benefit of online platforms used during the COVID-19 lockdown for engaging parents and grandparents.

Keywords: *Who's in Charge, CAPVA, parents, grandparents, neurodiversity, intergenerational, Zoom, WhatsApp, violence, abuse.*

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Introduction

Over the past decade, there has been a growing acknowledgement of the prevalence of child/adolescent-to-parent violence and abuse (CAPVA), however, it remains one of the least studied types of family and interpersonal violence (Simmons et al., 2018). There exists no legal definition of CAPVA in the United Kingdom (UK) (Sanders, 2020) and defining precisely what CAPVA is, becomes further complicated by different disciplines using inconsistent definitions and varied conceptual frameworks, on which interventions are based. Broadly, CAPVA describes a range of violent, harmful, or controlling behaviours, which includes acts of psychological, physical, emotional, coercive, sexual, or financial abuse by a child under the age of 18 years, toward a parent or primary caregiver (Holt, 2016; Brennan et al., 2022).

Some studies include any single incident of CAPVA in the definition whereas others categorise CAPVA as a pattern of behaviour (Simmons et al., 2018) which complicates the range of experiences that can be defined as CAPVA. Furthermore, there are many terms which refer to this phenomenon, such as child-to-parent violence (Wilcox et al., 2015), child-to-parent-abuse (Simmons et al., 2018), and adolescent violence in the home (Sutherland et al., 2022). The variations in the labels and definitions of CAPVA reflect the lack of consensus among disciplines and agencies regarding how CAPVA is conceptualised and understood in context. This article will use the term CAPVA, in recognition that abuse is not always physical, nor always well-represented by the term 'violence', and to acknowledge the wide age range of young people who enact CAPVA.

Much of the research literature has attempted to conceptualise CAPVA and explore contributory factors through single-theory frameworks. For example, social learning theories emphasise the role of exposure to violence as a child, by either being the victim of child abuse or witnessing domestic abuse, and propose that through the transmission of intergenerational violence and observational learning the young person develops violent and abusive behaviours themselves (Margolin, Baucom, 2014). Other perspectives, such as feminist approaches, emphasise the gendered nature of violence and focus on gender inequality, control of women, and misogyny when exploring contributory factors (Burck, Walsh, Lynch, 2019). More recently, researchers have been promoting the advantages of using multifactor frameworks, in order to synthesise existing research and to address the fact that complex

behaviours in young people (e.g., violence and abuse) are determined by interactions of multiple processes at the individual, family, community, and societal levels. Bronfenbrenner's social ecological model (1979) is particularly useful in this regard and is increasingly being utilised to explore the context of CAPVA (Simmons et al., 2018).

It is important to note that how CAPVA is conceptualised often varies between service providers, caregivers (victims) and young people (instigators). It has been reported that parents often view their child's violent and abusive behaviours through a pathological lens of diagnoses and disorders (Clarke, 2015). This can provide some comfort to parents by repositioning self-blame regarding the abuse in the context of impulse control disorders. Understandably, clinicians recommend against this strategy of conceptualising CAPVA due to the risk of normalisation of violence leading to unwillingness on behalf of the parents to report crimes or implement strategies to resist or prevent violence (Baker, Bonnick, 2021). Though, it should also be noted that a young person's diagnosis of mental illness or recognition as neurodivergent can open doors to specialist services and community support (Clarke, 2015). Therefore, acknowledgement of the young person's diagnoses and integration into interventions is not inherently harmful.

Qualitative studies have indicated that parental blame is a common explanatory factor for parent/caregiver victims of CAPVA. Williams, Tuffin and Niland (2017) demonstrate that mothers and grandmothers questioned their competency in parenting and felt responsible for the violence they had experienced, whilst also attributing blame to the absence of a father figure and the impact of their child lacking a male role model. There is a notable absence of the views of young people who instigate CAPVA in the literature. One thematic analysis of adolescent's accounts of CAPVA in the UK (Papamichail, Bates, 2022) demonstrated that the young people, similar to the parents in Williams et al.'s study, viewed the absence of their biological father as a contributory factor to their violence. Though unlike the findings of Williams, Tuffin, and Niland (2017), half of the young people lived with a step-father, indicating that a sense of rejection from their biological parents contributed to their conceptualisation of CAPVA, rather than the lack of a male role model. The theme of rejection was a consistent finding in Papamichail and Bates' study (2022), which reported that the young people also felt rejected by other members of their family.

This article aims to explore the phenomenon of CAPVA through an evaluation of one intervention program in the UK. This evaluation combined routinely collected data, interviews, and focus groups with clients and staff involved in the *Who's in Charge* program (Holt, 2015) to investigate the barriers and enablers of this approach to helping families living with CAPVA. The following sections will outline the difficulties of determining the prevalence of CAPVA within the UK and throughout Europe, and will discuss the *Who's in Charg*e program, and the evidence relating to its efficacy. This is followed by presentation of the methodology used and demographic data, followed by the results of our analysis. The article is concluded by relating our findings to the complex intersection of risk factors associated with CAPVA and providing recommendations to improve the provision of CAPVA interventions and enable early support for families.

Prevalence of CAPVA

The prevalence of CAPVA in the UK, and globally, is currently difficult to distinguish, due in part to differing conceptualisations of CAPVA, inconsistent definitions and the variety of research methods which can be used to assess prevalence rates. Further obscuring true prevalence rates of CAPVA is the hidden nature of this phenomena, similar to other types of abuse, victims feel high levels of shame and stigma which can result in hesitance to disclose what is happening or lead to a fear of repercussions from their child (Burck, Walsh, Lynch, 2019). Additionally, some parents and caregivers choose not to report occurrences of CAPVA due to mistrust of police or social services, worries about their child being removed from the home, or fears of criminalising the young person and affecting their future as an adult (Brennan et al., 2022).

In large-scale population surveys from the US, Canada, and Australia, prevalence rates range from 4.6% to 20% (Holt, 2021), and one examination of CAPVA across five European countries (England, Ireland, Bulgaria, Sweden, and Spain) estimated that CAPVA affects 1 in 10 families (Wilcox et al., 2015). Community based survey data often reveals even higher prevalence rates. Simmons et al.'s (2018) literature review estimated the global prevalence of physical CAPVA to be between 5% and 21%, and psychological CAPVA to be between 33% and 93%, however this study did not differentiate between sin-

gle instances of violence and patterns of behaviour, which likely contributes to the large range of these prevalence estimates.

In the UK, a small number of studies have utilised self-report survey data from young people to estimate the prevalence of CAPVA. One cross-sectional study examined CAPVA among 890 secondary school students in England (aged 11 to 18 years) and revealed that 64.5% of the sample reported an incident of either psychological (64.4.%) or physical (4.3%) CAPVA in the last 6 months (McCloud, 2017). These results do not necessarily represent patterns of abuse because the responses 'sometimes' and 'often' are combined in these figures, which may lead to inflation of the rates of abuse, however, the overall prevalence of CAPVA is comparable to a similar cross-sectional study in Serbia (Stevković, 2022) which reported that 69.5% of 1335 students (aged 12 to 19 years) had been psychologically or physically violent to a family member at some point. Another study explored the prevalence of CAPVA among a sample of 210 college students in England (aged 16 to 18 years) and reported lower frequencies of psychological and physical patterns of CAPVA (Baker, 2021). This study more clearly distinguished between one-off incidents and patterns of behaviour, revealing that 94% reported psychological aggression and 18% of the sample reported physical aggression to parents at least once. The author devised six thresholds of patterns of physical and/or psychological abuse to identify potential cases of CAPVA; overall 10% of the sample met these criteria.

It is also possible to estimate the prevalence of CAPVA by examining police and crime statistics and youth justice samples. Although these data are likely to be lower than the true prevalence, due to under-reporting on behalf of victims, and potential areas of bias in arrest and prosecution rates leading to boys being more likely to be identified in these samples (Sanders, 2020). Brennan et al. (2022) examined CAPVA-related offences across London, using Metropolitan Police Service (MPS) incident data from 2018 to 2020, as well as data from the annual Crime Survey for England and Wales (CSEW) from 2011 to 2020. Their analysis revealed that 60% of incidents reported to MPS involved physical violence (violence against the person), with a lesser proportion consisting of criminal damage (25%). However, this data is limited because MPS only record a primary offence, therefore it is possible that multiple offences were committed but only one could be recorded. Furthermore, analysis of CSEW data (Brennan et al., 2022) revealed that approximately 40% of CAPVA victims did not report any offence to the police, and even when

CAPVA-related crimes are reported to police, there is no consistency in how this is recorded and managed due to a high level of police discretion (Miles, Condry, 2014). Therefore, the utility of using police and crime statistics to estimate CAPVA prevalence is limited.

Who's in Charge[4]

Who's in Charge is a solution-focused parenting support programme developed by Eddie Gallagher in Australia (Holt, 2015). Emerging from support groups for mothers who experienced CAPVA, the aim of the programme is to empower parents through a supportive environment and solution-focused discussions, to build self-esteem and reduce shame, and to encourage practical changes by implementing consequences to change unwanted behaviour. Based on the idea that parental guilt about being victimised by their child may contribute to sustaining unbalanced power dynamics in the parent-child relationship, *Who's in Charge* emphasises parental assertiveness and self-care, while discouraging victim-blaming perspectives on CAPVA. This programme acknowledges that young people engaged in CAPVA are unlikely to meaningfully engage with CAPVA interventions initially, and that sessions with CAPVA instigators and victims together may cause violence and abuse to escalate. For these reasons the *Who's in Charge* programme focuses on working to support and empower parents, who are likely more motivated than the young person to enact change in the home. The programme is aimed at parents and caregivers of children aged 8 to 18 years.

Who's in Charge is a structured group support programme, typically consisting of nine sessions in a three-part structure, involving worksheets, hand-outs, and group discussions. The first part of the programme focuses on understanding the nature of CAPVA, parental attitudes about their child's behaviour, and exploring the roles of entitlement, shame, and power in the parent-child relationship. The second part of the group focuses on the use of consequences in parenting, aiming to empower the parents to become more confident and assertive. This section also explores the difficulties of identifying appropriate consequences and implementing them in a safe and practical manner. The final section supports parents to sustain and reinforce changes within the home, as well as exploring topics such as anger (both from the par-

ent and from the young person), self-care, and assertiveness. The programme is followed up 2 months after completion with a group session exploring goal achievement and evaluation of the impact of the programme, as well as providing support for parents to set future goals and sustain changes.

Who's in Charge is recognised as an emerging effective practice from the Youth Justice Board for England and Wales (Baker, Bonnick, 2021). There are no specific protocols for working with neurodiversity, English as a second language, or additional learning needs. Gallagher highlights that due to the use of handouts and worksheets in sessions, those who struggle with reading and writing may experience barriers in the programme, however there are no recommendations for ameliorating these difficulties (Holt, 2015). Anecdotally, Gallagher reports that over two-thirds of young people, whose parents or carers engaged with the programme, demonstrate meaningful changes in CAPVA-related behaviours (Holt, 2015). There are no published quantitative data relating to programme effectiveness, Gallagher states that a qualitative evaluation was conducted in 2007, however this report is not currently available.

Methodology

This paper is based on an evaluation combining focus group interviews, individual interviews, and routinely collected data about the *Who's in Charge* programme, to examine the referral processes currently in place and explore the views and experiences of clients and staff involved in the programme. The dataset below reveals essential information about the delivery of the programme and routinely collected information from clients over a period of 29 months from the start date in April 2020. To provide a deeper understanding of the programme, focus groups with *Who's in Charge* clients (N=4) and staff (N=3), and an interview with the *Who's in Charge* manager were also conducted (total participants, N=8).

Data collection

Participants for the two focus groups and the individual interview were identified and recruited through the intervention team, and data collection and analysis were conducted by the research team at the University of Hull.

Ethical approval was granted from the FACE Ethics Committee at the University of Hull, and all participants provided informed consent verbally. The client focus group took place online and consisted of four parents and grandparents who had completed, or were currently participating in the *Who's in Charge* programme. The staff focus group took place online and was conducted with three employees from the programme who facilitate the *Who's in Charge* programme, their job titles included family harm prevention worker, senior domestic abuse (DA) prevention worker, and young person's harm prevention worker. Two members of the research team conducted the focus groups, and one researcher interviewed the program manager. An individual interview with the *Who's in Charge* manager was also conducted. All qualitative data collection used a strengths-based approach, which focused on affirmative experiences and outcomes of the programme and explored what could be done to further enhance the *Who's in Charge* programme. A semi-structured interview schedule was designed for each focus group and the interview. Each consisted of up to 13 open-ended questions, with multiple prompts, questions included "What is the most important lesson you can take away from your experience of this programme?" (client focus group).

Access to routinely collected data regarding referral and demographic information of clients was supplied to the research team by the program provider. This consisted of all referral information between the dates April 2020 and September 2022, and included basic demographic information of 398 clients who had been referred to the *Who's in Charge* programme.

Data analysis

We conducted a SWOT analysis of each qualitative data source, which enabled us to identify the overall Strengths, Weaknesses, Opportunities, and Threats of the *Who's in Charge* programme from the perspectives of clients, staff, and the delivery manager. The findings were combined to provide an overall impression of what is currently working well and to identify areas which could be expanded upon to provide additional value or opportunities to enhance and streamline the delivery of the programme. The following sections provide an overview of the findings from the routinely collected data, focus groups, and the individual interview, and recommendations based upon these findings will be discussed.

All results are presented anonymously and although we interviewed the manager separately, we have taken the decision to merge any quotes from the manager with the wider staff group to avoid breaching anonymity. Any identifying details or context were altered or removed for the same reasons, and we have generally sought to include those quotes that are representative of the general sentiment and that do not relate any personal details.

Results

Referral and demographic data

Between April 2020 and September 2022, the *Who's in Charge* programme received 398 referrals. The service demonstrated rapid growth between the first and second year of operation and appears to be maintaining this level of service into the third year. Overall, 45 out of the total 398 were repeat referrals, demonstrating that the service is continually reaching new clients and the majority are not re-referred. Clients were referred from a range of agencies and organisations, the three most common referral pathways were from Children and Family Support Services (N=99), Children and Young People Services (N=91), and directly from the young person's school (N=74).

Table 1. *Demographics of clients in Who's in Charge for the period 2020-2022*

(N)		2020-2021	2021-2022	2022 (April–September)	Total (2020-2022)	
		(N)	(N)	(N)	(%)	
Gender	Female	30	229	111	370	93.0
	Male	5	14	9	28	7.0
Age	18 - 35	9	85	35	129	32.5
	36 – 50	20	122	61	203	51.0
	51 +	6	26	19	51	12.8
	Unknown	0	10	5	15	3.7

Risk level	Standard	30	218	110	358	90.0
	High	4	24	9	37	9.3
	Very High	0	0	1	1	0.2
	Unknown	1	1	0	2	0.5
Number of children	0	2	12	3	17	4.4
	1	8	46	22	76	19.1
	2	13	70	40	123	30.9
	3	5	66	30	101	25.5
	4+	7	49	24	80	20.1
Disability	Physical	2	3	10	15	4.0
	Mental health	7	75	29	111	28.0
	Learning	0	5	3	8	2.0

Most people referred to *Who's in Charge* were female (92%), White British (91%), with a standard level of risk (90% of cohort). Only one case in the data from 2020-2022 was assessed as a very high level of risk. The ages of adult clients referred to *Who's in Charge* ranged from 25 to 76 years, with a mean age of 40 years (SD=8.41), although it should be noted that 15 clients had not provided their age or date of birth, and therefore were not included in this analysis (Table 1).

The number of children of people referred to *Who's in Charge* ranged from 0 to 8. Those recorded as having 0 children typically meant that the children were not currently in the care of the client, or the client was a grandparent or other relative. 76% of clients had more than one child. Nearly one third (28%) of clients were classified as registered disabled in relation to mental health, far higher than physical (4%) or learning disabilities (2%). The genders and ages of children, and whether they had any disabilities or additional needs, were not recorded (Table 1).

Strengths, Weaknesses, Opportunities and Threats

a) Strengths

The importance of group-based work, peer-support and the use of a WhatsApp group were deemed to be particularly beneficial by both parents and staff:

> "You knew people weren't going to judge you because everyone was in the same boat (…) so you can just be open and honest about the things you were struggling with and I think that's important, and you have to kind of give that vulnerability to get something out of it." (Parent)

This sense of support was further enhanced by the use of a WhatsApp group which allowed parents to talk to each other and offer support 24/7. As one staff member put it:

> "We started at the end of the group saying 'how about you form a WhatsApp group between you all', because obviously we only work Monday to Friday 9-5, so then they've got that added support after we finish working, and we've been doing that now for every group that we've done (…) I do that's very beneficial to have that and have it as a closed group and not an open, rolling program." (Staff)

This sense of being able to talk to other people living through the same experience was deemed hugely valuable by the parents. In particular, the sense of not being judged – or having to explain – made people feel more comfortable talking about their experiences. The 'closed' WhatsApp group allowed this sense of group cohesion and support to develop and sustain itself after the programme ended.

Related to this, one surprising result was the value parents and staff placed on the 'online' delivery of the programme using Zoom. At one level it feels counter-intuitive that remote delivery would make people feel comfortable, but the overwhelming opinion was that the online format worked well, made people feel more comfortable and safer:

> "When I'm doing the *Who's in Charge* program [online] I've found definitely that people…if they're not sat in a room with somebody, they seem to be able to be more open, and maybe tell us more than they would tell us if

they were in a room being looked at directly by somebody. So, I think they actually feel more open to sharing their experiences online." (Staff)

"[on Zoom] we've got a lot less people missing sessions, I think because it's online for those who maybe have previously worried about the anxiety of how they're portrayed in front of people and face to face, this is a nice barrier and a nice support and protection for them." (Staff)

Whilst some parents/grandparents expressed initial anxiety about meeting online, they all told us that they quickly became more confident as they had used various video-conferencing platforms during COVID-19 lockdown. The logistical advantages of not having to travel (especially in terms of managing childcare, work obligations and travel costs) were seen as very beneficial. Similarly, familiar surroundings made parents feel more relaxed and less like they were under a 'microscope'.

Beyond the clear importance of the group dynamics and peer-support, another major strength that was identified was the way in which the programme engendered a positive mindset and behaviour change in parenting style:

"Things changed for me straight away, as in my mindset, but things we were implementing took time." (Parent)

"Sometimes you can feel like the process is slow, but it is going in the right direction and it's just about having the momentum and the motivation and having the support behind you to just keep going." (Parent)

b) Weaknesses

There were two weaknesses identified during the interviews. The first of these is a dissonance between the parent and staff group regarding the role of neurodiversity in a child's behaviour:

"It still confuses me as to which behaviours are driven by the autism and that I need to be compassionate to and understanding of, and which behaviours are the ones that need the consequences and the challenging and dealing with…and it's just trying to find that balance." (Parent)

"I (….) have a child with ADHD, ODD, autistic tendencies, anxiety disorder, attachment disorder to me, and it (…) was a minefield of what is classed as learned behaviours, whether that's within the home or outside of the home like at school, or what is actually linked to my child's conditions." (Parent)

"I think sometimes referrals are probably mis-referred, because the child might be diagnosed with ADHD or autism, and it's probably not the right particular programme- there might be other agencies that should be involved, but due to time scales and waiting lists and things like I just feel like, it's very rare that we'll say 'no I'm not accepting that'." (Staff)

No single programme can realistically be expected to meet the complex needs of every child. The staff group generally seemed to ascribe to the view that they can offer help with the parenting skills whilst the parenting group exhibit some frustration about more specialist needs regarding neurodiversity. Some of this dissonance is almost certainly to do with the nature and focus of the *Who's in Charge* programme compared to how parents make sense of their children's behaviour.

Another weakness that both parents and staff pointed to is the limited age range of the *Who's in Charge* which is aimed at 8 -18 years of age. The consensus was that many behaviours are entrenched by age 8 and it would be a very good idea to extend *Who's in Charge* or develop a sister programme aimed at younger children as an early intervention initiative. The perceived benefit of this is that it would avoid needless suffering for the parents, nip the problem in the bud and reduce the risk of 'learnt behaviour' from other siblings in the family household (a pressing concern as 76% of clients had multiple children).

"Because this is an 8-18 program, I think when you get the older children, I think their behaviour is so entrenched (…) and I'm not saying it won't change, but I think it takes that behaviour longer to change, because I think that by the time they get to 17 or 18 they're not bothered because their behaviour is that entrenched." (Staff)

"In assessments we ask parents 'when did your child's behaviour start to concern you?' and I would say that a massive percent of them would say 'I started to notice by the time they were 18 months or 2 years of age and

> they weren't behaving developmentally appropriately (…) but if you've got parents who are only coming to us when their child is 8, 9, 10 , 11, 12, and they've been experiencing this behaviour since the child was 18 months…how can we recoup 8 or 9 years in 8 weeks? And a lot of the time we do it successfully." (Staff)

These comments directly inform some the findings in the 'Opportunities' section below. It was very clear from the parent group that many of them had been wrestling with their children's behaviour for many years before reaching the *Who's in Charge* programme. A history of blocked access to services, misplaced advice from well-meaning (but largely unhelpful) law enforcement and education services and a great deal of 'self-medication' to manage an increasingly fraught homelife suggests that an earlier engagement with families would reap dividends and potentially head off other social problems stemming from CAPVA.

c) Opportunities

Two clear opportunities relate to the aforementioned weaknesses regarding neurodiversity and the age-range of the programme. For example:

> "I think if intervention is done earlier with a child then the outcome could be a lot better, whereas some children and families do not get this opportunity, so they suffer, suffer, suffer for long, long periods of time, and by the time children get to their teenage years some stuff is lost, some stuff you just can't reprogram, some things you can but for others that is it, because if you don't get it at an early enough age then it's a whole different can of worms, so the whole process earlier and intervention earlier is a must." (Parent)

> "It would be nice to cover that age group wouldn't it, like going back to the wish list, if maybe we could have a slightly different program that could deal with the behaviours of much younger children as well, to nip it in the bud while they're young, rather than them then becoming teenagers that are more difficult to handle." (Staff)

Another element that many of the parents felt would be beneficial was more meaningful advice and support about how to stay calm, manage family life and cope with the stresses and strains that led many of them to struggle with their own health and wellbeing. For some people, this meant becoming too reliant on alcohol or painkillers, for others it was the damage done to their own confidence and mental health. These represent hidden needs that create additional pressures on families and services:

> "I think maybe that's a piece that's missing, is that mental health support. I know we do have our individual workers and they are very good, but they're not counsellor-type level trained, and yeah, I guess if we are the key ones to be at the root of moving our children forward then we need our own support too." (Parent)

> "Everyone tells you to stay calm but they don't tell you how, they just tell you 'the best thing to do is stay calm' well how the hell do I stay calm when I've got someone coming at me with a pair of scissors, coming at my face, how the hell do I stay calm in that situation?" (Parent)

A final opportunity relates to the limited awareness of the *Who's in Charge* programme. Both staff and parents expressed some frustration with the police and school response to this type of domestic abuse in their home, suggesting a need for some partnership engagement and clearer referral routes. These opportunities are fundamentally about external engagement, awareness raising and routes into *Who's in Charge*:

> "Parents phone the police and are told 'it's your child deal with it' and the phone is hung up…I know the police force is run ragged just like we are, but I think it's just that understanding, and that training and support for them to realise it's happening in our communities (…) and I know we're keen to try and train up a lot more within the local police so they understand that it is happening in our community." (Staff)

> "My experience with the police and my child's behaviour is not a healthy… good one…at all. I thought 'oh my god I've got to ring the police'. I was at the lowest, so low it was unreal, I didn't know what to do and I didn't know where to turn, and so I rang the police and I got a lecture off the policeman on the other end of the phone, saying 'do you realise what you are

doing? Your child will have this on their record for the rest of their life', so then he made me feel that I was the person in the wrong, well no, my child was, because my child was hitting me all the time and that is not right or acceptable one bit, so my experience with the police has not been the best at all." (Parent).

d) Threats

One of the most commonly cited frustrations by both staff and parents was the difficulties in getting referred to *Who's in Charge* and the confusion sometimes caused by other parenting programmes with slightly different goals:

"I've been waiting quite a few months to get her [a client] on the *Who's in Charge* program, so I did all the assessments and keep in touch with her, and she was due to start (…) the next core group, then they said 'we want her to do this parenting program before *Who's in Charge',* and I'd got this parent ready to start *Who's in Charge* program and now I have to close it." (Staff)

"You have to jump through hoops to get the help, you have to prove that you are not a bad parent, so straight away that question is there straight away, so you believe that what you are doing is wrong and that you are a bad parent, until you do these courses and someone says it's not you, it's that process that can take far too long for some of us." (Parent)

Similarly, the response from the police when contacted by parents was generally viewed as underwhelming:

"[Police] need to understand that [CAPVA] is happening in our community and when these parents reach out you can guarantee they've dialled the number 30 or 40 times before they've actually had the confidence to call and say 'I'm being physically abused, mentally abused by my child' to then be told 'it's your child, it's your problem, you have to deal with it'…it's not very helpful." (Staff)

"I've got a couple of clients where parents have called the police quite a few times and they either haven't been out or they've come out and said to them 'stop it, be kind to your mum' and then they're gone." (Staff)

These types of obstacles represent a real and present danger to *Who's in Charge* as they effectively block referrals and negatively impact the initial engagement with *Who's in Charge* due to poor prior experiences. Sometimes this is about competition between services that can lead to confusion for parents, and sometimes it is a lack of awareness about what advice and support is available to parents.

Discussion: Gender, age, abuse and neurodiversity

Gender

The evidence reported in the majority of the literature reflects that CAPVA is a gendered phenomenon, with mothers being more likely than fathers to be the victim of CAPVA (Simmons et al., 2018). Some studies have concluded that 'typical' profiles of instigators and victims are white males aged 14-17 and white adult females, respectively (Hong et al., 2012). Baker's (2021) exploration of adolescents' views on CAPVA revealed insights from the young person's perspective regarding why mothers are more likely to be targets. The young people in this study highlighted the role of their mother as primary caregiver meant closer physical proximity, as well as being more actively involved in parenting decisions. Furthermore, the young people described how they perceived their mother to be a 'safer' target; not only physically but also emotionally, with one participant stating, "I knew Mum would stay…no matter what would happen". The gendered nature of CAPVA is also evident in studies which focus on kinship care. Holt and Birchall's (2020) qualitative project investigating CAPVA in kinship care contexts in the UK reported that 24 of 27 participants were grandmothers. A similar qualitative examination of family violence in kinship care in Australia reported that 96% of 101 kinship carers in this study were female, predominantly grandmothers (68%) or an aunt (18%) (Breman, MacRae, Vicary, 2018).

Age

In a similar manner to the variation in definitions of CAPVA, the age range of young people who are instigators of CAPVA is also a contentious issue. The

majority of studies focus on young people aged between 10 and 18 years old (Brennan et al., 2022); the lower cut-off reflecting the minimum age of criminal responsibility in England and Wales (Brown, Charles, 2021). Simmons et al. (2018) argue that pre-adolescent children (under the age of 13) should not be included in CAPVA literature because their developmental stage precludes them from intending harm as a result of their actions. However, the usefulness of defining CAPVA based on 'intent' is diminished in the context of neurodivergent young people (Baker, Bonnick, 2021). Additionally, many definitions of CAPVA do not specify intent, but rather focus on the pattern of abusive behaviours and feelings of fear and control experienced by the victim (Paterson et al., 2002). By limiting our understanding of CAPVA to that instigated only by teenagers, may serve to perpetuate the hidden nature of this phenomenon, by overlooking families with younger children who are struggling, and ignoring the necessity of early interventions into violent and abusive behaviour (Thorley, 2017).

The upper age of 18 years is also debated in the literature. Although legally, in the UK, a young person aged 18 or over is considered an adult, in developmental terms adolescence is often considered to extend up to the age of 24 years (Sawyer et al., 2018). Furthermore, the number of young adults continuing to live with parents in the UK has increased by 24% since 2011 (Sharfman, Cobb, 2022). This has important implications for our conceptualisation of CAPVA, as much of the literature demonstrates that incidents of CAPVA tend to escalate over time in a similar manner to other types of domestic abuse (Simmons et al., 2018). There is a distinct lack of research that involves adult-aged children, however emerging research demonstrates that this phenomenon is present but often not captured in literature due to CAPVA services typically only providing support to under 18's and age-related exclusion criteria in research samples (Baker, Bonnick, 2021). Brennan et al.'s (2022) examination of CAPVA offences across London revealed that 65% of cases reported to the police involved a young person aged 19 to 25 years, demonstrating that CAPVA does not end when a young person legally becomes an adult. It is of particular importance to recognise the continuation of violent and abusive behaviours into adulthood, not only to support victimised parents, but also because research suggests that young people who have enacted CAPVA may then go on to perpetrate intimate partner violence in adult relationships (Ibabe, Arnoso, Elgorriag, 2020).

Mental health and neurodiversity

Multiple reviews into CAPVA have identified that young people with mental health concerns are more likely than their peers to engage in CAPVA (Baker, Bonnick, 2021; O'Hara et al., 2017; Simmons et al., 2018). However, the precise role of psychopathology in young people who instigate CAPVA is still unclear. It is important to note that although psychological disorders and neurological/neurodevelopmental disorders (i.e., neurodiversity) may co-exist, they are separate entities that affect people differently. Psychological disorders are typically related to emotional, behavioural, and mood symptoms that cause distress and negatively affect daily functioning. The term 'neurodiversity' is an umbrella term to describe alternate thinking and processing styles typically seen in autism spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD), and Tourette's syndrome, to name a few. The use of the term 'neurodiversity' communicates the idea that neurological differences are normal and valuable variations in the way that humans can process and use information, and therefore should not be seen as pathologies that necessitate a cure (Dyck, Russell, 2020).

Studies have reported that young people who enact CAPVA display high levels of general psychological distress, depression, and low self-esteem (Calvete Orue, Gámez-Guadix, 2013). Qualitative research from the UK with mothers experiencing CAPVA from their pre-adolescent children reported that all the participants in the study conceptualised CAPVA as resulting from mental health struggles, such as anxiety or emotional dysregulation (Rutter, 2020). Similar qualitative research with young people in the UK who enact CAPVA revealed that six (of eight) participants were involved with Child and Adolescent Mental Health Services (CAHMS), and five related their violent behaviour to emotional dysregulation and feeling 'out of control' (Papamichail, Bates, 2022).

In CAPVA literature, the role of neurodiversity and developmental disabilities in young people is often framed as a causative factor (Simmons et al., 2018). Disorders such as ASD and ADHD are frequently named as risk factors that may lead to CAPVA, often due to the emotional dysregulation, impulsivity, and struggles with social interactions inherent in these disorders (Baker, Bonnick, 2021). However, as noted by Sutherland et al. (2022), this view can be problematic due to the range of factors which may induce violence from neurodivergent young people, such as physical pain, fear, or methods of com-

munication. Furthermore, the authors argue that current frameworks used to understand CAPVA, such as feminist or social learning theories, tend to miss out these contextual factors that could contribute to violent behaviours. Some studies caution against framing neurodiversity as a cause of CAPVA, describing how parents may use their child's diagnosis as a reason to tolerate violence (Baker, Bonnick, 2021), while others describe how parents may attempt to assuage feelings of self-blame by positioning such diagnoses as the sole cause of CAPVA (Clarke, 2015). Crucially, there has been little evidence that demonstrates that CAPVA is caused by developmental disabilities, and therefore the role of neurodiversity would be best understood by taking a socio-ecological perspective (Sutherland et al., 2022). Taking such an approach would be particularly useful when developing CAPVA interventions, due to the lack of resources for these families, and questions regarding the suitability of existing interventions into CAPVA for neurodivergent young people (Holt, Lewis, 2021).

Conclusion: Recommendations and further research

Based on focus groups with parents, grandparents and practitioners involved in a *Who's in Charge* intervention in the UK, this article has provided fresh insights into the hidden phenomenon of CAPVA. *Who's in Charge* provides parenting skills combined with peer group support to help manage and reduce this type of largely unacknowledged domestic abuse. Our research demonstrates that whilst parents and grandparents found *Who's in Charge* to be a positive experience that did help them slowly introduce new, more successful, strategies for managing violence and aggression in the home, the efficacy of the intervention could be considerably enhanced by implementing the following recommendations.

We found that a stronger integration of the *Who's in Charge* intervention into education and law enforcement referral routes that provide clearer signposting, eligibility criteria and training about how to engage with, and support parents struggling with this difficult issue is needed. Further, a greater emphasis on supporting parents with neurodivergent children is required. Specifically, engagement with the sensory and behavioural experiences, and the support available for neurodivergent children was a missing ingredient

in the intervention. Parents, grandparents and practitioners also felt that the *Who's in Charge* intervention should be developed for younger children (4-8) as well as the 8–18 age range. Parents with lived experience of this phenomenon felt very strongly that the behaviour manifested earlier than 8-years-old, and if addressed earlier would be less likely to establish itself, or adversely affect their siblings. Finally, the benefit of online platforms to enable engagement with *Who's in Charge* was an unanticipated benefit of COVID-19 lockdown. The use of WhatsApp (or similar) to foster ongoing peer support was seen as a very important 'spin-off' from the intervention. The capacity of technology to offer greater reach, inclusivity and sustainability of the *Who's in Charge* intervention is worthy of further study, as is engagement with the young people (and their siblings) who benefit from living in a more tranquil family environment.

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Život u patnji: Nasilje i zlostavljanje roditelja i baka i deka od strane dece

U ovom radu je analiziran skriveni i nedovoljno istraženi fenomen nasilja i zlostavljanja roditelja od strane dece/adolescenata (CAPVA). Uprkos pažnji javnosti koja ja usmerena na parnersko i nasilje nad decom, malo se zna o tome zašto deca zlostavljaju svoje roditelje i šta bi trebalo uraditi da se to spreči. U radu je prikazano kako se ovaj oblik porodičnog nasilja objašnjava, kako utiče na roditelje i staratelje, kao i različite intervencije koje su se pojavile u cilju njegovog sprečavanja i suzbijanja. Polazeći od rezultata dubinskih fokus grupnih intervjua sa roditeljima, bakama i dekama i stručnjacima uključenim u interventni program *'Who's in Charge'* u Ujedinjenom Kraljevstvu, u radu je analizirana komplesna isprepletanost faktora koji doprinose pojavi i održavanju ovog oblika porodičnog nasilja, poput roditeljskih veština, međugeneracijskog nasilja, roda, neurodivezititeta i povezanog odgovora (ili odsustva istog) od strane obrazovnog i pravog sistema. U zaljučnom delu su date preporuke u vezi sa: 1) potrebom za boljim putevima upućivanja nasilne dece i roditelja/staratelja na program rane intervencije, 2) većim fokusom na neurodiverzititetu, 3) neophodnošću rane intervencije, i 4) prednostima upotrebe

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onlajn platformi koje su korišćene tokom COVID-19 lockdown-a za motivisanje i uključivanje roditelja i baka i deka u program.

Ključne reči: *Who's in Charge*, CAPVA, roditelji, bake i deke, neurodiverzitet, međugeneracijsko nasilje, Zoom, WhatsApp, nasilje, zlostavljanje.