Deconstructing children’s noncompliance: Mothers’ experiences of children exhibiting challenging behaviors and accessing parenting support systems

by

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The purpose of this qualitative study was to gain a better understanding of the phenomenon of children exhibiting noncompliant behaviors from the perspective of parents who seek clinical services for these challenging behaviors. Theory, empirical research and applied interventions have revolved around the construct of ‘noncompliance' and the assumption that such behavior is the consequence of incompetent or unskillful parental discipline (Kalb & Loeber, 2003; Patterson, 2013). The research questions and analyses of this study were approached with a broader conceptual framing than what has been used previously, sensitized not only by longstanding behavioral conceptions of noncompliance (Patterson’s, 1982) but also alternative conceptions from developmental psychology including attachment theory (Stayton, Hogan & Ainsworth, 1971), and social relational theory (Kuczynski & De Mol, 2015). Mothers from twenty-five families were interviewed about their relationship with their children aged 8-13, their interpretations and experiences of their children’s challenging behaviors, and their experiences of accessing parenting support services.

Empirically this study makes three contributions. First, this study contributes a more holistic understanding of the parent-child relationship context of challenging child behaviors. This perspective extends beyond a traditional focus on decontextualized interactions where parents respond to noncompliant or coercive behaviors to a focus on the larger relationship
context in which such interactions occur. Second, this study provides insight into the phenomenon of noncompliance as it appears in a clinical sample of children whose behaviors were maladaptive and difficult to manage by their mothers. These analyses provided evidence for two qualitatively different contexts of children's challenging behaviors – ordinary resistance and extreme aggression. Third, this study provides insight into experiences with practitioners that mothers perceive as helpful and not helpful when accessing parenting services for their children's challenging behaviors. Clinical implications are also discussed.
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Introduction: Deconstructing Noncompliance

Children’s propensity to conform or obey, or alternatively to resist or disobey requests and expectations of parents is a common phenomenon of family life, a central focus in research on socialization and a frequent target of interventions in the family (Kalb & Loeber, 2003; Patterson, 1982). However, many different theoretical constructions of this behavior are evident in the socialization literature. For example, Kuczynski and Hildebrant (1997) reviewed four different ways that children’s conformity and resistance that included traditional authoritarian perspective, an external control perspective, an internal control perspective, a resistance and autonomy perspective and a relational perspective. Each of these theories offer different ways of thinking about the origins of children’s resistance and conformity and different directions for how parents should respond to children’s behaviors.

Among these theories the external control perspective, also known as the behavioral perspective, has dominated the applied literature on clinical interventions in the family. In the behavioral perspective children’s nonconformity is conceptualized as noncompliance. Parents who perceive their child’s noncompliant behaviors as problematic are often referred to family support systems, such as parenting training programs, in an attempt to reduce children’s noncompliant behaviors (Barkley, 1987; Dishion et al., 2008). Specific programs, such as the Triple P: Positive Parenting Program (Sanders, 1999), or the Incredible Years Parenting Program (Webster-Stratton, 2011), are informed by behavioral definitions of noncompliance that suggest children should comply immediately, completely, and without complaint to parental requests (McMahon & Forehand, 2003)

Consequently, the focus of behavioral parent-training programs is on teaching parents how to authoritatively communicate commands and enforce them with negative consequences if
children do not respond to the command (McMahon & Forehand, 2003; Webster-Stratton & Mihalic, 2001). A common recommendation in these programs is that parents should be trained to define children’s noncompliance as a coercive behavior and suppress noncompliant children’s behaviors immediately after they occur (Forgatch, Beldavs, Patterson & DeGarmo, 2008). Despite evidence of success for interventions that use the behavioral definition of noncompliance (de Graaf, Speetjens, Smit Wolff, & Tavecchio, 2008; Reid, Webster-Stratton, & Hammond, 2003) as well as evidence that noncompliance defined in this way is predictive of various mental health outcomes (Kazdin, 2003; Romano, Tremblay, Boulerice, & Swisher, 2005) it remains the case that alternative conceptualizations of children’s nonconformity have been mostly ignored in the clinical literature. Moreover, there has been a failure to distinguish between children’s nonconformity and resistance as a phenomenon and noncompliance, which is a specific theoretical construction of the phenomenon.

According to Haig (2005) researchers should distinguish between phenomena, theory, and data. Phenomena are recurrent, relatively stable, features of the world that researchers seek to explain. Although they often take the form of empirical regularities, phenomena are comprised of objects, events, states, processes and any other features that may be challenging to classify (Haig, 2005). Data is differentiated from phenomena, because unlike phenomena, they are a result of a larger interaction of causal factors and are not general or stable. Data are suggested to be pliable and perceptually accessible, observable and open to public scrutiny, whereas phenomena are abstracted from data and result from processes of data analysis. Lastly, theories are constructed to further comprehend phenomenon, in an organized, rational, and logical manner (Haig, 2005). In the present thesis, the phenomenon under investigation can be generally described as children’s responses that do not conform to parental requests or expectations but
“noncompliance” is one of a number of theoretical constructions that exists in competition with other theoretical constructions and phenomenon that are available in the developmental and clinical literature.

Since the review by Kuczynski and Hildebrant (1997), there have been many advances in theory and research on children’s nonconformity particularly in families that do not specifically report maladaptive or problematic levels of nonconformity. In such families, children’s resistance and nonconformity can now be viewed as a multifaceted phenomenon with different underlying processes (Robson, Burke, Kuczynski & Song, 2015) that is expressed overtly and covertly and with varying levels of social skill (Parkin & Kuczynski, 2012). Moreover, parents have been found to respond to children’s resistance in a highly contextualized manner that depends on the nature of the social situation (Grusec & Davidov, 2010; Smetana, 2006). In addition, Cavell (1992) suggested that behavioral parenting programs that target specific noncompliant child behaviors should instead consider more selective discipline strategies that simultaneously balance firm limits and positive dyadic exchanges between children and parents.

The literature review explores how the phenomenon of noncompliance has been depicted at two levels of analysis, noncompliance as a theoretical construct and noncompliance as a clinical construct. First, middle childhood will be briefly examined, then three theoretical constructions of noncompliance will be reviewed: social interactional theory (Patterson, 1982), social relational theory (Kuczynski & De Mol, 2015), and attachment theory (Ainsworth, 1974; Bowlby, 1969). Lastly clinical constructions of noncompliance will be used to explore clinical literature and practice, and how clinical constructions of this phenomenon influence current parenting programs. Walsh’s (2003) critique of deficit and strengths based discourses in clinical practice will also be examined.
Middle Childhood

Middle childhood was of particular interest in this study because historically the majority of the literature on children’s noncompliant behaviors has heavily emphasized infancy and adolescence (Maccoby, 1984; Maccoby & Martin, 1983; Kalb & Loeber, 2003). The limited research examining noncompliance in middle childhood has often been focused on how parents have worked to change their children’s behaviors (Collins, Maccoby, Steinberg, Hetherington, & Bornstein, 2000; Maccoby, 2007). Although there have been refinements in this literature, research is required to promote a deeper understanding of parent-child relationships and the nature of noncompliance and resistance in early and middle childhood. In middle childhood, children who do not fit the traditional, commonly accepted view of normal child behavior were most likely to be identified as noncompliant by the adults in their lives such as, child care providers (DuPaul, McGoe, Eckert, & VanBrakle, 2001), teachers (Rimm-Kaufman, La Paro, Downer, & Painta, 2005), or parents (Barkley, 1987).

Noncompliance as a Theoretical Construct

The phenomenon of children not always doing as parents request or expect has been constructed in numerous different ways including noncompliance, resistance, and non-responsiveness. In the following section three theories are reviewed that offer different directions for understanding the phenomenon of children’s nonconformity to parental expectations: social interactional theory (Patterson, 1982), social relational theory (Kuczynski & De Mol, 2015), and attachment theory (Bowlby, 2005). These theoretical approaches have been selected based on their different directions and perspectives regarding children’s nonconforming behaviors and their influence on practice or their potential to influence practice in the future. The origins of these theories, key conceptions of child and parental behavior, agency and causality will be
explored to provide a theoretical analysis of child noncompliant behaviors. Agency is a dimension that will be used to explore parents and children’s capacity to initiate change, make sense of their environment, and make choices (Kuczynski, 2003). Causality is a dimension that will be used to explore parent-child interactional patterns and how the selected theories consider each individual’s ability to influence change in the relationship. Lastly, relationship context is a dimension that will be used to explore how exchanges between parents and children are conceptualized and what meaning is given to these exchanges.

**Social interactional theory (Behavioral perspective)**

Social interactional theory, proposed by Patterson (1982) underlies what is more commonly referred to as a behavioral parent training perspective (McMahon & Forehand, 2003), is rooted in Skinnerian and Hullerian learning theories and focused on learned connections between stimuli and responses (Maccoby, 2007; Reitman & McMahon, 2013). Patterson suggested that external behavioral contingencies, such as a child being punished for refusing to comply with a parental request, have a stronger causal role than internal cognitions such as relational expectancies. This research informed Patterson’s social interactional theory, in which child behaviors are suggested to be direct by-products of social exchanges and elicited by observable stimuli in immediate social environments (Patterson, Reid & Dishion, 1992).

The origin of children’s noncompliance in social interactional theory is described within the framework of Patterson’s coercive process theory (Patterson 1994; 2004), as a deviant coercive behavior (Chamberlain & Patterson, 1995) that occurs when children do not do what has been requested by parents or an authority figure (Patterson, Ray, Shaw & Cobb, 1969). Children are considered noncompliant when they fail to immediately carry out parental demands or to abide by a long-standing rule that was previously communicated by their parents.
Coercive process theory (Patterson, 1982; Reid, Patterson, & Snyder, 2002) is a model of bidirectional processes between the parent and the child, behavioral contingencies that describes how children and parents train one another to behave aggressively to each other. Patterson (1982) argued that aversive interactions between children and parents become engrained, leading to cyclical aversive interaction patterns, which increase the probability of children developing aggressive behaviors. In this cycle, Patterson proposed that parents demand compliance and children refuse compliance, which is detrimental if parents capitulate or back down. These coercive interactions are viewed as fundamental mechanisms that cause child aggression to emerge and stabilize during child development (Patterson, Dishion, & Bank, 2006).

Parents are instructed to deliver clear, forceful, and direct commands that are antecedents for compliance (Forehand & McMahon, 1981). Children are expected to comply to parental requests in 5-15 seconds or else the interaction is deemed unsuccessful (McMahon & Forehand, 2003). Parents are discouraged from using low power strategies such as explanation, negotiation, and reasoning, which are deemed ineffectual for eliciting immediate compliance (Kuczynski & Hildebrant, 1997; Forehand & McMahon, 1981).

The quality of the parent-child relationship is not an essential consideration in social interactional theory (Kuczynski & Hildebrandt, 1997). Patterson, Reid and Dishion (1992) suggested that the predictability and positivity required for stable parent-child relationships can only be established once children’s aversive behaviors, such as noncompliance, have been suppressed and parents have ensured that they are consistently and effectively experiencing compliant child behaviors. Good parent-child relationships appear to be consequences of compliance.
Conception of children’s behavior: Social interactional theory

The construct of noncompliance evident in social interactional theory has been researched using clinical populations. Since the 1960’s Patterson and colleagues at the Oregon Social Learning Centre have focused on researching children whose parents have accessed clinical parenting support due to concerns with aversive, aggressive, antisocial or problematic behaviors (Patterson, 1982). In this literature, children’s noncompliant behavior is depicted as the presenting problem for numerous diagnosed disorders such as depression, oppositional defiant disorder, attention deficit hyperactivity disorder and anxiety (Barkley, 1997).

In social interactional theory children’s behavior is largely defined by whether they are compliant. Noncompliance is described negatively, and is implicated to be the development of coercion and aggression (Patterson, 1982; Hollenstein, Granic, Stoolmiller & Snyder, 2004) and leads children to disobey their parents (Patterson, Reid & Dishion, 1992). By using noncompliant behaviors children are considered to be influential agents in bidirectional parent-child interactions, but this is a narrow and unconstructive view of agency whereby children coerce or manipulate parents to achieve their goals or evade parental efforts to influence them (Patterson, 1982). Patterson and colleagues described noncompliance as the beginning of an interconnected chain of child aversive behaviors that can lead children to experiencing conduct disorders (Patterson, 1974), peer rejection (Patterson, Reid, & Dishion, 1992), academic failure (Patterson, 1982), and serious behavioral issues (Patterson, 1982).

Conception of parent’s behavior: Social interactional theory

In social interactional theory (Patterson, 1982) children’s compliance and noncompliance are considered to originate in parents’ discipline and control practices for managing children’s behaviors. Good or skillful parenting practices, such as providing immediate consequences for
noncompliant child behaviors, promote compliance. Whereas inconsistent or unskillful parenting, such as giving in to a child’s request, or allowing compromises, promote and escalate noncompliant behaviors. Parents are active agents in social interactional theory, in the sense that they can arrange external behavioral contingencies to increase desirable child behaviors and decrease noncompliant child behaviors (Patterson, Reid, Jones, & Conger, 1975).

Additional concepts and empirical findings frequently cited in support of the behavioral management approach to parenting often comes from research on Baumrind’s (2012) parenting styles. Baumrind argued that skillful or authoritative parents use non-coercive power assertion, which Baumrind operationalized as confrontive power, whereas parents who are unskilled or authoritarian assert coercive power. Confrontive power assertion was defined as when parents “confronts when child disobeys, cannot be coerced by the child, successfully exerts force or influence, enforces after initial noncompliance, exercise power unambivalently, uses negative sanctions freely, and discourages defiant stance,” (p.37). For example, in the authoritative parenting style (Baumrind, 2012), the parent considers children’s attempts to negotiate, but in the end, the parent decides and exercises control to enforce compliance.

Social relational theory

Social relational theory (Kuczynski & De Mol, 2015) is a theoretical framework for studying parent-child dynamics from a developmental psychology perspective with a focus on family processes in normally developing families. Sources of the theory come from research on bidirectional processes of socialization building on the foundations of transactional models of human development (Sameroff, 1975; 2009), theory and research on parent-child interactions (e.g. Bell, 1968; Maccoby & Martin 1983; Grusec & Goodnow, 1994), research on personal relationships (Hinde, 1979; Maccoby, 2000), attachment theory (Ainsworth, 1982), and
contributes a broad conceptualization of parent-child relationships. In social relational theory parents and children are both considered to be active agents with the capacity to initiate change and make sense of their environments (Kuczynski, 2003). Transactions that occur between children and parents, who draw on individual, relational, and cultural resources to create contexts that make children and parents vulnerable and receptive to one another’s influence (Kuczynski & De Mol, 2015).

In social relational theory, children’s nonconformity to parental requests is described as “resistance” rather than noncompliance. Resistance is conceptualized as an expression of children’s autonomy that is co-regulated by parents and children within the constraints of close parent-child relationships (Kuczynski & Hildebrant, 1997). Resistance reflects children’s agency, including interpretive capacity and their ability to express autonomy within parent-child relationships (Kuczynski & Parkin, 2007).

The nature of influence in this model flows from parent to child and from child to parent (Maccoby, 1992). Parents and children are described as influencing one another by interpreting, constructing and responding to meanings from one another’s behaviors. Parents and children construct mutual expectations that reflect their experiences and individual understanding of making a difference in their relationships (De Mol & Buysse, 2008; Kuczynski & De Mol, 2015). These meanings are then resisted, accommodated or negotiated based on the mutual expectations of the parent-child relationship (Kuczynski & Parkin, 2007). Kuczynski and De Mol (2015) suggested that resistance should be understood in the holistic context of a mutual relationship which is described as close, interdependent, and enduring having a past and future dimension which affect the dynamics of interactions occurring in immediately present interactions.
Theoretical concepts and empirical support comes from research in developmental psychology, which has focused on non-clinical populations. In social relational theory, the focus has been on non-clinical populations where parents are assumed to be functioning well and children are assumed to be developing normally. The construction of resistance evident in social relational theory research is largely based on families who are well-educated, white and middle-upper class (Kuczynski, Robson, Burke, & Song, 2015; Robson & Kuczynski, 2013).

**Conception of children’s behavior: Social relational theory**

In social relational theory, the foundations of children’s cooperation with parental requests come from the history of cooperation and mutual responsiveness built up in the history of the parent-child relationship rather than shaped by parental discipline practices (Maccoby & Martin, 1983). Child agency is a major proponent of social relational theory. Kuczynski and De Mol (2015) suggested that parent-child relationships are the context for parents and children to create expectancies and meaning together. In this approach parents and children are described as equal agents with inherent capacities to initiate change and make sense of their environment (Lollis & Kuczynski, 1997). Parents and children use their agency to organize dyadic behaviours, such as resistance.

Social relational theory provides a more multifaceted perspective than behavioral perspectives on the forms of children’s opposition as well as the function and responses to children’s opposition. Resistance takes many forms that reflect the dimensions of assertiveness and social skill. For example, toddlers have been found to express direct defiance, passive resistance, simple refusal and negotiation (Kuczynski, Kochanka, Radke-Yarrow, & Maguire, 1987; Kuczynski & Kochanska, 1990). During middle childhood, resistance takes more differentiated forms such as negotiation, unresponsive/delay/ignore, minimal cooperation and
communication of non-acceptance (i.e. “attitude”) (Kuczynski, Robson, Burke, & Song, 2015). In adolescence resistance takes both overt forms such as direct opposition or negotiation and covert forms such as partial disclosure or concealed transgressions (Parkin & Kuczynski, 2012). Parents may experience resistance negatively if it is expressed in an unskilful manner that fails to accommodate the others perspective. Resistance may be experienced more positively if it is interpreted as a normal sign of children’s developing autonomy (Robson & Kuczynski, 2013) or if it is expressed in a positive or constructive manner such as negotiation (Kuczynski & Kochanska, 1990).

Conception of parent’s behavior: Social relational theory

In social relational theory parents are considered to be co-acting agents who are embedded in an enduring, ongoing, interdependent relationship with their children. Parents contribute to a history of interactions with their children over time, and based on the mutual expectations developed throughout the parent-child relationship, the emergent relationship becomes the context for future interactions (Kuczynski & De Mol, 2015).

Both parents and children are active agents who contribute to the mutual expectations developed in their relationship. Kuczynski (2003) argued that unequal power in parent-child relationships takes the form of an interdependent asymmetry. Parents have more experience, capacity, knowledge, and resources to draw upon in comparison to their child. Children have resources such as coercion, persuasive ability, and their own relationship with parents to support their influence on parents. Research suggests that parents use this experience to guide their responses to children’s resistance. For example, parents may take into consideration their children’s emotional state, their own emotional state, the circumstances of the situation, or the individuals present at the interaction before determining if they should respond to resistance with
leeway, flexibility, or confrontation (Robson & Kuczynski, 2014; Kuczynski, Robson, Burke & Song, 2015). Robson and Kuczynski (2014) suggested that, except for specific areas such as safety, parents did not conceive their rules as firm and inflexible. Rather parents allowed leeway as an important component of parent-child relationships, that enabled parents to adapt to develop, negotiate based on the situation and respond to resistance in a co-regulated manner.

**Attachment theory**

Bowlby (1969) and Ainsworth’s (1974) original attachment hypotheses explored children’s level of security and feeling of protection in their relationships with their mothers. Attachment researchers have examined responsivity in mother-child dyads, and suggested that consistent responsiveness from parents serves a protective function in terms of how children and parents participate in interactions (Richters & Waters, 1991; Stayton, Ainsworth & Main, 1971; Stayton, Hogan & Ainsworth, 1971). Subsequently, these insights about secure attachment as a source of children’s cooperation have given rise to applications such as attachment therapy and attachment based parenting interventions (Marvin, Cooper, Hoffman & Powell, 2006).

**Conception of child’s behaviors: Attachment theory**

Bowlby’s (1969) and Ainsworth’s (1982) attachment theory conceptualises noncompliance as the child’s non-responsiveness to parental messages. Responsiveness is described as children’s capacity and willingness to coordinate affect, cognition, and behavior to appropriately respond to their parent’s request (Kochanska, 2002; Matas, Arend & Sroufe, 1978). Children may vary their responses based on their developmental capacity, level of security, and previous attempts to exert influence when under stress (Kochanska, 2002).

Attachment theorists are particularly interested in parent-child bonds and how parent-child attachment styles can mediate children’s capacity to function independently (Maccoby,
1992). Children are described to have internalized their early attachment experiences with parents, which is represented in how much security and trust the parent-child relationship maintains over time (Maccoby, 1992). Kochanska (2002) suggested that children are more likely to be responsive, or to harmoniously interact with parents, when they have a history of positive interactions in which their needs, bids for attention, or attempts to exert influence were appropriately responded to by their parent. Non-responsiveness to the parents’ requests therefore may stem from children’s previous history of nonresponsive or insensitive interactions with their parent.

Conception of parent’s behaviors: Attachment theory

The nature of influence in attachment theory is parent to child, with the parent taking on the role as the provider of security for their child, responsible for meeting their child’s needs (Maccoby, 1997). The role of the parent is suggested to differ based on the type of attachment they have developed with their child. For example, children who are insecurely attached to their parents may exert influence by screaming and crying, causing their parent to respond immediately (Bowlby, 2008). In contrast, children who are securely attached are more likely to be confident in exerting influence and remain calm because of the security provided by their relational history in which their parent was appropriately responsive to their needs (Cummings & Schemerhorn, 2003).

Clinical Constructions of Noncompliance

Clinical perspectives on noncompliance have developed from families accessing services for the presenting problem of children exhibiting challenging behaviors. These behaviors are often framed as noncompliance or aggression. In this section, multi-stressed families, clinical approaches to noncompliance and clinical discourses will be examined.
Multi-stressed families

Multi-stressed families are one of the diverse groups of families in which noncompliance may be a presenting problem. The term multi-stressed reflects an attempt to recognize the difficult realities of families’ lives while still orienting service providers to capacities and abilities of families (Madsen, 2013). The argument is that children’s noncompliant behavior is not only influenced by family dynamics but is also influenced by numerous contextual factors such as socio-economic status (Shaw et al., 1998), addiction (Stein, Newcomb & Bentler, 1993), mental health differences (see Downey & Coyne, 1990) or intimate partner violence (Carlson, 2000). Although the presenting problem for families may be noncompliance, researchers have argued that children noncompliance may also present based on diagnoses such as conduct disorder (Dadds, Sanders, Morrison & Rebgetz, 1992), oppositional defiant disorder (see Burke, Loeber & Birmaher, 2002) or attention deficit hyperactivity disorder (see Cantwell, 1996). One of the main arguments evident in literature regarding multi-stressed families is that considering the contexts in which families take part in enables researchers and practitioners to consider the strengths, knowledge, and resources that families possess to address these stressors (Madsen, 2003).

Clinical approaches to noncompliance

Diverse clinical approaches differ in the way they construct or treat challenging child behaviors. In this study, three approaches will be examined that provide support to families whose children are exhibiting challenging behaviors that will be explored: behavioral/child guidance movement, attachment based approaches and lastly family therapy perspectives on the presenting problem of noncompliance. Further, the clinical discourses underlying clinical approaches will be examined.
**Behavioral and child guidance movement**

Behavioral approaches to noncompliance can be understood as a part of the larger approach known as the child guidance movement. This movement enhanced focus on noncompliant child behaviors. Practitioners began to work with teachers, parents and other authority figures to provide feedback regarding how they should be responding to their children’s behavior. The goal of the child guidance movement was to implement early psychological interventions, to deter children from manifesting noncompliant child behaviors, which would lead to problematic development. Child noncompliant behavior was described as a psychological disturbance that was assumed to be disruptive (Rasheed, Rasheed & Marley, 2011).

Children’s noncompliant behaviors became most commonly defined based on parents’ perceptions and assessments. As children developed, what parents noticed most often was whether children were complying with rules and if they avoided disrupting others in their day-to-day interactions. Family life was explored with interest only to the extent to which each parent had an impact on a child’s life (Rasheed, Rasheed & Marley, 2011). This focus on noncompliance is evident in clinical practice, where parents are given instructions in parenting programs to have clear, explicit commands and are trained that their child should respond immediately to these commands. Thus, most parenting programs were designed to reduce noncompliant child behavior and, due to the focus on altering child’s noncompliant behavior, often bear resemblance to Patterson and colleagues parent training program (Kalb & Loeber, 2003).

Social interactional theory is a common theory underlying behavioral parent training programs. An important tenet of discipline and reinforcement parenting programs is behavioral
modification (see review in Kaminski, Valle, Filene & Boyle, 2007). A few prominent examples of parent education programs and interventions informed by social interactional theory are The Triple P - Positive Parenting Program (Sanders, Markie-Dadds & Turner, 2003), Parent Management Training (Patterson, 1982) and Helping the Noncompliant Child Parent Training Program (Forehand & McMahon, 2003).

Parents are trained to modify children’s behavior by using clear commands and enforcing negative consequences for noncompliant behavior (Guillon & Patterson, 1968; Patterson, Reid & Dishion, 1992; Snyder & Huntley, 1990). In these programs, there is rarely a theoretically integrated position on relationships (Kuczynski & De Mol, 2013) because the parent-child relationship context is not considered essential for obtaining and maintaining compliance (Patterson, 1982). Therefore, parents are assumed to be capable of implementing the child management protocol that they have learned in the program in various contexts, including their family home (Sanders, 1999). Research has suggested that discipline and reinforcement parenting programs have been extremely effective for families who are dealing with noncompliance (see Brestan & Eyberg, 1998) but also that these programs fail to address relationship complexities (Malin, 1997) and neglect the long-term implications of the parent-child relationship (Cairns & Cairns, 1994).

**Attachment approaches**

Over the past decade, attachment theory has become a more common theoretical framework for parenting support systems (Marvin, Cooper, Hoffman & Powell, 2006). Attachment based parenting programs are also becoming more commonly endorsed by clinical practitioners (Marvin, Cooper, Hoffman & Powell, 2006). Attachment interventions address noncompliance but are focused mainly on the parent-child relationship. The central feature of
attachment based parenting programs is security, and that the child or adolescent can make sorties into the world with the knowledge that upon returning to their primary caregiver, their physical and emotional needs will be met (Bowlby, 1988). There are numerous different programs that utilize an attachment framework (see Zeneah, Berlin & Boris, 2011 for review) including, for example, the Circle of Security. In this program parents are introduced to the ideas of a secure base and safe haven (Ainswoth, Blehar, Waters & Wall, 1978), and the ways that their child may be cuing or miscuing them. Over the course of the intervention the goal is for caregivers to comprehend their children’s signals and how to respond to signals. This program was designed to be individualized for each caregiver-child dyad, and to use evidence based assessment procedures (Marvin, Cooper, Hoffman, & Powell, 2006).

**Family therapy approaches**

Children’s challenging behaviors, including noncompliance, is also frequently the presenting problem for which families come into family therapy. In earlier family therapy approaches challenging behaviors were regarded as acting out (Minuchin, Auerswald, King & Rabinowitz, 1964). Acting out is defined as children’s capacity to use templates from historical family interactions in an attempt to reformulate patterns of interaction that serve only the needs of an individual child (Kerr, 1991; Minuchin, Colapinto, & Minuchin, 2007).

More recent postmodern perspectives explore communication patterns in the family as well as emphasize communication between the therapist and the parent client. These postmodern approaches challenge dominant discourses and universal truths, encouraging professionals to consider the ways that language, knowledge and experience is contextualized in historical, communal, cultural and social processes (Anderson, 2012). Further, this theoretical approach to therapy suggests that in gaining an understanding of these various contexts, therapists can engage
in a collaborative relationship with clients, by participating in mutual inquiry and meaning making (Anderson, 2012). This movement in family therapy places the client as the expert of their own experience and the therapist as a participant-observer or participant-facilitator (Anderson & Goolishian, 1992). The professional and the client are both viewed as interpretivists, developing and responding to meaning as dialogue is generated (Anderson, 1997). In postmodern approaches the therapeutic relationship moves from traditional understandings of the professional as the “knower” to a process of shared inquiry with the client (Gergen, Hoffman & Anderson, 1996).

Related to family therapy’s emphasis on communication between the therapist and client, is the therapeutic alliance. The therapeutic alliance is defined as the strength and quality of the connection between an individual and professional (Horvath & Bedi, 2002). Existing literature has emphasized the importance of the professional and client relationship, suggesting that it is one of the strongest predictors of change when receiving professional services (Horvath & Symonds, 1991; Friedlander, Escudero, Heatherington & Diamond, 2011). There are various components of this therapist-client relationship that have been suggested to be particularly important to the therapeutic alliance, such as engagement, a shared sense of purpose and emotional safety (Friedlander, Escudero, & Heatherington, 2006). Further, one of the central roles of this alliance is for professionals and clients to develop a common sense of purpose regarding client goals and how to use the therapeutic context to work towards these goals (Escudero, Friedlander, Vaerla & Abascal, 2008).

Clinical discourses

Walsh (2003) identified two types of practical discourses that are evident in socialization literature: deficit discourses and strengths based discourse. In deficit discourses, researchers and
service providers are focused solely on family problems and issues and good family functioning is equated with an absence of symptoms (Gergen, 1994). In contrast, in a strengths based discourse researchers and service providers focus on families’ strengths and resources in an attempt to enhance family functioning (Nichols & Schwartz, 2011; Walsh & Crosser, 2000). Saleebey (1996) suggested that Western parenting literature has become saturated in deficit discourse, focused on pathology, deficit, problem and disorder. This pathologizing orientation has led to the objectification of children’s problematic behaviors and parental incompetence, suppressing positive possibilities (Saleeby, 1996).

Each theory explored earlier can be analyzed from the perspective of deficit or strengths discourses. Social interactional theory (Patterson, 1982) and attachment theory (Bowlby, 1967) appear to have underlying deficit discourses. These theories identify problematic noncompliant or a lack of responsivity to child behaviors and suggest that it is parents’ role to enforce their parental authority to rectify these behaviors. In comparison, social relational theory and postmodern family therapy perspectives endorse a strength’s based discourse. In social relational theory, Kuczynski and De Mol’s (2015) theorized resistance as a form of agency and developing autonomy. Conflicts regarding resistance are framed as an inherent aspect of parent child-relationships, in which parents and children are given an opportunity to be flexible regarding expectations. This flexibility is developed based on past experiences and enacted while considering future interactions and the unique trajectory of the parent-child relationship (Parkin & Kuczynski, 2012). In family therapy, families and therapists work together towards amplifying family strengths and resources (Walsh, 2013). Therapists collaboratively engage with families to develop client-centered goals (Anderson, 2015).

Clinical perspectives: Next steps
In summary, there are numerous theories and perspectives that underlie clinical parenting support services. Although many of these services have been successful in effectively providing support for families given the diversity of services, conceptions of resistance and approaches, an integral component that appears to be missing is parental views and lived experiences. This gap in the literature, and the ongoing complexities of comprehending children’s challenge behaviours and parent-child relationships, provide the foundation for this study.

**Study Rationale**

**Purpose**

The purpose of the current study is to gain a better understanding of the phenomenon of children exhibiting noncompliant behaviors from the perspective of parents who seek clinical services for these behaviors. There is little literature that explores parents’ perspectives on parenting children with the presenting problem of noncompliance or resistance, and how support system recommendations or strategies fit with parents’ lived experiences. Further, the research that does exist is often quantitative in nature and uses quantitative tools such as scales or questionnaires to measure parental experiences (see Kalb & Loeber, 2003). The objectives of this study were to qualitatively a) gain insight into parents’ experiences of noncompliant child behaviors in middle childhood, b) further comprehend the phenomenon of noncompliance, and c) explore any differences or similarities in parents’ lived and parenting program experiences.

**Research questions**

The specific research questions of this study are as follows:

1) How do parents experience their relationships and interactions with their children who exhibit noncompliant behaviors?
2) What are parents’ experiences of receiving and attempting to receive parenting support for their children’s noncompliant behaviors?

The purpose of these research questions was to focus broadly on parents’ lived experiences of parenting and accessing parental support systems. Further, to explore the ways in which parents described and responded to their children’s behaviors. Rather than assume or anticipate the ways that mothers experienced this phenomenon, these questions guided the priorities of this study, which was to qualitatively examine the mothers’ constructions and lived experiences of parenting. More specifically, the purpose of the first research question was to learn from these parents how they described their relationships with their children and their children’s behaviors. In the semi-structured interviews parents were asked about the nature of the relationship with their child and the nature of exhibited behaviors. The purpose of the second research question was to learn from these parents how they experience accessing parenting support systems, and the sources or forms of support that worked for their family. In the interview, parents were asked about the seeking support, and how these supports fit with their needs.

**Research Design and Methods**

**Grounded theory methodology.** Grounded theory methodology (GTM) was used in this study to collect and analyze the data. GTM provided a framework to examine social psychological processes, organize and analyze data and generate theories that describe and explain social processes (Charmaz, 2005). The aim of grounded theory is to discover and define processes by developing a theoretical analysis of data collected which has relevance to a specific field of study (Charmaz, 1996). There are several distinguishing features of GTM. First, research questions are typically more general rather than tightly framed preconceived hypotheses. These
questions are used to guide grounded theorists in following interests, hunches and leads that they may identify while gathering the data (Charmaz, 1990). In this study, this approach enabled me to consider multiple realities, and use these broader research questions as tools for inquiry (Charmaz, 2002).

Secondly, researchers using GTM will collect and generate data at the same time. Due to simultaneous data collection and analysis, in which the researcher is moving back and forth between identifying the similarities among and differences between the emerging categories (Charmaz, 2001; 2006). As suggested by Daly (2007) this enables researchers to develop explanations in the process of collecting and analyzing data. Throughout this study, to the best of my ability, I analyzed the data after each interview, allowing me to subsequently gather more data based on emerging questions and themes (Charmaz, 1996). The ongoing analysis contributed to changes and adjustments in the interview, based on the past participants’ responses.

**Constructivist grounded theory.** Constructivist grounded theory (CGT) emphasizes the influence of the researcher, participants and their relationship on the analysis and interpretation of data (Charmaz, 2006). In CGT Charmaz (2006) argues that the process of gathering and interpreting data is never neutral, rather researchers can position themselves as participants in the construction of understanding. This enables researchers to be focused on interpreting the meanings of process or experience, rather than attempting to access a single truth (Charmaz, 2000). A CGT approach encourages researchers to reflect on the influence of their knowledge, interests and theoretical orientations in conjunction with their relationship with research participants (Daly, 2007). Participants are considered active partners in the research process, with the capacity to negotiate, process and reflect on their lived experiences (Charmaz, 2006).
Theoretical sensitivity. Theoretical sensitivity is a principle common to many qualitative approaches that recognizes the role of preexisting ideas such as theory, empirical literature, and experience in the researcher’s initial approach to the exploration and interpretation of data (Kuczynski & Daly, 2003). Throughout this study there were multiple theoretical sources that informed my thought processes, analyses and reflections. Particularly important sources of contrasting initial ideas regarding parenting and the nature of children’s challenging behaviors were the behavioral orientation of social interactional theory with its focus on coercive processes (Patterson, 1982) and the developmental orientation social relational theory with its focus on relational processes and children’s agency (Kucyznski & De Mol, 2015) and attachment theory, with its focus on parent-responsiveness and child security (Ainsworth, 1974; Bowlby, 1969). An important component of grounded theory is sensitizing concepts. Blumer (1953) defines sensitizing concepts as general points of reference that provide guidance in approaching empirical instances. Rather than the specifications of attributes or benchmarks, sensitizing concepts merely suggest directions along which to look. These concepts are background ideas that offer ways of organizing, seeing, and understanding experiences that are embedded in disciplinary emphases (Charmaz, 2003). In the present study, the primary sensitizing concepts were theoretical constructions such as behavioral, relational and attachment, social constructions such as strengths and deficit discourses, and clinical constructions of noncompliance, which are described in the literature review.

Sensitizing ideas served two functions in this study. The contrasting theoretical concepts and practical experiences provided sensitizing ideas that initially guided my research questions and analyses of the narratives. In the interview questions the probes were designed to be non-leading to give space for the parents to fill in meaning. During the analysis, the sensitizing
concepts provided an initial guide to the interview, but I prepared myself to be surprised by the data and to capture unique ideas that are not present in existing theories. However, the sensitizing ideas also enabled me to identify ideas in the data that did not conform to existing ideas. Thus, I was alert to ideas in the narratives that contradicted existing theory or were not present in the literature. These contradictions provided conceptual puzzles that guided novel interpretations (Kuczynski & De Mol, 2015).

I position myself within a social constructivist epistemology and therefore recognize that I elicited a particular version of a participants’ reality (Daly, 2007). I attempted to be cognizant of the ways that my personal, professional, and academic experiences may influence my perspective. My experiences working as a family therapist has afforded me familiarity with some of the challenges and strengths evident in parenting support systems. I also recognize that in my professional practice I practice from a narrative, strength-based, relational lens. I am aware that I, as the primary researcher, had an influence on the findings.

Methods

Recruitment. Ethics approval was received from the Research Ethics Board at the University of Guelph (see Appendix A). The participants of this study were mothers of children between the ages of 8-13 who had accessed parenting support systems for support concerning their children’s challenging behaviors. Parenting support systems were defined broadly as agencies or organizations that provided formal training or support programming for parenting children with noncompliant or resistant behaviors. A local non-profit counseling agency helped in recruitment by circulating recruitment posters to parents accessing one-on-one and group support for parenting children exhibiting noncompliant behavior. Posters (see Appendix B) were also circulated through various personal and professional connections, city centers,
community centers and local agencies. Compensation was provided to participants in the form of a $10 gift card to a location of their choice. Although recruitment posters stated parents (see Appendix B), only mothers responded to participate in this study.

**Participants.** Twenty-five mothers participated in this study. Mothers were asked to complete a demographic survey before the interview to gather information on the age and gender of the child, any diagnoses, and the nature of the formal supports that parents received (see Appendix C). The mothers in this study lived in southern Ontario. Their average age was 39 and ranged from 28-50. There were 16 mothers who identified as White/European, 3 who identified as Black/African/Caribbean, 2 who identified as Arab, 2 who identified as South Asian, 1 who identified as Canadian/Irish and 1 who identified as Latin American. There were 15 mothers who had graduated from college or university, 6 mothers who had completed high school and 4 mothers that had completed graduate education. Twelve of the mothers stated they were single, nine of the mothers were married, and four of the mothers were common law.

The ages of the target children ranged from 8-13, with an average age of 10 years. Thirteen of the children were male and twelve of the children were female. Nineteen of the children had siblings and 6 of the children did not. Each of these mothers stated that they had accessed support services for the presenting problem of challenging child behaviors. The services accessed by mothers varied and included family therapy, individual therapy, group therapy, or psycho-educational classes. Ten participants described services as following an attachment orientation, 5 participants described services following a behavioral orientation, and 1 participant described services following a trauma orientation. The other participants did not know the particular orientation of the program.
Eighteen children had been formally diagnosed (American Psychiatrict Association, 2013), with classifications that included: Asperger Syndrome, Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder, Anxiety, Conduct Disorder, Depression, Gifted, Oppositional Defiant Disorder, Sensory Process Disorder, Sleep Disorder, and Unspecified Learning Disability. The range of diagnoses reflects the diversity of conditions in which noncompliance can be a presenting problem.

The final sample size was determined based on consultation with my advisory committee and reaching theoretical saturation (Strauss & Corbin, 1998; Charmaz, 2006). Theoretical saturation is reached when no new theoretical categories emerge from the data, suggesting that the data collected is robust and compelling (Charmaz, 2006; 2012). Saturation is reached not based on repetition, rather based on the quality and richness of these theoretical categories (Charmaz, 2006). It is the role of the researcher to judge when saturation occurs and to determine when the complexity of the categories has been captured (Daly, 2007; Strauss & Corbin, 2008). In this study, elements of theoretical saturation became evident at around the twentieth interview. At this stage, participants were providing rich data detailing their experiences of parenting. In consultation with my committee, I interviewed five additional participants to ensure that no new ideas emerged that enhanced the core theoretical categories (Strauss & Corbin, 1998).

Interview. The interview guide (see Appendix D) was developed based on the research questions of this study. In grounded theory, the purpose of the interview guide is to develop an initial frame work to co-construct open ended conversation. This approach enables researchers to attend to the visibility of standpoints on the topic, and thus a range of viewpoints and hidden assumptions can become apparent (Charmaz, 2015). The interview guide in this study was
updated throughout the early stages of the study, using initial coding and categories emerging from participants’ interviews to shape the modified versions of the interview.

The semi-structured interview was divided into three sections. The first set of questions focused generally on the parent-child relationship and parenting. Mothers were asked about what it was like to parent their child, things they felt they did well as a parent, challenges and what has influenced their parenting style. The second set of questions focused on the nature of children’s challenging behaviors. Mothers were asked to describe and define what they viewed as challenging behaviors from their child. They were also prompted to describe how they responded to these behaviors and what they found helpful when responding. The second set of these questions were developed based on the critical incident technique (Butterfield, Borgen, Amundson, & Maglio, 2005). Mothers were asked to recall one incident of everyday resistance, and one incident of challenging or harder to manage child behaviors. The critical incident technique elicited specific situations from parents, which provided contextual richness to their narratives.

The third section of questions focused on parents’ experiences of support systems. Mothers were asked about their experiences accessing supports and the way these supports talked about challenging behaviors. Further, mothers were asked if they had the opportunity to provide feedback to a support system, or to other parents having similar experiences, what kind of suggestions or recommendations they would provide. The interviews took from one hour to two and a half hours to complete. Interviews took place on the phone and in person depending on the participant’s preference. Each participant received a ten-dollar gift certificate for participating, to a location of their choice.
Rapport building. An important part of this study was building rapport with the participants. I believe that rapport building is an integral part of qualitative research and that this had a major influence on the interview (DiCicco-Bloom, & Crabtree, 2006). In an attempt to build rapport early, I began conversations by describing the importance of researchers gaining a better understanding of parenting experiences and how to support families. I asked each participant in the first conversation where they would like their gift card to be from. I also tried to give multiple options to mothers regarding where they wanted to meet and what time. I attempted to be flexible and understanding of schedules, sometimes meeting later in the evening or early in the morning before school. I offered and provided bus tickets for mothers who needed support with transportation.

I explained to mothers that I work as a therapist in the community, specifically with families and children. I explained how long I have been working in the field and that for the last few years I have been providing support mainly for children and parents who experience violence and/or trauma. I spent time going over the consent form, demographic questionnaire and discussing duty to report in great detail. I answered any questions and provided information for community resources when asked.

The strengths based perspective I used throughout the interview helped me to continue to build rapport with parents. A strengths based perspective amplifies families’ strengths and resources in an attempt to enhance family functioning (Nichols & Schwartz, 2011; Walsh & Crosser, 2000). For example, one of the questions in the interview was “What is one thing you feel like you do really well as a parent?” In addition, the focus on parents’ actions may have enabled participants to reflect on their sense of agency in challenging situations. Lastly, upon
summarizing the results, I emailed a thank you and a summary to the mothers who participated in the study.

**Data analysis.** The collection and initial analysis of the data occurred simultaneously (Charmaz, 2006). Once the interviews were complete, I attempted to transcribe and analyze each interview before conducting another. This is an important part of GTM, which allows for changes to be made to the interview questions (Charmaz, 2006). This practice was an important component of the study that enabled me to conduct constant comparisons, and attune to the early process of theoretical sampling. I transcribed the first nineteen interviews myself and two research assistants completed the other six. We worked together to identify other forms of communication throughout the interviews such as pauses, laughter, inflection and sighs. The interviews were kept on my encrypted laptop.

I began with line by line coding, in which open coding was used to frame and distil the data from the interviews (Charmaz, 1996). This coding was aided by MAXQDA qualitative software, beginning with open coding (Charmaz, 2003). Open coding refers to the process of choosing ways or language to describe the data (Daly, 2007) that is active (Charmaz, 2003) such as anticipating or attending. In keeping the codes active I was able to consider processes, and focus on what mothers were actively doing during these processes (Charmaz, 1996). I attempted to use the language of the participants in order to illustrate their descriptions of experiences.

The next stage of coding was focused coding, which refers to when the researcher focuses on codes from the initial coding that continually reappeared (Charmaz, 1996; Daly, 2007). During this stage of coding I was more selective and conceptual, exploring whether mothers were making earlier responses more explicit and rich or if these initial codes were not applicable to a larger set of data (Charmaz, 2002). I considered which codes made the most
analytic sense, and began to organize data in a more complete and accurate manner (Charmaz, 1996). During this stage of analysis categories of meaning were progressively identified from the data. These categories were used to designate groups of instances that share central characteristics or features.

Typically, as GTM progresses the researcher can interpret, rather than simply label, instances of phenomenon. By categorizing, I was able to select codes that seemed to have an overriding significance in processes and explicating experiences in the data (Charmaz, 1996). For example, when I looked more closely at mother’s sense of the therapeutic relationship, I selected the category of “getting it” as one way mothers were describing the fit of the relationship. By raising a code to a category, I could consider the consequences of professionals getting it, the conditions under which professionals “got it”, and how getting it related to other aspects of accessing services (Charmaz, 1983; Glaser, 1978).

Throughout the process of initial, open, and focused coding, I used memoing to elaborate actions, assumptions and processes which are subsumed in data and code (Charmaz, 1996). Memos were a helpful tool to make comparisons, and engage in constant comparative methods (Glaser & Straus, 1967) by comparing participants’ responses, situations, and experiences. Straus (1987) suggested five types of memos: observational, reflexive, operational, textual, and conceptual or theoretical. I used observational memos to capture the setting of the interview, and what I experienced, saw or felt before, during or after the interview. I would typically write these memos before and after the interviews. Reflexive memos were used to consider my role in the interviews. In these memos I reflected on uncertainties, attending to power and privilege, feelings, and my experience of the participant’s experience. Operational memos were used to document ideas around analysis, categories, interview questions, and methodological
considerations. Textual memos were completed on an ongoing basis, in relation to the content of the interview. Lastly, conceptual or theoretical memos provided me with the opportunity to reflect on sensitizing concepts, categories and the ways my own preconceived notions were influencing the data.

**Trustworthiness.** In qualitative research, trustworthiness has been defined as the ability for a researcher to ensure that the research presented demonstrated rigour and consistency (Lincoln & Guba, 1985; Shenton, 2004). Lincoln and Guba (1985) outlined four types of trustworthiness: credibility, transferability, dependability, and confirmability. These types of trustworthiness were used in this study to ensure rigour.

Credibility is defined as the congruency between the results and the reality of the participants (Lincoln & Guba, 1985). In an attempt to ensure credibility, I met regularly with my advisor to discuss the emerging interpretations of parental narratives and the consistency of the coding. We reviewed each category and sub-category, exploring the transcript excerpts and developing comments based on these excerpts. Further, I also had regular committee meetings with my advisory committee, to increase the scope of the analyses and the theoretical interpretation of the data. My committee provided feedback and constructive criticism which aided in the credibility of the study. Lincoln and Guba (1985) also suggested that it is the responsibility of the researcher to ensure that an appropriate level of contextual information and thick description of the phenomenon under investigation is provided for readers to enhance transferability. In this study, I have provided numerous details regarding the phenomenon of noncompliance and the conditions in which this study took place.

In order to attend to dependability, I reported the processes within the study in great detail (Shenton, 2004). I developed an audit trail, which outlined and documented each step of
the study. Charmaz (2003) suggested that memos enable researchers to remain focused on the analysis, by keeping track of reflections, personal biases and emergent categories. I created memos before and after each interview, during the analysis and throughout the study. I used the memos for reflection, to consider biases, and develop categories and sub-categories (Daly 2007; Charmaz, 2002). Lastly, I established confirmability by using my memos and advisor/committee meetings to reflect on my own influence on the research process.

**Results**

The results are organized into three primary categories: mothers’ perceptions of their relationships with children, their perceptions of challenging behaviors, and their experiences of formal support systems. The first category captures mothers’ descriptions of their relationships with their children. Mothers indicated that their relationships with their children were complex and effortful to maintain, and required mothers’ continuous investment and determination. Within this category mothers described three different parts of their relationship with their child: providing security, experiencing closeness and hurt, and attending to authority.

The second category concerned how mothers perceived and managed their children’s challenging behaviors. Mothers described two qualitatively different kinds of challenging behaviors, ordinary resistance and extreme aggression, each of which involved different kinds of behaviors, different explanations and different approaches for managing the behaviors. The third category concerned mothers’ experiences of the support systems that they accessed for treating their children’s problem behaviors. Mothers reported a spectrum of positive and negative experiences while accessing support systems and described the ways in which the advice offered by their support systems differed from or matched their lived experiences of parenting.
**Parents’ characterization of their relationships with their children**

The first analyses considered the relationship context of children’s behaviors (see Appendix E) and four sub-categories emerged. The first sub-category *relational effort* indicated that mothers’ relationships with their children were close but complex and effortful to maintain. The remaining three sub-categories captured the ways that mothers were participating in the parent-child relationship by: (a) providing security, (b) experiencing closeness and hurt, and (c) acting as agents of socialization.

**Relational effort**

Mothers described the amount of effort that went into maintaining and enhancing the quality of the parent-child relationship. Mothers did not take their relationship with their children for granted but instead, expressed their determination to continuously work at improvements. For example, one mother reported, “I just guess it’s like a constant work. Every single day you don’t, you just don’t go into autopilot, you can’t and you shouldn’t. I try to be mindful of every minute and be purposeful” (Family 4, 9-year-old son). This relational effort was evident throughout these transcriptions but also, more specifically, in the sub-category of anticipating and knowing the child.

**Anticipating and knowing the child.** Mothers described the effort it took to anticipate and gain knowledge regarding the child’s actions and choices. Mothers stated it was important to “understand where they are coming from” (Family 4, 9-year-old son). Further, mothers explained that knowing how to respond to the uncertainty that their children generated was a skill that was honed “over time” with “hard work” (Family 14, 10-year-old son).

Mothers reported the most common way to predict their child’s behaviors was to consider the events that occurred before the behavior. One mother reported,
the most aggressive times, there is always something that, and maybe not right away, but eventually that you can pick up on and are like oh ya of course she is hitting. Like if she had a bad day, or one time she was missing her dad, or she got in fight with her friend. (Family 10, 12-year-old daughter)

Another mother said “Or D makes a new friend with a really sassy attitude, or her Dad forgets to pick her up. So I guess it’s like, I am working on knowing just sort of how to react in those moments or like what we need in those moments” (Family 16, 12-year-old daughter).

Mothers talked about the need to adapt to the changing circumstances of the child’s behaviors. Mothers stated that based on their knowledge of the child, their responses could fluctuate on a day to day basis. For example, one mother reported, “I wish I could tell you I have a magical wand that ‘poof’ helps but I don’t. I mean I try different things, and the things I try, are different depending on the day or what she’s got going on” (Family 8, 8-year-old daughter). She reported that her daughter’s behavior changed every day and therefore she worked on adjusting her parenting style accordingly. This mother explained,

I don’t know if I could say to you like – I am a strict parent all the time, or I am a laid-back parent all the time. I can be laid back and I can be strict. But it isn’t always the same because D is like never the same. She can be up the wall, or totally mellow, and sometimes you can predict it and sometimes it just hits you in the face. (Family 8, 8-year-old daughter)

One mother described how she was learning to predict which strategy worked better based on the emotion her child was experiencing,

like, sometimes she is just really sad or mad. And so I try different things to help, and sometimes they work and sometimes they don’t. So it’s like okay what’s next.
It's like having a Christmas list of stuff that you are checking off so like, okay sending to her room didn’t work when she was sad but it does work when she’s mad, so remember that and cross it off for mad. Or, like, okay taking away electronics when she’s mad or sad doesn’t seem to work, but if she is calm it might work, so keep that in mind. It’s complicated. (Family 10, 12-year-old daughter)

**Providing security for children**

Mothers reported that one of their important roles in the parent-child relationship was to provide security for their children. Mothers reported that they worked to be a “secure place” (Family 18, 12-year-old daughter) that their children can “come to and know I will be there for them” (Family 17, 13-year-old daughter). One mother said that in order to provide consistent and continuous security for their child she “have got to be grounded. It takes everything you have got” (Family 1, 13-year-old son). By providing unwavering security, mothers said that they hoped their children would feel comfortable turning to them no matter the circumstance. For example, one mother said “things can get pretty bad... like she spat or hit me.. but I am so relieved that she knows from what we have been through, that she can come to me” (Family 6, 11-year-old daughter). The two sub-categories used to capture these experiences were - being there for my child and supporting my child no matter what.

**Being there for my child.** Mothers reported that they made constant efforts to maintain the state of mind and composure necessary to fulfill the role of being a stable base for their child. *Being there* was defined as mothers supporting their child to manage their own emotions and taking the time to be “totally hurried and unrushed” (Family 4, 9-year-old son), “being grounded so that he knows he has a secure place to be” (Family 23, 11-year-old son), and “being steady” (Family 8, 8-year-old daughter). Being there was when mothers were physically present to
provide reassurance through physical contact, such as a hug or kiss, or emotionally present, to provide emotional reassurance through emotional contact such as communication or advice for the child. Mothers said that being there when children needed support was an ongoing commitment.

Mothers also reported numerous strategies for supporting their children. For example, one mother described an interaction in which she chose to meet her child’s needs by providing physical reassurance, in comparison to an interaction in which she chose to meet her child’s needs by providing emotional reassurance. These decisions were made based on the mother’s perceptions of her child’s emotions or needs in specific contexts. She offered physical support when her child’s behaviors were escalating, “I am trying to provide her with that kind of support if she wants it. Like that she knows she can come to me for a hug or whatever” (Family 10, 12-year-old daughter) but she offered verbal support when her daughter was experiencing day to day frustrations with a school routine,

Like, when she comes home from school freaking out, that is something I try to jump on right away. I ask her about it because I feel like that’s a time that she needs that connection, she needs to be heard. (Family 10, 12-year-old daughter)

This mother explained that she assessed what her child needed and chose how to be there for her child depending on her assessment, “I think sometimes she just needs me to hear her and to listen and help her sort it out. And other times she needs a hug and other times she needs her space. But I think she, ya, she just needs me to be her parent during those times” (Family 10, 12-year-old daughter).

Mothers reported that children seemed to be aware that their mothers were a secure base because of the history of responsiveness in their relationship. For example, one mother said, “I
think I am steady, she knows that I am always going to be there, because I have been there a number of times before” (Family 8, 8-year-old daughter). Another mother stated, “I know that’s when she wants to talk or she needs something or maybe it’s even just like a snuggle... but ya I think she just has learned and knows that I am there for her” (Family 16, 12-year-old daughter).

Supporting my child no matter what. Mothers described providing love “unconditionally” (Family 1, 13-year-old son) and “no matter what” (Family 8, 8-year-old daughter) to their children. For example, one mother described how she provided her daughter with “unending love. That no matter what she knows I will be there and love her and work it out” (Family 6, 11-year-old daughter), while another mother stated that, “no matter the problem, or how long it’s going to take, or what time of the night it is, that he can come to me and I will be there for him” (Family 17, 13-year-old son).

Mothers emphasized the importance of unconditional support when their child was acting in an extremely aggressive manner such as “endangering other people” (Family 7, 8-year-old daughter), “hitting and spitting” (Family 6, 11-year-old daughter), or “smashing a toy” (Family 20, 10-year-old daughter). One mother said that, “as a parent it’s important to make sure your kid knows that no matter what kind of shit hits the fan, that you are in it with them through thick in thin... you will figure it out” (Family 8, 8-year-old daughter). Another mother reported that her child,

He is screaming ‘I’m going to kill you’ and gets right up in my face and I’ve found a place where I can be compassionate and really loving. And also like a tree, just grounded and because I would get emotional and react so if he threw a rock at me and I would cry and say you want to hurt me, how could you want to hurt me. And I had to get past that
and say okay this happened this is what we are going to do and what you need to do.

(Family 1, 13-year-old son)

Mothers reported that providing unconditional support led to opportunities to discuss different ways to handle extreme aggression. For example, one mother encouraged her child to work on their behaviors after they had escalated, “Yet, you know, no matter what happened today S – you know that I love you no matter what, we just really need to work on this whatever it may be” (Family 13, 13-year-old son). Another mother provided her child with support in making changes to his behavior,

Once the storm has passed we talk it out… so I can say to D, wow that seemed really upsetting for you, why do you think that was? Or, something like, what did that feel like inside and how could we change that? (Family 5, 13-year-old daughter)

**Experiencing closeness and hurt in the relationship**

It was apparent that mothers who participated in this study were also invested in maintaining a close relationship with their children that was personally satisfactory. Mothers described how they and their children experienced enjoyment, happiness, closeness and at times hurt from their interactions with one another. This dimension of the relationship was captured with the following six sub-categories: enjoying quality time, being empathetic, making relationships repairs, understanding what’s beneath children’s behaviors, experiencing hurt in the relationship, and having relational doubts.

**Enjoying quality time.** Mothers described moments and interactions in which they appreciated their time with their child. Mutual or shared positivity was an opportunity for mothers and children to connect, often through verbal communication or physical touch. For example, one mother reported how much she enjoyed the time that she and her daughters spent
communicating with one another “You know, they listen to me, they take care me, I take care of them if it going out. We sort of, it’s a good thing” (Family 12, 13-year-old daughter). Another mother reported how her and her daughter enjoy physical connection, such as a hug. She explained that even when frustrated with one another they work towards an opportunity for positivity,

D and I have such a great relationship and um in that I just- I don’t get angry with her and I accept that that’s where she’s at and- and then that anger she has at me doesn’t last very long, you know and at bedtime...I’m still reading to her and she’s so happy and hugging me and loving me. (Family 15, 11-year-old daughter)

When sharing these interactions, mothers often described the positive qualities of children, such as “loving and caring” (Family 15, 11-year-old daughter), “brings joy to our life” (Family 3, 12-year-old son), and “big hearted” (Family 23, 11-year-old son). For example, one mother stated,

He will sit on my lap or we will have a really good snuggle in bed at night, or we will have long conversations about things. I think that he definitely knows that we love him. He definitely knows that he is loved and cherished… and so do I. (Family 4, 9-year-old son)

Another mother reported the joy she experienced when spending quality time with her daughter. She explained “Well, like D and I are close.. we like to do those kind of girlie things together, get our nails done…go to the mall and window shop. We just know each other really well and definitely feel just like comfortable together” (Family 16, 12-year-old daughter).

Enjoying their interactions with their child appeared to be something mothers cherished and one
mother explained it is “like a dream.. it makes it the best to parent” (Family 20, 10-year-old daughter).

**Being empathetic.** Mothers stated that they were able to sense their child’s distress and consider their distress from multiple perspectives. Mothers were empathetic towards their child during times of distress. For example, one mother said that “my heart goes out to her” (Family 6, 11-year-old daughter) or that “it is the worst thing ever to see your kid in that place” (Family 10, 12-year-old daughter). Some mothers also explained that they made allowances and did not believe that their children were intentionally hurtful when they acted out. Rather than blaming their children they focused on enjoying the positive qualities of their child. For example, one mother explained the importance of considering the context of her child’s behaviors,

> It’s not D’s fault, it’s something bigger then D…our doctor always talks about them... like she owns and can control them all the time... Not sure how I feel about that (pauses) actually I do know, I know she can’t be held responsible for them, I know she needs support. (Family 6, 11-year-old daughter)

Another mother described her empathy for her daughter when she is being extremely aggressive,

> So I think it’s an outlet, when she is aggressive or violent it’s like she has just totally reached her wits end. It’s shitty, I don’t think she wants to do it and she knows I don’t want her to, but it’s like she doesn’t know how yet to get it out in any other way… It just makes you think, what kind of pain does she have in her that she has to do this and like how did it get there?... She has tough times just like anyone else and is just trying to get it out of her. (Family 10, 12-year-old daughter)
Mothers explained that they chose to be empathetic because they understood that their child didn’t always have the necessary skills to express their emotions in a healthy or safe manner. For example, one mother explained her child’s aggression, “S is not doing this because he wants to, there is a reasoning behind it that is complicated” (Family 3, 12-year-old son). Other mothers stated that their child’s behaviors were “not done purposely” (Family 21, 10-year-old son) or that “she is just a kid dealing with a lot and doesn’t know” (Family 6, 11-year old daughter).

Making relationship repairs. Mothers explained that an important part of the relationship was to make repairs after setbacks when one relationship partner has caused another distress. For example, one mother stated, “I am able to admit when I do something wrong… I can say… I’m sorry I blew it” (Family 23, 11-year-old son). In making repairs to their relationship it was evident that mothers experienced relief and happiness due to the opportunity to reconnect with their child and move past the negative experience that occurred. For example, one mother reported, “Usually I can almost expect that when I see him next he will be like ‘I am so sorry about that’... I’m happy that he is recognizing it, I am happy that he is acknowledging it…lets move on” (Family 11, 13-year-old son).

Mothers reported that they typically initiated repair verbally by apologizing to the child or explaining their actions to children. For example, one mother stated, “I’ve tried to talk to them and say okay, you know how you lose your temper sometimes and you shout at mommy... I said sometimes grownups do that too... and it’s not the right thing to do” (Family 24, 12-year-old daughter). Another mother reported how she will go back to her child after they are both calm and tell her child “I’m sorry, I blew it… you know, I am able to admit when I mess up” (Family 18, 12-year-old daughter).
Mothers also reported that their child verbally and non-verbally initiated repairs. Mothers appeared to interpret nonverbal signs of remorse as reassuring indicators of their child’s continued investment in the relationship. One mother reported that her child “feels really bad. Usually I can almost always expect that when I see him next he will be ‘like I am so sorry about that’, or, he’s umm… he feels guilt about it” (Family 11, 13-year-old son). Another mother reported an example of her son initiating repair non-verbally,

He feels badly and realizes that he has been crazy. He realizes that he has acted in a way that is inappropriate and he is really big on being appropriate. So the good thing is that he rebounds, he doesn’t hold on to anger or frustration. Um. He’ll come back and like be, ‘want to watch a show with me Mom?’ You can see that he is carrying an olive branch. (Family 4, 9-year-old son)

**Understanding what lies beneath children’s behaviors.** Throughout the interviews mothers emphasized the importance of comprehending the context, or causes underlying their children’s behaviors. This was especially evident when mothers reported instances of extreme aggression. These explanations were often accompanied by sighs, pauses, or tears. Mothers said it was important for them to look past these instances of extreme aggression to connect with their child. For example, one mother reported,

having a greater understanding of where this is coming from, knowing that he is a not a jerk, jack-ass bastard who is really rude and insolent. It appears on the surface as rude and insolent and um inflexible. It is those things but it’s because of how he is feeling, his anxiety…not him. (Family 4, 9-year-old son)

Another mother explained,
I mean I think I’ve learned a lot about S. I think that when he feels ashamed he reacts. So all you see is the defiance and the anger but I know underneath he is hurting, really hurting. I get that. You have to pay attention and open your heart and not react when you react you don’t see that part of him. (Family 1, 13-year-old son)

**Experiencing hurt in the relationship.** Mothers reported that they were working to improve their responses when their children were behaving in a hurtful manner towards their mother, causing mothers distress. Many mothers stated that their children knew how to upset them and would use this knowledge to “push my buttons” (Family 8, 8-year-old daughter) or “to drive me crazy” (Family 25, 11-year-old son). For example, one mother reported, “I think I’ve got, I’m still working on, not personalizing it. Because I mean that kid breaks my heart in two seconds. He tells me that I am whatever, he will call me dumb or something like that” (Family 1, 13-year-old son).

Mothers described that at times their children chose to speak to them with the intent of causing their mothers distress. For example, one mother reported “he knows that it pushes my buttons when he talks, when he uses racist language or says racist and sexist things. So he does it just to get me going” (Family 1, 13-year-old son). Another mother reported that when her daughter was not getting her way, she would express frustration with her mother’s mental health. This mother reported “So, she knows that I feel guilty about not being the best parent when I was having a hard time with my depression. And she only brings that up when she is on that mission for blood” (Family 10, 12-year-old daughter).

Mothers perceived that their children were more likely to be hurtful when children were experiencing their own emotional distress. Mothers explained that this was one way children would displace emotions, by projecting their frustrations onto their mothers. One mother
suggested that her daughter “understands now what hate, maybe not fully, but that those words are hurtful. So, that’s her way of hurting us because she’s feeling hurt” (Family 7, 8-year-old daughter).

At these moments mothers absorbed the hurt from the physical and psychological coercion and instead attended to the perceived needs and emotional state of their children. Mothers described attempting to approach these situations when the child had “cooled down” (Family 2, 8-year-old son), in a “calm and supportive” manner (Family 24, 12-year-old daughter). For example, one mother reported how she was learning when to address the behavior with her child,

He was just saying it to be mean or to hurt me. It is really based on the things he is feeling or saying. I have to know where he is coming from and previous experiences with him. I know his mood, so I can tell, I can just leave him and he will come down. Whereas sometimes I know it will carry on if I don’t address it. (Family 2, 8-year-old son)

**Having relational doubts.** Mothers reported doubts regarding their own capacity and their child’s capacity to contribute constructively to the relationship. Mothers worked through relational doubt regularly, it was evident that they experienced stress in their efforts to maintain a positive relationship with their challenging children. One mother reported her doubts about her parenting capacity and the implications for her child “It’s just such a scary and unpredictable thing. Like, I go over in my mind all the time, should I have said that differently? Did I do that wrong? It’s like tormenting yourself….at times that can feel really lonely” (Family 22, 10-year-old daughter).

Another mother reported her concerns about her daughter, noting a parallel between her coercion and that of her husband “she’s storming around and I am starting to get this panic about
oh my, she’s like her Dad, she can’t control her anger, what is the future going to be like for us, and sort of like being triggered by it” (Family 8, 8-year-old-daughter). In times of distress, mothers questioned how their relationship with their child had reached the point that it had and who was a fault. One mother reported her anguished thoughts that “It just makes you think, what kind of pain does she have in her that she has to do this and like how did it get there? What did I do? What did we do? So I hate it.” (Family 10, 12-year-old daughter).

**Acting as agents of socialization**

In addition to acting as caregivers and maintaining a personal relationship with their children, mothers talked about their efforts to fulfill their responsibility as authority figures who ensured that their children responded appropriately to rules, requests and expectations. These were captured using the following two subcategories – standing ground and carrying out consequences.

**Standing ground.** The majority of mothers stated that there were two specific circumstances in which they stood their ground and firmly expected compliance from their child during daily routines and during issues with safety or morality, such as daily chores and hygiene or curfew and respect for others. Mothers described these circumstances as “not negotiable” (Family 24, 12-year-old daughter; Family 3, 12-year-old son). However, as will be reported in the next section, such firm enforcement was reserved for ordinary resistance and not extreme aggression when children were interpreted as having lost intentionality and self-control.

During these interactions mothers made clear requests and expected their child to comply accordingly. For example, one mother stated that she tells her child, “You, you need to just comply with the instructions... this has to be done in 5 minutes. Get up and get it done and then we’re going!” (Family 24, 12-year-old daughter). Other mothers suggested that when it comes to
daily routines or safety that she is “forced to be more direct, parenting in a way that gives somebody so much less choice” (Family 3, 12-year-old son) or one mother reported that she would “dig my heels in” (Family 2, 8-year-old son) to ensure her child’s safety.

Mothers explained that they firmly enforced compliance to promote longer term improvements in the child’s behavior. For example, one mother suggested that when the issue was her child’s safety, she stood her ground, “So I think right now... I will have to stand my ground or do whatever and then hopefully in the long run that means that things will be a little bit easier than they are now” (Family 25, 11-year-old son). Another mother reported that she persisted with enforcing compliance with chores despite resistance in the hope of better behavior in the long term her daughter does not want to help with cleaning the dishes, “Always an issue, every single day we go through it. So I stick to it because I think that someday we will not have to do it” (Family 8, 8-year-old daughter).

Carrying out consequences. Mothers reported that they imposed consequences to obtain compliance from their child. There were two types of consequences mothers discussed, consequences put into place by mothers and natural consequences. The consequences enforced by mothers were discussed in relation to the child’s daily routines, such as not completing chores, and issues around safety or morality, such as being disrespectful. Natural consequences were discussed solely in relation to ordinary resistance.

Mothers explained a variety of ways they enforced consequences. One mother reported that when her child refused to complete her homework she would set limits regarding children’s use of digital technology to minimize distraction, “not getting homework your homework done when she’s been told to so I’ll say okay. No devices were not, no TV, no computer” (Family 24, 12-year-old daughter). Another mother discussed the consequences she imposed when her
daughter hurt someone or broke something. She explained the importance of pairing the consequence with her daughter’s behaviors,

So if she kicked the babysitter then she is writing an apology card to the babysitter, and maybe she doesn’t get her usual playtime with the babysitter the next day. If she broke a lamp, then she is saving her allowance to pay for a small part of that lamp, and she is cleaning it up. I want to make sure she understands that dangerous behaviors are dangerous, that safety is important, that respect is important. (Family 6, 11-year-old daughter)

Mothers also reported that they relied on natural consequences, which were consequences that occurred without the mother’s intervention as an inevitable result of the child’s own actions. Mothers described how natural consequences enabled children to comprehend the consequences of their actions in a larger context, providing a “real world... learning opportunity” (Family 5, 13-year-old daughter) for their child. For example, one mother reported,

I have told you three times to put your bike away and now it’s raining, the gears are getting rusty. That has happened twice and we have had to oil it. So I feel like I don’t have to punish him because his bike isn’t working and that is sort of punishment in itself. (Family 2, 8-year-old son)

Another mother reported how her daughter refused to put her laundry in the dirty laundry pile. She stated,

It’s Thursday night and your uniform’s not clean. I guess you have to wear it like that. You know and hopefully that’s a one of lesson where it doesn’t keep happening you know that’s something you have to learn. I mean yeah okay is that gross that she has to wear uniform that was all sweaty. Sure it is! But who’s fault
is that? (Family 24, 12-year-old daughter)

Summary

Mothers reports emphasized the complex and effortful nature of not only managing the behavior of challenging children but also caring for their wellbeing and striving to maintain a positive relationship with them. It was evident that mothers were putting effort into maintaining three aspects of the parent-child relationship—providing security, experiencing closeness and hurt and acting as agents of socialization. These categories captured the complexity of mothers’ efforts in when the relationship is considered as a holistic long-term and interdependent context. These analyses also bring attention to a neglected aspect of challenging parent child relationships by highlighting the importance that mothers placed on their personal relationship with children.

Parents’ conceptions of challenging child behaviors

The participants of this study described two qualitatively different forms of challenging behaviors exhibited by their children, ordinary resistance and extreme aggression (see Appendix F). The nature of the child behaviors, mothers’ explanations of the behaviors, and mothers’ strategies differed markedly for these two categories of behavior. The inference was that mothers recognized that their children had two ways of functioning in their challenging behaviors. Ordinary resistance was considered a normal expression of children’s autonomy whereas extreme aggression was regarded as emotionally reactive or dis-regulated.

Ordinary resistance

Participants in this study reported that ordinary resistance was a part of their daily experiences and interactions with their children. Mothers described ordinary resistance as the child making a choice not to follow parental requests for carrying out requests, and responsibilities. This kind of resistance appeared to be an expected part of the mother-child
relationship. The two sub-categories evident related to ordinary resistance were acting out and displaying attitude.

**Acting out.** Mothers described the way children acted out ordinary resistance in three different ways – refusing, ignoring and delaying compliance to rules, requests or expectations. Mothers reported that these kinds of resistance were expected occurrences from their child and occurred regularly. The following examples provide evidence of children refusals, “refusing something or it’s like I’m not going to school tomorrow, I’m in a really bad mood or I hate it you know I have no friends I’m not going” (Family 15, 11-year-old daughter), “I ask him to move them and he won’t. But he will already be upstairs getting ready for bed, I’ve asked him 3 times, he didn’t do it” (Family 2, 8-year-old son) or “she might stomp out of the room, refuse to get dressed” (Family 8, 8-year-old daughter).

Another way children resisted their mothers was by ignoring their rules, requests or expectations. For example, one mother reported when her daughter is supposed to complete a chore, “Mostly ignorance, she ignores. She wouldn’t necessarily say – Oh you don’t know, or you know. But um (pause) she just ignores” (Family 12, 13-year-old daughter). Another mother reported an example of her son ignoring her when asked to take out the garbage, “there’s definitely some times where I feel like I am purposely being ignored, where I need to de-stress, and it’s just like… and it’s just like [sighs] or it’s like are you not listening to me?” (Family 21, 10-year-old son).

Lastly mothers reported that in certain situations, their children delayed responding to rules, routines or expectations. For example, one mother expressed her frustration with her son continuously delaying getting off his gaming station, “So he is like, ‘just one more minute, just
one more second, I have to kill this one robot, I just have to pass this one level’ (laughs), it’s always something. Isn’t there always one more level” (Family 25, 11-year-old son).

**Displaying attitude.** Most mothers reported that their children confronted their authority by verbally or nonverbally displaying expressions of attitude. Attitude was described by mothers as the child being “surly and sassy” (Family 11, 13-year-old son) or “snarky” (Family 2, 8-year-old son). Children expressed attitude by “talking back” (Family 17, 12-year-old son), “rolling their eyes” (Family 16, 12-year-old daughter), or “being rude” (Family 20, 10-year-old daughter).

Often children complied with their mother’s request or expectation but expressed displeasure by means of sighs, eye rolling, stomping, slamming doors and muttering under their breath. For example, one mother explained her daughter giving attitude when she was trying to get her to put a dish away, “So she puts it away, like not nicely though... she will sigh really loud... or like she is a big eye roller... or that whole Mom whine” (Family 16, 12-year-old daughter). Another mother reported, “She rolls her eyes but also gives me that knowing look like, “ya you are right, I know we have already talked about this, I don’t like it but I get it Mom, I’ll do it”’ (Family 20, 10-year-old daughter). Although in this outcome the child is eventually meeting the expectation, the child used attitude to make it known that they are not pleased with completing the request or expectation.

**Parental explanations for ordinary resistance**

“**It’s who they are**”. Mothers explained that when their child was expressing ordinary resistance, it was often due to inherent characteristics that were a part of the child’s personality or temperament. For example, one mother reported, “He’s got a very zesty character and I didn’t want to take that away from him. I just wanted him to be able to function and for me to function”
(Family 13, 13-year-old son). Another mother reported the reason for her son’s resistance was due to his “oppositional character... since he was small” (Family 3, 12-year-old son). These characteristics appeared to be one way that mothers attributed normal variations in temperament unique to each child.

**Normalizing resistance.** The other attribution mothers used to explain their child’s ordinary resistance was to attribute the behavior to developmental norms and milestones. Mothers would report “she’s at that age so some of this is probably pretty normal” (Family 10, 12-year-old daughter), “it’s gotten more challenging as he’s hitting puberty, but with all the change, and emotions and the anger coming up um it’s been a lot more challenging with him” (Family 23, 11-year-old son), “I guess it’s her age or the age of them, attitude and peer pressure” (Family 12, 13-year-old daughter), and “she is obviously a teenager now, and so it’s like the terrible twos time but it’s more for like, teenagers, right?” (Family 16, 12-year-old daughter). Mothers attributions of their children’s every day resistance to developmental changes in their children indicated that they did not regard the behaviors as deviant or abnormal.

**Parental responses to ordinary resistance**

**Preparing children by being proactive.** Mothers described the importance of problem solving and developing strategies for addressing ordinary resistance. In an attempt to rectify future ordinary resistance, mothers proactively put into place rules to prevent uncooperative behavior. For example, many mothers reported issues with their children spending too much time on technology such as tablets, phones and gaming systems. One mother reported that when her child began to resist getting off their tablet, she would plan with the child a clear schedule for when and how long they could use technology in the future. This mother reported, “I guess you could say we are trying to be preventative by setting up rules” (Family 22, 10-year-old son).
Mothers also reported that it was helpful to implement proactive routines or schedules to minimize resistance in future interactions. One mother provided an example of a proactive routine developed in response to her child delaying tasks and chores. She stated,

We come up with a weekly schedule for him so that he knows what is happening regularly and anything unusual like a doctor’s appointment or something is written on his schedule. So things like that seem to be helpful and I think they are helping. (Family 9, 9-year-old son)

Another mother reported how she and her daughter worked together to develop proactive routines in response to ordinary resistance. She explained that her daughter would regularly express resistance in the morning regarding eating her breakfast, what to wear to school and leaving the house. Therefore, as a way to minimize this kind of resistance “every night, together we pick up her clothes, what she wants for breakfast” (Family 6, 11-year-old daughter). This mother and daughter proactively developed a routine that reduced the chances of ordinary resistance occurring in future interactions.

**Sticking to it.** Mothers stated that when their child resisted a rule or did not fulfill an expectation, mothers would “make it clear” (Family 16, 12-year-old daughter) to the child what was expected, and “be really direct” (Family 3, 12-year-old son) about how the child could successfully fulfill that expectation. For example, one mother reported,

I have to push him to do and it’s usually a battle every single time. It’s funny because he does the same things ever single Saturday, he has a list that is step by step, but every single time I have to inspect and be like you forgot to do this, did you do this. It’s always an argument to get him to do his chores. (Family 2, 8-year-old son)
Mothers emphasized the importance of firm reminders for reducing resistance in the long term. For example, one mother suggested she would tell her son, “Sit down and eat your fruit, sit down and eat your cereal, sit down, sit down, sit down. The consistency and following through is so important during that time” (Family 3, 12-year-old son). Another mother reported that she continues to provide her child with firm reminders, ensuring that she repeats the task in the manner expected. She explained, “I think making her repeat it and talk about it is hopefully planting that seed that will grow eventually” (Family 5, 13-year-old daughter).

**Attending to and fostering children’s responsibilities.** Mothers described using their position of authority to step back from their child’s ordinary resistance and support their child to make a better decision. Consistent with some mothers’ interpretation of resistance as normal expression of autonomy, mothers actively supported this development by tolerating resistance or encouraging its expression in a socially appropriate manner.

For example, one mother said it was important to support her daughter to her express developing autonomy. She explained that her daughter “is learning how to stand up for herself and how to ask for what she wants or set boundaries. That is something that we have been working on, and that, I think, is important for kids” (Family 20, 10-year-old daughter). This mother encouraged her daughter to express resistance in a socially skillful way. She suggested to her daughter “don’t be rude, don’t be disrespectful” (Family 20, 10-year-old daughter). This mother stated that if resistance was expressed skillfully and respectfully, she was open to adjusting routines or expectations based on her daughter’s feedback. Another mother reported, “I think it’s okay for them to say no I am not gonna do that now but here’s why is that okay? That’s not a problem! We wanna have some flexibility too!” (Family 24, 12-year-old daughter).
Children were encouraged to consider the ways they were expressing resistance and provide reasoning for these behaviors.

**Extreme aggression**

Unlike ordinary resistance, events involving extreme aggression occurred less frequently, were perceived as having different causes and were handled in a qualitatively different manner. Mothers described four sub-categories of extreme aggression - destroying property, physically hurting someone, verbally coercive, and children hurting themselves. Mothers attributed extreme aggression to two factors - their children’s mental health and children losing control. Mothers described extreme aggression using language such as defiant, oppositional, aggressive, explosive, destructive or violent. These behaviors appeared to occur infrequently and were often described as the height of crisis or breaking point for their child.

**Destroying property.** Destroying property was described as the child “kicked a hole in the wall” (Family 22, 10-year-old son), “breaking a window” (Family 1, 13-year-old son), “cut the couch with scissors” (Family 6, 11-year-old daughter), and “cutting up a picture of us” (Family 10, 12-year-old daughter). Mothers reported that when their child appeared to destruct property as a way to express distress. For example, one mother stated,

He had this big demonic toy that he picked and um, he had people that were in his life in a house and he was smashing the house and he said nobody sees this but me. And he was smashing the furniture and smashing the house, he was smashing the people, this rage that came out of him. My son who is very careful with his toys was busting up this house and I was just, I remember being blown away, I had no idea he carried this kind of emotion or rage. (Family 11, 13-year-old son)
Most mothers were shocked that their child destroyed property and questioned their child’s capacity to comprehend their actions. For example, one mother reported,

I was scared and so I took my time. But I got in there and he is sitting on the couch with a lighter. A lighter! I am like oh god how did he get a lighter. So I ask him, S what you got there. And when he looked at me, it was like, oh god we are in trouble. Like I remember thinking to myself, holy shit this isn’t my kid. Honestly it was just so unbelievable. He didn’t seem himself at all… he lights the picture frame on fire. (Family 17, 13-year-old son)

Another mother reported an incident of her child breaking a friend’s toy “She smashes it. So I am like D, that’s not ours, we have to respect other people’s things” (Family 20, 10-year-old daughter). Many mothers referred to their child not seeming like themselves when they destructed property, and that their destruction of property was out of character.

Physically hurting someone. Most mothers reported that their child was interpersonally aggressive. Mothers described interpersonal aggression as physical aggression against another person such as a peer, an authority figure, or family member. For example, some mothers reported that their children were aggressive at school. One mother described her son getting into a physical altercation with a peer in the playground, “So it turns out he beat this kid to a pulp, it was really bad... because the kid was hospitalized” (Family 17, 13-year-old son) or another mother reported that her son “received an in-school suspension for cutting a little girl’s hair off in his class” (Family 3, 12-year-old son).

Mothers also described interpersonal aggression against family members. For example, one mother reported that her son attacked her, “He has, he’s been very aggressive at times. So that’s the one when he has come at me… but he would just run at me and come at me” (Family
1, 13-year-old son). Mothers described their children to be in a heightened state of distress when becoming interpersonally aggressive.

**Verbal coercion.** Verbal coercion was the most common form of extreme aggression reported by mothers. Mothers defined verbal coercive behaviors such as yelling, shouting or screaming. For example, one mother reported how when her daughter became upset she would start “screaming at the top of her lungs... we had to stop the car and like everyone was staring at us in the parking lot because this child sounded like she was being, her toenails or fingernails were being ripped out one by one” (Family 7, 8-year-old daughter). Another mother reported, “But a serious temper tantrum where he will yell at me, and get really angry and storm off to his room or yell hurtful things” (Family 2, 8-year-old son). These instances of verbal coercion appeared to occur when something did not go the child’s way, or if the child was attempting to express some sort of distress.

**Children hurting themselves.** A small number of mothers reported that their child harmed themselves or discussed hurting themselves as a form of extreme aggression. These acts were understood to be acts of distress, when children were struggling to communicate their emotions in any other way. For example, one mother reported,

> He decided that he was going to trash his room, and then he actually kicked a hole in the wall but the worst part is after all this he got really quiet, sort of curled up, and very slowly started talking about not wanting to be in this world (crying)...who trains a parent for this? We have never been suicidal. (Family 22, 10-year-old son)

Mothers reported feelings of intense emotion and fear when their child engaged in these behaviors. One mother described how her daughter had overdosed on prescription medication. She explained “that was a time that I felt I had completely lost her. The choice she made was one
that I, to this day, I just can’t figure it out. There’s nothing I can say or do’” (Family 10, 12-year-old daughter). Another mother reported,

There was a time where we had to talk to someone because she would get so mad that she would hurt herself. Like she would get so upset that in the moment she would slam her hand down on something, or kick something, and it would hurt her. So that was when I was like, okay, I need you to talk to someone else. Because seriously, I was scared she was going to hurt herself. Badly. (Family 8, 8-year-old daughter)

**Parental explanations for extreme aggression**

Mother’s explained their child’s extreme aggression in two different ways – mental health and losing control. These attributions contrasted with when children displayed ordinary resistance, when mothers attributed child behaviors to personality characteristics and developmental considerations.

**Mental health.** Many mothers explained their child’s extreme aggression by attributing it to their child’s mental health diagnosis, such as conduct disorders, anxiety or depression. For example, one mother explained her daughter’s aggression in relation to her conduct disorder. She explained how she should have predicted her child’s aggression due to previous experiences with her conduct disorder,

I probably could have seen that one coming with the bad day at school, and the tone that was already set by that. But that’s the thing, right, with a conduct disorder. You can often see it coming because she is so aggressive, or she acts out in a way that is usually noticed. (Family 6, 11-year-old daughter)

Another mother explained that her child’s extreme aggression toward herself and his brother as an unintentional consequence of her child’s mental health. “I don’t think he does it to
be mean to me, or like he is doing it because he actually hates his brother. I think he has another stuff going on like his mental health stuff...this isn’t going anywhere good” (Family 25, 11-year-old son). One mother used the metaphor of an uncontrolled canoe to explain parenting a child with anxiety. She said, “having a kid with anxiety or behaviors is like jumping into a canoe with no paddles, no life jacket, and going on the river. Because you are basically stuck in that canoe, like you can’t get out and you are the only two in there” (Family 10, 12-year-old daughter).

Mental health explanations appeared to enable mothers to avoid blaming the child and consider factors outside of the child’s intentional control as influences on children’s aggressive behaviors. One mother reported, “But I think it’s the most common part of conduct disorders, saying no, being aggressive, it goes hand and hand. So I think that it’s not about D, it’s about what’s going on around her” (Family 10, 12-year-old daughter). Another mother explained how important it was for her and her support system to understand the ways that her son’s conduct disorder contributed to complexity of her child’s extreme aggression. She reported, “So really gives it context and explains how the behavior is tied to a conduct disorder. I like that because I think it allows us to consider it as not S’s fault, as something bigger then S” (Family 6, 11-year-old daughter). Another mother reported how when her child was escalating in front of a neighbor, she found it helpful to explain her son’s response by explaining the ways his anxiety influences his behaviors. She stated,

I describe them as having roots in anxiety. I need to do that. Otherwise he looks like a jerk. He is dealing with a pretty high level of anxiety all the time and it shows itself as frustration. So when I describe him I describe him as, really needing and being particular and at times prone to frustration but I do always tie it back to anxiety. (Family 4, 9-year-old son)
**Losing control.** Mothers stated that at the heightened point of their distress, their child’s aggression could escalate to be out of the child’s control. This was described as children going from “one to a million” (Family 10, 12-year-old daughter), “it’s like she can’t slow it down or she doesn’t know how to. It’s totally a 0-10 sort of thing” (Family 8, 8-year-old daughter), or “in a trance” (Family 16, 12-year-old daughter). Mothers described the change in their child as a “light switch” (Family 25, 11-year-old son) and a “breaking point” (Family 24, 12-year-old daughter) in which the child changed from expressing extreme aggression to “totally losing themselves” (Family 12, 13-year-old daughter).

Mother’s expressed an awareness regarding when their child would reach the point that they may become aggressive. For example, one mother reported,

there is probably a 2-minute window that you have to be able to jump on to get her when she is still in a place that you can get her to reach out to you. Because after that, it’s like all hell has broken loose. (Family 8, 8-year-old daughter)

If mothers were unable to connect with their child during this time, they suggested that an aggressive spiral was inevitable. For example, mothers reported, “you missed your chance to fix this and now it’s going to war” (Family 25, 11-year-old son), “when he is going, if we don’t get to him in time, it’s like, see ya later. Seriously though, he is totally not himself and we can’t catch up with him” (Family 22, 10-year-old son), “bracing yourself for the storm, you know, it’s like, what’s that saying, battle down the hatches” (Family 16, 12-year-old daughter), and “she gets to that point where she is seeing red, it’s like, well I’m done. It’s basically impossible to bring her back from that” (Family 10, 12-year-old daughter).

Mothers described that at this point their children were no longer themselves, and did not have full control over their actions. Mothers reported that their child was “reaching a certain
point that she’s just not there” (Family 24, 12-year-old daughter), or “loses herself” (Family 8, 8-year-old daughter), and “can’t see past herself” (Family 6, 11-year-old daughter). For example, one mother reported,

Seriously it’s the worst…. and I honestly don’t think he even knows that he’s doing it, it’s like S, are you in there, is that you. Because it’s sort of just (sighs) it’s just like not him. He isn’t that kid who is trashing our house, swearing at his brother, calling me a fucker. Like where does he learn that language, my god. But even like I said, the look in his eyes, it’s like, hey S are you in there? (Family 25, 11-year-old son)

Parental responses to extreme aggression

Mothers described their responses to their child’s extreme aggression in three different ways – verbally reassuring, physically reassuring and making relational contact. These responses contrasted with when mothers responded to ordinary resistance, in which they responded by directly addressing the behavior.

Verbally reassuring. Mothers used verbal communication in an attempt to soothe their child when they expressed extreme aggression. Verbal reassurance was consistently calm and supportive. For example, one mother stated, “just let her know that we are here, we are not going anywhere, we are going to stay here even though you are acting like this but when you calm down we are still going to be her” (Family 7, 8-year-old daughter). Another mother suggested that when her child heard her mother’s voice, “she hears me and can slow down because I am supporting her to slow down” (Family 6, 11-year-old daughter).

Mothers reported that communicating with their child provided reassurance and contributed to de-escalation. For example, one mother reported, “So I guess sometimes if I can get her to talk during that time, it’s the best approach and I think it’s most helpful for both of us”
(Family 20, 10-year-old daughter). This mother explained that verbally communicating enabled her and her daughter to work through their behaviors, “If she can talk about it then usually that helps, like she can work it out and we can work it out together” (Family 20, 10-year-old daughter). Another mother reported how she had worked to communicate to her son in a way that let him know that although his behavior was not appropriate he could still be confident of parental support. She stated,

I want S to know that it is definitely not okay to hurt someone or hit them, and that he can make better choices during that time. But I also want him to feel like he can come to me, and talk to me, and you know, just that we are in it together. So it’s like, I don’t want to yell at him because it’s not helpful, but I don’t want him to think that when he hits and we are talking that it means it is okay. (Family 22, 10-year-old son)

Physically reassuring. Mothers described making a physical connection such as a hug, touch on the arm, or kiss as a way to work with their child towards a more positive outcome during extremely aggressive behaviors. For example, one mother explained how when her child was extremely aggressive she would, “I’d start to rub her back, her you know pet her hair or whatever. I wouldn’t say anything; I’d just stay there” (Family 24, 12-year-old daughter).

Another mother stated, “I guess just like kind of being close to her or touching her or snuggling or whatever, it seems to help” (Family 16, 12-year-old daughter) or one mother reported, “If I can get to her to, like if she isn’t tearing around our house, if I can give her a hug and get her to sit calmly with me. That is usually the best way about it” (Family 20, 10-year-old daughter).

These mothers reported that some sort of physical reassurance helped their children to de-escalate.
Making relational contact. Mothers described relational contact as the mothers’ ability to have a physical presence when their child was extremely aggressive, without making any physical contact. Mothers reported that having this presence, of either being close by the child or able to have some sort of visual contact, contributed to the child’s ability to de-escalate. For example, one mother described a situation in which her son had picked up the ladder from his bunk bed and was threatening to hit her with it. She explained that,

That was the moment, I had been really working on it and saying that I have to be firmer and stronger. It was that moment and I stood there, and I did not move. He was holding that thing up and I didn’t move, I stayed there. I knew if I could just get him to look me in the eye, that he wouldn’t do it. That he would remember I was his Mom. That is probably the last time he actually did that. (Family 1, 13-year-old son)

This mother used visual contact to leverage her personal relationship and change the outcome of the interaction with her son. Other mothers also described using relational contact to change the course of extreme aggression. For example, one mother reported “So I just stay with her or near her, which is like hiding behind a chair in case she throws something, but she can always see me when she’s like that. And eventually she slows down” (Family 6, 11-year-old daughter) and another mother explained, “he like glares at me and pushes me out of the way to storm upstairs…So I just tried to be with him, even though I was totally terrified. I stayed near him, I was like okay if he knows I am nearby… it will make a difference” (Family 17, 13-year-old son).

Summary

In summary, mothers reported two different types of behaviors displayed by their children, ordinary resistance and extreme aggression. These two behaviors were explained in two
different ways, ordinary resistance was explained to be due to children’s personalities and developmental norms, whereas extreme aggression was explained to be due to mental health diagnoses and a loss of control. It was also evident that each one of these behaviors was responded to differently by mothers. Mother’s responded to extreme aggression using relational strategies in comparison to ordinary resistance in which mothers chose to respond using mainly behavior management strategies.

**Parental experiences of support systems**

Mothers reported that they accessed services when they felt they did not have the appropriate resources to support their child. There were numerous parenting supports systems that mothers had accessed, including parenting groups, family therapy, one-on-one therapy, the Children’s Aid Society and Big Brothers Big Sisters (see Appendix C for details). Mothers described a range of experiences with support systems that varied from positive to negative. These support system experiences were captured by the following three sub-categories: sense of therapeutic relationship, congruity of services, and accessibility of services.

**Sense of therapeutic relationship.** Mothers described the therapeutic relationships in terms of how they fit the parents’ and children’s lived experiences or needs. The fit of the therapeutic relationship was described based on the way the professional provided service and the professional’s capacity to “get it”. The phrase “get it” was used by over half of participants, to describe when the professional connected well with families by validating their experiences and understanding their needs. For example, one mother reported, “she just seems to get it. S and I can go, and be feeling awful, and somehow we always leave feeling good or I feel like I have got a tool or trick to try out. She remembers stuff” (Family 8, 8-year-old daughter). Another mother reported “I really needed her to know that she really helped us and she has done nothing
at this point in terms of intervention. But she just, she really just got it” (Family 3, 12-year-old son). Lastly one mother reported that the therapist exhibited an understanding and responsiveness comparable to that of a parent.

She doesn’t push D, sometimes if she doesn’t feel like talking, they do a craft or draw or something. I just think she gets us, like she gets it. So I would thank her for that, and for not judging us and just sort of, gosh, for caring about D like this. It’s almost like, having a co-parent. (Family 16, 12-year-old daughter)

Mothers explained that some of the ways the professional seemed to “get it” or enhance the fit of their therapeutic relationship were by demonstrating a personal investment and going above and beyond for the mother or child. Mothers stated that professionals demonstrated that they were invested in the family by the ways that they tried to engage with the family’s life outside of the presenting issues. This occurred when the professional made a personal connection by recalling a special event the child had mentioned or remembered to follow up about a previous experience. For example, one mother reported, “I was thankful they made an effort to get to know what worked and what didn’t. They remembered the little things, D’s birthday, or her spelling competition, and would ask about it” (Family 8, 8-year-old daughter). Another mother reported how their family therapist “remembered D’s birthday and had a little card for her at her session, even though it was a week later. The small things. I think she really cares for us” (Family 6, 11-year-old daughter).

Mothers explained that when a professional went above and beyond what was strictly professional for their family it also enhanced the therapeutic relationship. One mother reported how her son had attended a school for children experiencing behavioral challenges. She provided
an example of the school professionals going above and beyond by attending her son’s sports game out of town. She stated that the principal,

drove all the way out of town to watch one of his games. I mean that is the kind of stuff that shows that they are, it’s building the relationship and saying, this is important to me. We are in this together, it is above and beyond. (Family 1, 13-year-old son)

Another way that mothers viewed professionals going above and beyond their strictly professional capacity was when they tailored their sessions based on the child’s needs. For example, one mother reported how her daughter loved Lego and her therapist would have Lego set out when she arrived to therapy (Family 25, 11-year-old son), another mother reported how her son could not sit still in session and the clinical psychologist would have walking sessions with him outdoors (Family 1, 13-year-old son), and lastly, one mother reported how her daughter loved story-telling and her therapist incorporated story-telling into their sessions, building on the child’s interests to talk about different types of emotions (Family 10, 12-year-old daughter).

These different ways of going beyond professional actions signaled to mothers that the professional was working hard to meet the child’s needs and provide them with support.

The other end of the continuum was when professionals did not “get it”, meaning they did not connect with the family, exhibit adequate understanding, or provide services that were helpful. Mothers reported different reasons why the relationship with a professional was not a good fit – the professional didn’t understand the family/family context or that the professional’s work was deficit focused. One mother reported her general experience of professionals supporting her child,

When it comes to understanding a kid like S you either get it or you don’t get it. And we have met teachers who get it and those who don’t... and the people who get it are the
people are the people I feel comfortable around. The people who don’t get it, you feel marginalized around. (Family 1, 13-year-old son)

Another mother reported her frustrations with the facilitators of a parenting group she attended,

Some of the people running those things, and it’s like you have no idea what this is like. You can picture them with their probably perfect little kids and houses and husbands (laughs) and it’s like, must be nice. Let us know when you have one second to get in the trenches with a kid like S, who might swat you or call you a motherfucker, or god, even threaten you. (Family 25, 11-year-old son)

One of the challenges mothers encountered when connecting with professionals, was the professional’s communication of a deficit perspective of the child’s capacities. It was difficult for families to work with professionals who consistently emphasized what was wrong with their child or their family. For example, numerous mothers reported how during the assessment process professionals were quick to pathologize their children and their inabilities without considering the context or situation. One mother reported,

The teacher thought he was just a really bad boy and that’s what they thought, he was a bad boy with bad behaviors who didn’t want to listen but he is not a bad boy. Yes, he is doing things that he shouldn’t be doing and they are bad things but there is a reason behind those bad things so why can’t we figure out what the reasons are and find strategies to fix that or help that. (Family 13, 13-year-old son)

Mothers reported their frustration with being treated poorly for reaching out to access services and support. One mother explained that she found it ironic that the services in which she should receive support, seemed to place blame and focus on her inabilities as a parent. She stated
that she wished she could tell the therapist to “get it together. Like not all families are these horrible families that beat their kids, like just because I need some help, doesn’t mean I am totally useless, you know?” (Family 25, 11-year-old son). One of the mothers stated more generally of her experiences accessing services that “It is not helpful when you are not hopeful, when you can’t see hope for us, and see each situation as unique. S was showing a lot of scary signs but he also had a lot of supports going for him that were helpful” (Family 1, 13-year-old son).

**Meeting us where we are at.** Participants in this study discussed the helpfulness of the strategies provided by parenting support services in terms of their congruence with their family’s needs, and experiences. Mothers reported experiences of strategies being congruent with family needs when the professional providing services “met us where we were at” (Family 17, 13-year-old son). Meeting families where they were at appeared to be when professionals used client centered language, strengths based approaches, and worked to “get it”. For example, one mother reported how her therapist used client-centered language to provide strategies for her and her son to make different choices “So, she would kind of use the words we used. She talked a lot about the idea of making choices, so like S would be encouraged to make better or different choices. That was actually kind of the same with what she would talk to me about... making better choices” (Family 17, 13-year-old son).

Mothers reported that they found communication strategies helpful, especially when tailored to their family’s needs. For example, one mother reported,

Then she mostly saw D, and worked with her on stuff like controlling emotions, or using her voice rather than freaking out. It was that kind of stuff – sometimes D would come home with a list of things she could do when she was angry, and she would be asked to
check them off if she did them and write a little bit about if they were helpful. (Family 8, 8-year-old daughter)

Another mother explained how her therapist helped her to communicate her emotions and consequently, she changed parenting approach which led to a change in the ways she was able to connect with her daughter. She explained,

So instead of freaking out, the counselors have taught me ways to focus on talking about feelings. I am sure you have heard of it, but like using I statements, or focusing on her feelings, that kind of stuff. So ya those are just helpful ways to connect with her that I still use. (Family 16, 12-year-old daughter)

There were also many mothers who reported that the strategies recommended by parenting support systems did not fit their family’s needs. There were two ways that mothers explained this lack of congruency in strategies and lived experiences, the first being that the strategies were not able to be implemented into effective, “real world” strategies and second that the strategies did not consider the unique nature of the child and context.

The majority of mothers experienced a disconnection from the strategies that the professional recommended and their lived experiences of parenting. One mother reported the challenges of mobilizing the recommended parenting strategies into practice. She stated,

We go into the session for an hour and it’s wonderful. But then when we get home, it’s like wait what did we talk about. It’s really hard to expand the ideas or strategies into your real life…We talk so much in theory and it’s really hard to bring it into our life.

(Family 9, 9-year-old son)

Another mother reported how the strategies suggested by their therapist were unrealistic for her family,
It was kind ‘la de da de’. Like bunnies and unicorns. I mean, it’s a great idea to have a
time-in, and I can totally understand how that might work for some people. But seriously
when D is kicking, screaming and maybe going to hurt herself or someone, I will take a
pass on that…. and I don’t know if that’s right, or if that’s the right kind of parenting, but
that is just the real world. (Family 8, 8-year-old daughter)

One mother explained how frustrated she was when her therapist suggested that she lay in
bed with her daughter every night until she falls asleep. She reported “well in the real world, in
our house, I need to get some sleep, my husband needs to sleep, my son needs to sleep…we need
to get our sleep because life goes on. So that wasn’t super helpful.” (Family 5, 13-year-old
dauhter). Another mother reported how her therapist couldn’t see the bigger picture and only
understood her child’s behaviors that she was seeing in the session “He plays games with the
therapist he sees right now and she’s like wow, this is great. And I am like (laughs) ya right, it is
great, because you only have him for 45 minutes of a game. Try this every day, try to deal with
this every time. Good luck!” (Family 9, 9-year-old son).

Another mother explained how her child’s psychiatrist had suggested that she respond to
her child’s extreme aggression using the same behavioral strategies each time. She reported,
They wanted this sort of, not strict but very matter of fact parenting. Like when D does
this you do this. Or when D throws this you do this. But for me, it doesn’t work that way.
Because when D throws a cup vs. throwing a stuffed animal, it’s probably for different
reasons. And the situations are probably different, and if I treated them the same, it
wouldn’t work…. I support consistent parenting but I also live in the real world. (Family
6, 11-year-old daughter)
Each of these mothers described how their lived experiences of parenting differed from the strategies provided by professionals. It was evident that these mothers felt that some of the strategies suggested by professionals were not a good fit for their family. Further, it was clear that mother’s felt the uniqueness of their child or the situation were not always being considered by professionals. For example, one mother reported how her therapist had recommended a star chart to reward the child for consistently demonstrating positive behaviors. This mother stated,

We tried this like star chore chart thing. So basically, it was supposed to be kind of a reward chart, that if you get a certain amount of stars then you get a prize. But it was kind of a joke. We tried it for a day, and eventually she would be putting stars up (laughs) and we couldn’t find the stickers. As I said, she’s just not that kind of kid. (Family 10, 12-year-old daughter)

Another mother reported her frustration with the idea of “time-ins”, which was a positive parenting strategy suggested by their family therapist. Time-ins in contrast to “time outs” were a tool used to keep the child close by after challenging behavior, as an opportunity to cool down and discuss what happened. She explained “Now the new parenting thing is time-ins as opposed to time-outs, which again, she isn’t typical, her behavior is not typical so that typical time-in doesn’t work for her either. She just becomes more enraged” (Family 7, 8-year-old daughter).

Another mother reported,

I mean I have tried all kinds of things, you name it. I’ve tried those little star charts, I’ve tried the magic wand, I’ve tried an allowance. But I do find a few things helpful but again, I know it sounds repetitive, but it is different. Like if D is hanging from the chandelier, screaming and hurting someone, then its immediate. (Family 6, 11-year-old daughter)
One mother reported how the strategies provided by her therapist were generic and did not take into account the unique circumstances of each family. She explained,

The things they are suggesting are the same for each Mom, or each kid when, I mean at least I think, in real life that’s not the case. So what D and I went through, no matter what, will always be different than what anyone else went through, just like how whatever anyone else went through is different from us. I think even if there are similarities (sigh) there are always differences. So, for example, they gave us this thought tracking exercise and D hated it. It’s just, like it was really not her style. (Family 20, 10-year-old daughter)

**Accessing services.** Participants reported varied experiences with accessing parenting support services. Mother’s explained that they had experiences in which services were easily accessible and experiences in which services were not easily accessible. Many mothers reported that they found services most accessible in times of crisis. For example, one mother reported,

Because I think that’s sort of how the system works maybe? Like if something really bad is happening to you, then, voila, have the services. So in the start it seemed that easy and we were really lucky. But no, I mean over the past little while I guess it’s like, not that easy. (Family 20, 10-year-old daughter)

Another mother stated that she first attempted to access mental health services but was unable to get support and therefore turned to crisis services. She explained,

Some of the other stuff, like mental health services, when I called they would be like – sure you can have an appointment in 4 months. So I was like, uh, no. We needed something quickly and so crisis services seemed to be the only place that you could get something quickly. (Family 17, 13-year-old son).
Participants explained that if their child or family was not in a stage of crisis then accessing services was challenging, or at times felt “impossible” (Family 1, 13-year-old son). Many mothers reported that if their child wasn’t “bad enough” at the time of reaching out to services, they would quickly be turned away. For example, one mother reported that at the time of accessing services her daughter “had some anxieties, and some social issues with her friends, and she worried a lot about things. But that wasn’t enough of a priority for her to get service because she wasn’t a safety or flight risk or aggressive” (Family 5, 13-year-old daughter).

Another mother reported when they attempted to access services,

    every place we went seemed to have another reason to tell us no. This kid is incredibly articulate and he has a C- in oral communication, which right or wrong, accessed appropriate or not, it is what it is. These are red flags and how does no one else see them. (Family 3, 12-year-old son)

    One mother explained, “If we wanted to get assessed at the school we, he’s not the worst. There are way more kids in need, and he, because he’s bright and hardworking and conscientious, he does not appear like a kid that is in need” (Family 4, 9-year-old son). Mothers expressed frustration with their inability to access services if they were not presenting in absolute crisis. One mother reported,

    What has to happen to get services. Does S have to hurt somebody? How serious does it have to get before we can access services? And that’s what it felt like – thanks for all that information that you emotionally poured out again for 3 hours, again, again, and again. But we can’t help you right now because we have a list of a million kids. (Family 3, 12-year-old son)

**Summary**
Mothers reported a range of experiences related to accessing parenting support systems. The therapeutic relationship was described as an essential part of the experience, in which mothers described the importance of professionals “getting it” and going above and beyond the professional relationship for them. Mothers expressed frustration and disappointment with professionals who were unsuccessful in connecting with their families, and who approached the family from a deficit-based perspective.

Mothers also reported different ways that the strategies suggested by professionals fit with the families lived experiences. Participants explained that when the therapist met the family where they were at by tailoring strategies and getting to know the child’s needs, services were more effective. In comparison, mothers suggested services did not fit when they were not “real world” strategies and they did not consider the unique nature of the child. It was evident in these experiences that there was a dissonance between the strategies suggested and the mothers lived or “real world” experience.

Lastly, mothers described the ways that they accessed parenting support services. Many of the participants reported that services were most easily obtained in times of crisis. Otherwise mothers described accessing services as challenging and fraught with complications. The notion of their children not being “bad enough” to access services was described, and mothers explained their inability to obtain services unless their child was at the peak of a crisis.

**Discussion**

This study provided insights into parent-child relationships and parent-child interactions of mothers who sought clinical services for challenging behaviors exhibited by their child. Theory, empirical research, and applied interventions have revolved around the construct of ‘noncompliance’ and the assumption that such behavior is the consequence of incompetent or
unskillful parental discipline (Kalb & Loeber, 2003; Patterson, 2013). The research questions and analyses of this study were approached with a broader conceptual framing than what has been used previously, sensitized not only by longstanding behavioral conceptions of noncompliance (Patterson's, 1982) but also alternative conceptions from developmental psychology including attachment theory (Stayton, Hogan & Ainswoth, 1971) and social relational theory (Kuczynski & De Mol, 2015).

Empirically this study makes three contributions. First, this study contributes a more holistic understanding of the parent-child relationship context of challenging child behaviors. This perspective extends beyond a traditional focus on decontextualized interactions where parents respond to noncompliant or coercive behaviors to a focus on the larger relationship context in which such interactions occur. Second, this study provides insight into the phenomenon of noncompliance as it appears in a clinical sample of children whose behaviors were maladaptive and difficult to manage by their mothers. These analyses provided evidence for two qualitatively different contexts of children's challenging behaviors – ordinary resistance and extreme aggression. Third, this study provides insight into experiences with practitioners that mothers perceive as helpful and not helpful when accessing parenting services for their children's challenging behaviors.

**Maintaining a complex relationship**

The mothers in this study described the complexity and efforts they put into maintaining a close and nurturing relationship with their children exhibiting challenging behaviors. It was apparent that mothers were multitasking on a daily basis within a parent-child relationship that made complex demands upon them. These tasks included providing security in the relationships
as attachment figures, striving to maintain a close personal connection with their children, and simultaneously managing their children's behaviors as authorities and socializing agents.

Mothers’ efforts to provide security in their relationship with their children was evident in their narratives about the importance of being there unconditionally for their children through emotional and physical means, even when their children were exhibiting resistance, aggression, or a loss of control. In the attachment domain, mothers’ interactions with their children when children were exhibiting challenging behaviors were similar to how attachment theorists define the concept of maternal responsiveness to children's distress in securely attached relationships. For example, mothers described the ways that they supported children's exploration, encouraged learning (Ainsworth, 1979; Ainsworth, Biehar, Waters & Wall, 2015) and provided protection or security when the child sought out their parent (Bretherton, Golby & Cho, 1997). Many mothers discussed how they read their children's' cues and responded accordingly to their children's needs (Van Ijzendoorn, Schuengel & Bakermans-Kranenburg, 1999). Mothers responded to their child in an empathetic, and prompt manner, especially when their child began to exhibit challenging behaviors, by providing reassurance and promoting cooperation.

A novel contribution of this study concerned the personal domain of mothers’ relationships with their children which captured mothers’ attempts to maintain a mutually satisfying personal relationship with their children beyond the aspects of the relationship where mothers act as providers and disciplinarians. These reports of closeness were consistent with research on parent-child intimacy (Harach & Kuczynski, 2005; Oliphant & Kuczynski, 2011) and Weingarten's (1991) conception of intimate interactions, in which individuals coordinate their actions by co-creating meaning, leading to mutual meaning-making during momentary interactions. In this study, mothers described being engaged with their children in coordinated
interactions or quality time that was mutually enjoyable. These interactions included physical touch, communication, problem-solving and completing an activity or working together towards a shared goal.

The term personal domain of relationships was used in preference to intimacy domain in order to more fully capture mothers' experiences of parenting, including experiences of personal hurt, relational doubt, and repair. The term intimacy has been used in attachment literature to capture warm and harmonious parent-child interactions (Kochanska, 2002), in which parents engage in mutually enjoyable moments and foster mutually driven goals and interests (Grusec & Davidov, 2007). The term intimacy has also been used in social relational theory to capture a domain in the parent-child relationship that is focused on feelings of relatedness, and mutual positivity (Kuczynski & De Mol, 2015). However, in both theories, there is little consideration of hurt and relational doubt which also were of personal significance to mothers in this study. In these findings, interactions were not always positive and harmonious (Bowlby, 2008; Kochanska, 2002) and the partners in the dyad did not always completely comprehend the other's actions (Kuczynski & De Mol, 2015).

These moments of uncertainty and the ways that mothers and children worked through them to maintain their personal relationship is missing from the developmental literature. It was evident that hurt and doubt impacted the relationship at the time of the interaction. For example, mothers shared the ways that hurt from their children caused them to doubt their parenting skills or how mothers had to take time to gather themselves after being hurt. In this study, in times of hurt or doubt mothers reported that they or their children engaged in exchanges of repair, in which the mother or child acknowledged wrongdoing towards the other and attempted to make amends. These repairs were one example of the interdependency evident in the mother-child
relationship, in which mothers described how each partner was receptive and vulnerable to the other's actions (Kuczynski & De Mol, 2015). For example, mothers expressed their relief when their child reached out to repair, and experiences of anticipation and uncertainty while waiting for repair to be initiated.

The attempts at reconciliation and repair after mothers or children hurt one another or caused relational doubts suggested that the relationship, despite difficulty, was important to both parents and children and that both had a stake in the relationship which they wished to preserve. Mothers reported that each of the partners’ efforts to repair demonstrated their connection and investment in the parent-child relationship. These efforts addressed personal relationship issues rather than just child management issues (Harach & Kuczynski, 2005; Jarret, Parra & Choen, 2015; Kuczynski & De Mol, 2015).

Mothers reported that they could understand where their child’s perspective was coming from and were empathetic towards their children, specifically during times of extreme aggression or distress. Similar to the literature on empathy, mothers expressed understanding and an interest in comprehending their children’s emotional experience that led to how they displayed their behaviors. Mothers were understanding and resonating with their children's emotional experience by working to take their perspective (Mikulincer, 2001; Rogers, 1975).

The third aspect of the parent-child relationship reported by mothers concerned interactions where mothers acted as socialization agents by setting and enforcing rules and expectations for appropriate behavior in every day contexts. Mothers described the ways they chose to exercise or not to exercise their greater power in their relationship to have their child follow through with parental expectations. These results are consistent with descriptions of interactions in the authority domain of the relationship (Grusec & Davidov, 2010; Kuczynski &
De Mol, 2015). In this domain mothers enforced rules by standing their ground (Forehand & McMahon, 2003), managing children's behaviors by carrying out consequences (Grusec & Davidov, 2010), and utilizing their power as a parent to have their expectations met (Patterson, 2016). These results suggested that mothers were using relational knowledge of their children when exerting authority, rather than exerting their greater power by making unilateral decisions. Mothers’ relational knowledge and connection with their child were used to inform choices regarding how to respond to each of these challenging behaviors. When children expressed ordinary resistance, mothers described exerting authority based on their knowledge of the child’s temperament, or their understanding of the way the child has responded to these exertions of authority in the past. When children exhibited extreme aggression, mothers used their connection with their child to assure them and provide reassurance. In both instances mothers described the ways they considered their children’s perspectives and used their personal relationship and knowledge of the child in the best interest of the dyad. This finding is novel and is not consistent with behavioral conceptualizations of parental authority in which mothers are coached to achieve their expectations immediately and without complaint (Patterson, 1982; Forehand & McMahon, 2003). In this literature, mothers are often depicted as the enforcers of rules, responsible for the unilateral implementation of discipline practices without considering the relational implications of their actions.

In summary, mothers’ descriptions of parent-child relationships were consistent with domain approaches (Kuczynski & De Mol, 2015). Mothers’ narratives revealed the importance of the holistic relationship context in their approach to interacting with their children when they are exhibiting challenging behaviors. Mothers did not consider these challenging behaviors in isolation from other aspects of their relationships with their children. Rather, participants made
simultaneous adjustments to different aspects of the relationship as a whole. These findings are consistent with domain theories on parent-child relationships that suggest that parents and children cycle through several interrelated domains, such as attachment, authority, and intimacy. Therefore, what happens in one domain may have implications for the other domains. For example, mothers considered the moments that they enjoyed with their children in the personal domain, and how they might be impacted by the ways that mothers exerted authority in the authority domain.

It was evident in this domain model that, unlike behavioral models (Patterson, 2016) mothers had multiple goals beyond compliance (Cavell, 1992). Mothers described parenting as relational in nature, rather than behavioral. Mothers understood, responded, and located their children’s behaviors in the context of the parent-child relationship rather than immediately reacting and treating children’s behaviors as isolated incidents. Similar to attachment theory, mothers described goals that included providing security for their children and maintaining a close, cooperative, personal relationship with personal significance to the mother (Kochanska, 2011). These goals influenced the ways mothers interacted with their children when exhibiting challenging behaviors, and further, the strategies or methods mothers used to support their children.

**Unpacking children's noncompliant behaviors: Ordinary resistance and extreme aggression**

Mothers distinguished two qualitatively different types of noncompliance: ordinary resistance and extreme aggression. Mothers described ordinary resistance as an expected part of children’s developing autonomy. Indeed, the examples that mothers provided such as ignoring, assertive refusal, delaying, and expression of attitude corresponds to findings of children's resistance strategies during early (Kuczynski & Kochanska 1990), and middle childhood
(Kuczynski, Robson, Burke & Song, 2015). Moreover, mothers normalized this form of resistance, attributing ordinary resistance to child development or their children's personality traits (see also Kuczynski, Robson, Burke & Song, 2015). Mothers' responses to this phenomenon were similar to control strategies found in previous research on families who have not accessed clinical services (Kuczynski & Hildebrandt 1997; Kalb & Loeber, 2003) ranging from exercising firm control and administering consequences to enforce compliance to every day requests to proactive behaviors aimed to prevent resistance to reasoning and explanation.

In contrast to ordinary resistance, extreme aggression was the second form of challenging behaviors exhibited by children. There were similarities between mothers' descriptions of extreme aggression and definitions evident in clinical literature. For example, hitting, yelling or destroying property, were consistent with clinical descriptions of children's aggression (Patterson, 2016; Parke & Slaby, 1983). In contrast to the normalizing attributions that mothers ascribed to children's ordinary resisters, mothers' attributions for the causes of extreme aggression referred to children's mental health or loss of self-control. In addition, whereas mothers' descriptions of ordinary resistance were often accompanied by anger or laughter, mothers' descriptions of extreme aggression were often accompanied by empathy for their children, or remorse for behaviors that they felt was out of their children's' control.

An important finding was mothers use of relational strategies when their child was exhibiting extreme aggression or was emotionally dis-regulated. Relational strategies avoided control and instead used physical reassurance, verbal reassurance or mothers made relational contact using their physical presence. For example, mothers expressed the ways that relational contact could help their children to de-escalate by mothers “being nearby”, “getting him to look me in the eye.. then he would remember I was his Mom..”. Mothers did not merely act to control
the children’s behavior to obtain compliance but also addressed their children's needs for security by assuring them of their support and providing responsive care to alleviate their children's emotional dis-regulation. Rather than treating these challenging child behaviors as intentional deviant aggression (Dishion, Reid & Patterson, 1992; Parke & Slaby, 1983) mothers were empathetic to the child and attributed their behaviors to a lack of control by their child. Such recourse to relational contact is inconsistent with prescriptions of demands for immediate compliance or aversive consequences such as time out in response to defiance or aggression (Forehand, Lafko, Parent, & Burt, 2014).

The distinction between two different child behaviors, attributions, emotions, and strategies for each challenging behavior also has theoretical implications for the three sensitizing theories highlighted in this study. In previous research, developmental research on noncompliance with families who have not accessed parenting support systems emphasized the positive and accepted role of resistance for autonomy development. Whereas behavioral models have focused on aggressive children where noncompliance was conceptualized as deviant behavior or coercion. To some extent this has led to very different ideas in the two literatures about the ways that noncompliance, resistance or acting out should be handled. Yet, the results of this study suggested that both types of noncompliance exist in the same families and may both be at least partially relevant. In these results, it was evident that children's resistance was at times expected, tolerated or even welcomed by parents, as a form of negotiation or opportunity to make changes to parental expectations. Thus, a direction for future research is to explore how insights from developmental psychology and clinical psychology could be integrated in the etiology and treatment of children exhibiting challenging behaviors.

**Parental experiences accessing parenting support systems**
Mothers in this study accessed support programs that had different theoretical approaches for children exhibiting challenging behaviors. Throughout these programs mothers consistently identified the importance of the professionals' relationship with themselves and their children, mentioned the understanding of the parents’ lived experiences when interacting with children and emphasized the extra-professional actions of the therapist that communicated their empathy, personal interest, and commitment to their well-being with the parent or their children. When describing negative experiences mothers critiqued the specific techniques or strategies for managing children's behaviors given by professionals and expressed their frustrations with the challenges of finding a program or professional that fit with their lived experiences of parenting.

A contribution of this study is a qualitative understanding of mothers’ lived experiences of the therapeutic alliance. Previous research has emphasized the importance of the therapeutic alliance. For example, Kazdin and Whitley (2006) suggested that in a parenting program for children exhibiting noncompliance, the better the quality of the therapeutic alliance, the greater improvements evident in parenting practices. Shirk and Karver's (2003) meta-analysis of multiple parenting programs suggested that the therapeutic alliance was a central contribution to therapeutic change. The descriptions of the therapeutic alliance in this study were similar to literature suggesting collaborative and interactive therapeutic relationships have a significant impact on client retention and the outcomes of therapy (Anderson, 2011; Horvath, 2001). In this study, mothers reported that the therapeutic alliance was the strongest when professionals supported families beyond the presenting problem of children exhibiting noncompliant behaviors. Mothers reported that behaviors indicative of personal involvement and commitment such as therapists recalling a child's birthday, sports event, or achievements, were factors that enhanced the therapeutic alliance. Similar to Goh’s (2015) research, mothers also reported that
they appreciated when professionals went above and beyond for their client by tailoring sessions, attending extracurricular activities, or accommodating specific family needs, also appeared to enhance the therapeutic alliance. Future research could explore the ways that joining with families outside of the presenting problem, and tailoring sessions based on each family, impacts the process and outcomes of therapy. This research could be used to identify if these skills, or this approach to therapy, need to be considered and taught more deliberately to family therapists.

Another important aspect of these results was that mothers experienced a dissonance between the content delivered in parenting support systems and their lived experiences of parenting. This dissonance was particularly evident regarding general parenting strategies, which mothers described as generic, not realistic and not a good fit with mothers’ lived experiences of parenting, the severity of their children's behaviors or the unique personality and reactions of their children. One example of a strategy recommended was "time outs" in behaviorally based parenting support systems (Forehand & McMahon, 2003) and “time-ins” in attachment interventions (Cassidy, Cooper, Hoffman & Powell, 2000). Mothers expressed frustration with the general nature of strategies and the lack of consideration for the uniqueness of each family and child. These results call into question the ways that research has been moved into practice, and further, how parental accounts of programming could be considered for more effective programming.

Clinical implications

There are four practical considerations that emerged from this study. First, the finding that parents distinguished ordinary resistance and extreme aggression as two qualitatively different domains of children's noncompliance has implications for practice. Clinically, practitioners could use these distinctions to consider that noncompliance is not always an issue,
or maladaptive. This could have implications not only for assessments but also for treatment planning and provide support to families while they access services. In assessments, parents could be asked about the function of these behaviors and explore how extreme aggression differs from ordinary resistance. Further, in treatment planning, extreme aggression, and ordinary resistance should be approached differently by practitioners, knowing that one can be dangerous or lead to a loss of child control, where the other is an expected and sometimes helpful tool that contributes to change. Practitioners may tailor their recommendations based on these differences and could use this approach to help amplify and mobilize parental strengths.

There were also two sets of strategies that mothers reported using for ordinary resistance and extreme aggression. One of which appeared to be behavioral with relational underpinnings, and the other relationship focused, are also valuable insights for helping professionals. Practitioners should take into consideration that parents in this study have reported relational strategies to be most effective for extreme aggression, rather than the behavioral strategies evident in a significant portion of clinical literature (Kalb & Loeber, 2003). Practitioners could support parents by first collaborating with families to determine the different kinds of strategies parents are using and how these might differ based on the child behaviors. By acknowledging and working with parents to explore the qualitatively different types of parental responses, professionals may be more successful in providing support that is not focused on one point in time, rather is amendable to the context, relationship and environment surrounding these interactions and strategies.

It was evident that social interactional theory (Patterson, 1982), attachment theory (Bowlby, 1979), and social relational theory (Kuczynski & De Mol, 2015) each had important theoretical tenets to contribute to practical programming for parenting children with challenging
behaviors. For example, in this study mothers at times found it helpful to use behavioral or relational strategies and tailor their levels of responsiveness. It was also evident that the scope of these theories appeared to be too narrow when mobilized into practice, and when individually applied there were gaps and limitations evident in each program informed by these theories. One recommendation from this study would be to consider the ways that each one of these theories has been effective in practical programming, and if consolidating the most effective contributions of each of these theories could resolve some of the gaps and issues. For example, research on the effectiveness of behavioral based programs is extensive (see review in McCart, Preister, Davies & Azden, 2006). Yet despite these intense evaluation efforts, effects of behavioral programs still appear to be small to moderate (Matthys & Lochman, 2017). Research has suggested that relationship based parenting programs are effective due to the focus on the interactional nature of the parent-child relationship (Couch, 2009; Couch, 2013; Coufal & Brock, 1984; Malins, 1997). Research has also suggested that there is a lack of relational focus in behavioral parenting program, which may contribute to the attrition rates in programs (Malins, 1997). Although social relational theory has been applied to practice in only one piloted parenting program (Couch & Evans, 2012), this theory may be a helpful tool for filling some of the gaps evident in behavioral programs, in which the parent-child relationships is considered secondary to children's noncompliant behaviors (Forehand & McMahon, 2003). Social relational theory (Kuczynski & De Mol, 2015) could be utilized to help understand the importance of child agency, emphasize the ways that three domains of the parent-child relationship can influence parental responses and child behaviors, and build these keystones into future programming.

Also, the findings of this study suggest a few different ways professionals can build this relationship with clients. First, by acknowledging and providing support around the amount of
work and effort that goes into maintaining the quality of the parent-child relationship, and how mothers are simultaneously balancing three relationship domains. Practitioners may be able to use this domain model to build the therapeutic alliance and provide support to understand the various complexities of these domains and the ways that these domains influence one another. It was also evident that a focus beyond the presenting problem of noncompliance was a helpful strategy for professionals to consider the complexities contributing to children’s behaviors. Parents highlighted children's agency and the ways that children were positively and negatively contributing to the relationship. Mothers described that their children were contributing to change and reaching out to repair, but mothers also described the stress, ongoing efforts and at times, exhaustion that accompanied maintaining the quality of the relationship. These findings provide further evidence that there could be a therapeutic benefit to having children and parents accessing resources together in parenting support systems to gain support and enhance parenting skills (Couch, 2009; Kazdin, 2003). Therapist could explore with children the ways they can positively contribute to the relationship, which could have the potential to alleviate some of their mothers' stress.

Lastly, this research could be a helpful start to reconsidering traditional constructions of the nature of families who access parenting support systems. In clinical literature on parenting children exhibiting noncompliant behaviors, it is evident that there is often a dichotomy created between parents who have accessed parenting support services and parents who do not seek or engage with parenting support services. The focus of literature and research on mothers who have accessed parenting support systems for their children's noncompliance is often on parental deficits such as a lack of parenting skills (Patterson, Reid & Dishion, 1992), parental mental health issues (Smith, 2004), or substance misuse (Velleman & Templeton, 2007). Whereas the
focus of literature and research with mothers who have not accessed parenting support systems for behavior problems is often on the strengths of the parent (Walsh, 2013). The findings in this study challenge these notions of clinical and nonclinical families by highlighting the effort and work that mothers engaged in to access helpful support services for themselves and their children.

Research is also required on the best methods of mobilizing clinical implications from research to practice. Models or methodology for moving these theoretical terms into programming are difficult to ascertain. Fisher and Gilliam (2012) suggested that parenting support systems are developed by abstracting constructions of noncompliance out of their original theoretical frameworks, placing them into program frameworks and organizing these constructions based on their relevance to performance objectives specific to each program. Future research could explore the exact mechanisms used for these processes. For example, determining how to ensure the flow of knowledge and information among multiple groups that lead to social, intellectual and economic benefits (Bennet et al., 2007; Hawkins, 2011) and the adoption of better and new ways to provide services (Greenhalgh et al., 2004; Ungar et al., 2015).

Limitations

Some limitations in this study should be noted. The primary limitation was the general nature of inclusion criteria. The diversity and variety in experiences and support systems accessed by the participants may have influenced the results. For example, most families had accessed parenting support systems with an attachment orientation. Therefore, these parents may have been attuned to their relationships with children in different ways than parents exposed to a behavior management perspective. In the recruitment inclusion criteria “parents who have
accessed services for their child's challenging behaviors" might have captured a subgroup of the population who accesses clinical services. For example, certain parents could have interpreted challenging to mean extreme behaviors as opposed to ordinary resistance.

Second, the individuals who participated in this study were primarily white, females and their children were their biological children. Future research could explore the experiences of fathers, children, caregivers and more diverse populations. These different family constellations, backgrounds and contexts could provide a more in depth account of parenting experiences and children’s behaviors. Further, the mothers who participated in this study were highly educated, with many completing university graduate degrees. This could have influenced the results as these mothers appeared to have access to different resources, and many were professional involved in the field of mental health. Although this appears to be a different sample then Patterson’s (2016) work, it was evident that at times these families experienced a similar phenomenon of noncompliance.

**Future directions for research**

The results of this constructivist GTM study provides several directions for future research and theorizing. First, it was evident that each one of the sensitizing theories, social interactional theory (Patterson, 1982), social relational theory (Kuczynski & De Mol, 2015), and attachment theory (Ainsworth, 1979; Bowlby, 2008), were useful for understanding various aspects of mothers' experiences of parenting and accessing support services for the presenting problem of children exhibiting noncompliant behaviors. Further exploration is required to examine in more detail the ways that these three theories could be amalgamated to gain a more holistic understanding of parent-child relationships and children's behaviors. For example, researchers could explore more specifically which parts of each theory are complementary, and
the implications of combining or utilizing multiple theories to inform a practical approach. The findings of this dissertation also document and expand on the relationship domain model, in which an attachment domain, personal domain and authority domain are central to comprehending children's resistance, aggression, and emotionally dysregulated behaviors. This model could be explored further with similar and different populations, to determine the ways that this framework could be a helpful tool for comprehending parent-child relationships.

Lastly, this research could be helpful for practitioners, mental health workers, and individuals working in parent support systems. First, to further explore the concept that noncompliance is not universally maladaptive. This finding encourages consideration of two qualitatively different forms of resistance, which led to two different kinds of responses for mothers. Researchers and practitioners could continue to examine the ways that parents are experiencing this phenomenon and what it might look like in a more diverse sample. Practically, these results could also be a helpful tool for practitioners to consider the content of programming and how deficit based paradigms impact families who access support services. The domain approach may be an opportunity for practitioners to explore strengths and determination, and the ways that parental strengths can be mobilized to help further support families.
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Appendix A: University of Guelph Research Board Certificate

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<td>Kuczynski, Leon (<a href="mailto:lkuczyns@uoguelph.ca">lkuczyns@uoguelph.ca</a>)</td>
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<td>Title of Project:</td>
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The members of the University of Guelph Research Ethics Board have examined the protocol which describes the participation of the human participants in the above-named research project and considers the procedures, as described by the applicant, to conform to the University's ethical standards and the Tri-Council Policy Statement, 2nd Edition.

The REB requires that researchers:
- Adhere to the protocol as last reviewed and approved by the REB.
- Receive approval from the REB for any modifications before they can be implemented.
- Report any change in the source of funding.
- Report unexpected events or incidental findings to the REB as soon as possible with an indication of how these events affect, in the view of the Principal Investigator, the safety of the participants, and the continuation of the protocol.
- Are responsible for ascertaining and complying with all applicable legal and regulatory requirements with respect to consent and the protection of privacy of participants in the jurisdiction of the research project.

The Principal Investigator must:
- Ensure that the ethical guidelines and approvals of facilities or institutions involved in the research are obtained and filed with the REB prior to the initiation of any research protocols.
- Submit a Status Report to the REB upon completion of the project. If the research is a multi-year project, a status report must be submitted annually prior to the expiry date. Failure to submit an annual status report will lead to your study being suspended and potentially terminated.

The approval for this protocol terminates on the Expiry Date, or the term of your appointment or employment at the University of Guelph whichever comes first.

Signature: [Signature]
Date: May 7, 2015

A. Papadopoulos
Chair, Research Ethics Board-NPES
Appendix B: Recruitment Poster
Are you a parent to a child that is 8-13? Have you accessed parenting services for your child’s behaviours?

We would like to hear from you! If you are interested in participating in this study, you will be interviewed by a researcher for approximately 1-2 hours. You will be asked about parenting, your child's behaviours and the kinds of parenting services you have accessed.

Participants will be provided compensation.

Please contact Jane Robson at robson@uoguelph.ca or 519 824 4120 ext. 52757. Jane Robson is a graduate student at the University of Guelph and works at Family Counselling and Support Services of Guelph-Wellington. This project has received approval from the University of Guelph's Research Ethics Board.
## Appendix C: Demographics

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<th>Parenting Support Accessed</th>
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<td>Attachment</td>
</tr>
<tr>
<td>Family 22</td>
<td>10</td>
<td>M</td>
<td>Family therapist, nurse, play therapist, psychiatrist</td>
<td>Not specified</td>
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<tr>
<td>Family</td>
<td>Age</td>
<td>Gender</td>
<td>Role</td>
<td>Diagnosis</td>
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<tr>
<td>---------</td>
<td>-----</td>
<td>--------</td>
<td>-------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Family 23</td>
<td>11</td>
<td>M</td>
<td>Big Brothers Big Sisters, family therapist</td>
<td>Behavioural</td>
</tr>
<tr>
<td>Family 24</td>
<td>12</td>
<td>F</td>
<td>School counsellor</td>
<td>Attachment</td>
</tr>
<tr>
<td>Family 25</td>
<td>11</td>
<td>M</td>
<td>Family therapist, parenting program</td>
<td>Not specified</td>
</tr>
</tbody>
</table>
Appendix D: Semi Structured Interview Guide

**PART 1**
Warm up questions. **Purpose:** To build rapport

So, to begin, do you any questions?

- What made you decide you wanted to take part in an interview today?
- How do you describe your child?
  - What are your hopes for your children?
  - How do you describe your relationship with your child?

**PART 1: Parenting**
- We are going to talk a bit about your parenting. Tell me about parenting (child’s name)?
  - What is one thing you feel you do really well as a parent?
    - PROBES: How do you know?
  - What is something you would like to work on as a parent?
    - PROBES: How do you know?
  - Who has influenced how you parent?
    - PROBES: In what ways?

**PART 2: Child behaviours**
- What do you call your child’s behaviours when they are challenging?
  - PROBES: How do you make choices about what you call this? How do you know when to?

- What do you as a parent view as challenging behaviours from your child?
  - If _________ was here today, and I were to walk into the room, how would I know that _________ was experiencing these behaviours?
    - PROBES: How do you notice? How did you react then?
  - How do you think these challenging behaviours impact your parenting style?
    - PROBES: How do you notice these differences?
  - When does this change?
    - PROBES: For what reasons? When your child engages in this kind of behaviour, what do you make of that?

**Specific typical interaction**

I have heard from a few different families that there are these different kinds of challenging behaviours – what do you think? How do you differentiate them?
• First, could you please describe a typical event in the past week when your child did not fully cooperate with your directions.
  o PROBES: What did your child do? What did you think about this behaviour?
  o How do you respond?
    ▪ PROBES: How do you know how to? How does this interaction go?
  o Are there times or situations when this behaviour is okay?
    ▪ PROBES: What makes it okay? Can you give me a specific example of a time that it was okay?

• Second, could you please describe an event when your child’s behaviour was challenging or harder to manage.
  ▪ PROBES: What did your child do? What did you think about this behaviour? What did you do? What happened next? How did you feel about it?

PART 3: Parents’ perspectives on parenting support systems
• One of the things I am interested in is the kind of parenting supports that parents have received to help out. Can you tell me about your experiences getting support for your child’s challenging behaviours? (PROBES BELOW)
  o How did you experience these supports?
  o How did you know about these supports?
  o What was it like getting these supports?
  o How did that service influence what you are doing now?

• How did the facilitators, or leaders of these programs talk about challenging child behaviours?
  ▪ PROBES: What did you think of this? How did this fit with your own experiences?
  o How did the facilitators or leaders of these programs talk about your parenting?
    ▪ What did you think of this (appraisal question)? (why?)
      • What sort of strategies did they recommend to manage these challenging behaviours?

• What service or program stands out as most helpful?
  o Why?

• Is there one service or program that stands out as not as helpful? Why?
  o Why? (PROBE: what was missing?)

Advice to professionals and parents
• If somebody (a helping professional, instructor etc.) was here from that support, what kind of advice or feedback would you want to give them?
Is there any advice or feedback you would want to provide on the process of accessing support more generally?

- Is there advice or feedback you would give to parents who may be going through the same process?

**Noncompliance**
- Lastly, I am interested in the terms noncompliance and compliance:
  - Are these words familiar to you? (PROBES BELOW)
    - Where have you heard these terms before?
    - Could you describe the behaviours you associate with these terms?
    - Who has used these terms before or who would you imagine would use the terms compliant or noncompliant?
    - When might they be used?

**FEEDBACK ON INTERVIEW**

- Is there anything that I missed?
- Do you have any suggestions about how to improve the interview?
### Appendix E: Parents Characterization of their Relationships with their Children

<table>
<thead>
<tr>
<th>Categories</th>
<th>Number of mothers</th>
<th>Proportion of mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relational effort</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anticipating and knowing the child</td>
<td>19</td>
<td>76%</td>
</tr>
<tr>
<td>Providing security</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being there for the child</td>
<td>16</td>
<td>64%</td>
</tr>
<tr>
<td>Supporting my child no matter what</td>
<td>15</td>
<td>60%</td>
</tr>
<tr>
<td>Experiencing closeness and hurt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enjoying quality time</td>
<td>19</td>
<td>76%</td>
</tr>
<tr>
<td>Being empathetic</td>
<td>16</td>
<td>64%</td>
</tr>
<tr>
<td>Making relationship repair</td>
<td>14</td>
<td>56%</td>
</tr>
<tr>
<td>Understanding what lies beneath</td>
<td>17</td>
<td>68%</td>
</tr>
<tr>
<td>children’s behaviors</td>
<td>15</td>
<td>60%</td>
</tr>
<tr>
<td>Experiencing hurt in the relationship</td>
<td>11</td>
<td>44%</td>
</tr>
<tr>
<td>Having relational doubts</td>
<td>17</td>
<td>68%</td>
</tr>
<tr>
<td>Maintaining positive regard</td>
<td>13</td>
<td>52%</td>
</tr>
<tr>
<td>Acting as agents of socialization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standing ground</td>
<td>13</td>
<td>52%</td>
</tr>
<tr>
<td>Carrying out consequences</td>
<td>10</td>
<td>40%</td>
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Appendix F: Parents Conceptions of Challenging Child Behaviors

<table>
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<tr>
<th>Categories</th>
<th>Number of mothers (N=25)</th>
<th>Proportion of mothers</th>
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</thead>
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<tr>
<td>Ordinary resistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acting out</td>
<td>24</td>
<td>96%</td>
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<tr>
<td>Displaying attitude</td>
<td>20</td>
<td>84%</td>
</tr>
<tr>
<td>Parental attributions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“It’s who they are”</td>
<td>11</td>
<td>44%</td>
</tr>
<tr>
<td>Normalizing resistance</td>
<td>17</td>
<td>68%</td>
</tr>
<tr>
<td>Parental responses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preparing children by being proactive</td>
<td>12</td>
<td>48%</td>
</tr>
<tr>
<td>Sticking to it</td>
<td>17</td>
<td>68%</td>
</tr>
<tr>
<td>Attending to and fostering children’s responsibilities</td>
<td>15</td>
<td>60%</td>
</tr>
<tr>
<td>Extreme aggression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Destroying property</td>
<td>17</td>
<td>68%</td>
</tr>
<tr>
<td>Physically hurting someone</td>
<td>19</td>
<td>76%</td>
</tr>
<tr>
<td>Verbal coercion</td>
<td>20</td>
<td>80%</td>
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<tr>
<td>Children hurting themselves</td>
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<td>24%</td>
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<tr>
<td>Parental attributions</td>
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<tr>
<td>Mental health</td>
<td>10</td>
<td>40%</td>
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<tr>
<td>Losing control</td>
<td>18</td>
<td>72%</td>
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<tr>
<td>Parental responses</td>
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<td></td>
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<tr>
<td>Verbally reassuring</td>
<td>8</td>
<td>32%</td>
</tr>
<tr>
<td>Physically reassuring</td>
<td>10</td>
<td>40%</td>
</tr>
<tr>
<td>Making relational contact</td>
<td>8</td>
<td>32%</td>
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