EMOTION WORK, LABELING, AND GENDER IN POST-PARTUM AND POST-ADOPTIVE DEPRESSION

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ABSTRACT

KANE, HEATHER: Emotion Work, Labeling, and Gender in
Post-Partum and Post-Adoptive Depression
(Under the direction of Sherryl Kleinman)

Based on 59 in-depth interviews with women who defined themselves as depressed after the birth or adoption of a child, this dissertation examines post-partum and post-adoptive depression (PPD and PAD, respectively). In Chapter 1, I address the women's discrepant feelings in relation to motherhood and analyze how they came to take on the labels PPD and PAD. Experiencing discrepant emotions, they tried to convince themselves that they were not bad mothers. After looking for alternative explanations, the women performed the work that "good mothers" should. They hoped that this would transform their feelings, but those feelings moved from discrepant to deviant emotions (Thoits 1985). Eventually, they blamed themselves for their feelings and appropriated the label. Some sought help from healthcare providers; others found relief in non-medical solutions and non-mother identities.

In Chapter 2, I analyze the husbands' strategies for alleviating their wives' pain. Doing emotion work, which is defined as women's work (Bartky 1990), might have threatened their masculinity. But, the strategies ultimately shored up white, middle-class masculinity. Guided by ideas of masculine control (Johnson 2005), the men offered breaks from child care, took charge of the situation, asked their wives to cheer up, and avoided conflict. They did so in ways that allowed them to believe they were good companionate

husbands and fathers. The women reported mixed evaluations of their husbands' efforts. They appreciated their husbands' "help," but their husbands did not change the women's circumstances or feelings.

In Chapter 3, I examine how adoptive parents dealt with the complex deviance associated with adoption. Adoption is simultaneously a form of positive and negative deviance. Adoptive parents fulfill prescriptions to become parents, but do so by means that are still considered dubious or "second best" (Fisher 2003). Parents managed the negative aspects of adoption by approximating biology: seeking children with similar physical characteristics and invoking cultural scripts associated with pregnancy and childbirth. Parents managed the positives by rejecting others' comments that they were "rescuing children"; these "compliments" devalued their children as charity cases. Finally, the parents ennobled themselves and their children for having endured more hardships in becoming a family.

To the women who have made this possible, especially my mother, Karen Kruse,
and my "sociological mother" Ruth Wallace

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TABLE OF CONTENTS

I. INTRODUCTION

Andrea Yates was a stay-at-home mother of five small children. As a fundamentalist Christian woman, being a wife and mother were her religious callings—the highest virtues a woman in those communities could achieve. Every morning, she sent her husband off to work at NASA and fed her five children breakfast. But one morning, she filled the bathtub with water. She called her three youngest sons into the bathroom, and, one by one, held them underwater until they drowned. She placed each child on his bed, and covered each with a blanket. Then, she returned to the bathroom, lifted her seven-month-old daughter from the floor, and drowned her. She called her oldest child Noah. When he came up the scene of his mother and dead sister, he asked, "What's the matter with Mary?" He realized something was amiss, and frightened, he ran. She chased Noah, and upon catching him, took him into the bathroom, where she repeated what she had already done four times.

Andrea then called 911 and reported her crime. She called her husband, Russell, and asked him to come home, telling him, "It's time." Andrea reported to the police that she had killed the children so that they could go to heaven. Their "bad behavior" proved that she was a bad mother, and they needed to be spared of her mothering. She also believed that she was Satan incarnate, and in getting the death penalty, Satan would be destroyed (Hyman 2004).

After the birth of her fourth child, in 1999, Andrea Yates had attempted suicide, experienced hallucinations, and been hospitalized. Psychiatrists warned Russell and Andrea

that having more children could be extremely detrimental to her health, but in 2000, she became pregnant again and gave birth.

Although her crime was heinous, her story struck a cord with many mothers. Railing against "the insidious cult of motherhood," columnist Anna Quindlen wrote:

> Every mother I've asked about the Yates case has the same reaction. She's appalled; she's aghast. And then she gets this look. And the look says that there are two very different kinds of horror here. There is the unimaginable idea of the killings. And then there is the entirely imaginable idea of going quietly bonkers in the house with five kids under the age of 7 (Quindlen 2002).

Andrea Yates exposed the unrealistic expectations for mothers. She managed the care and homeschooling of the children as well as the housework. At the same time, she also provided some care for her father, who had Alzheimer's disease. She was isolated from others and guilt-ridden about her mothering (Hyman 2004).

Andrea Yates represented some of the most challenging circumstances of motherhood, but she is on a continuum with other mothers. One of my friends, for example, experienced distress after the birth of her child. I didn't know that she was having problems until a mutual friend told me that Tina had confided in her. From my observations, she was managing everything with aplomb. She worked a full-time job, picked a terrific day care, and still managed to invite me over for coffee.

Hearing about her distress, I offered to bring a casserole and stop in for a quick visit. When I arrived with my covered dish, she greeted me with a smile and invited me in for coffee. I tried not to let on that I knew her secret, but asked how she was doing. She unraveled. She was exhausted from lack of sleep. Her nipples stung from breastfeeding. The baby demanded every ounce of energy she could spare. She said she couldn't take it anymore.

Having studied gender inequality, I knew women did the majority of child care, and I could easily imagine that caring for a small child would be difficult. Nevertheless, hearing my friend's gut-wrenching story, I felt confused. Why was she feeling this way? And, why hadn't I suspected sooner?

Surprised by Tina's experience and wanting to help her, I became interested in what is medically labeled as post-partum depression (PPD). I scoured the web for resources and asked for advice from friends. One person recommended that I read Verta Taylor's (1995, 1996) sociological work on post-partum illness. I was surprised to learn in *Rock a by Baby* (1996) that some adoptive mothers also defined themselves as depressed. Many of the explanations I had heard about post-partum depression, particularly in the mainstream media, suggested that it was a physiological phenomenon brought on by hormonal changes after giving birth. Reading that adoptive mothers had similar experiences to biological mothers led me to question this explanation and think about these women's experiences as a social phenomenon.

To investigate these puzzles, I initially planned to study support groups for post-partum depression (PPD) and post-adoptive depression (PAD), adding interviews with participants. My intentions were thwarted (see "Data & Methods," below), so I opted to conduct in-depth interviews with women who identified themselves as having had PPD or PAD. Because the women's experiences occur within the context of the family, I decided to interview the partners, if they had one. In his sociological work on depression, David Karp (2001) found that the person who is defined as ill share a "joint history" with his or her intimates. In total, I conducted 59 interviews: 22 with biological mothers (15 women were

interviewed with 7 interviewed twice for a total of 22), 9 with biological fathers, 18 with adoptive mothers, and 10 with adoptive fathers.

What circumstances created women's isolation in the home and changes in the belief systems that justified that isolation? Before the industrial revolution, many families survived through private cottage industries and farming. Each family member's responsibilities were critical for survival. In terms of child care, women bore many of the responsibilities, but fathers shared in the education and moral upbringing of children.

Throughout the 19th century, the industrial revolution contributed to an increasing division of private/home and public/work spheres, and a corresponding justification for the separate spheres. The "cult of domesticity" or "cult of true womanhood" defined (white, middle-class) women as the natural keepers of the home and children. A woman who left the home to perform public work lacked virtue. Similarly, men were seen as naturally suited for the public sphere and breadwinners for their families. The legacy of the separate spheres and male breadwinner/female homemaker arrangement continues today, even with so many women in the paid labor force. Mothering and caring work is still defined as women's work, and paid labor men's. Men's identities remain tied to providing a good family wage. Likewise, employers often suspect women in the labor force are less serious workers because they could become mothers on the "mommy track" (Tichenor 2005).

History can offer the context, but I turn to the sociology of emotions to understand the women's experiences. From this perspective, especially as discussed by symbolic interactionists (Hochschild 1979, 1983, 1990), emotions are social objects that we can manage, control, and manipulate to negotiate in interactions. Emotions serve as a barometer, what Hochschild calls a "signal function" (Hochschild 1983:29). Hochschild explained,

"Emotion, like seeing and hearing, is a way of knowing about the world. It is a way of testing reality" (Hochschild 1983:29). The experiences of women I interviewed (and my friend's distress) tell us about the exacting standards for white, middle-class mothers and the negative emotional consequences for women. Sharon Hays aptly captured these expectations in her concept of "intensive mothering." Douglas and Michaels added:

> Intensive mothering insists that mothers acquire professional-level skills such as those of a therapist, pediatrician ('Dr. Mom'), consumer products safety inspector, and teacher, and that they lavish every ounce of physical vitality they have, the monetary equivalent of the gross domestic product of Australia, and, most of all, every single bit of their emotional, mental, and psychic energy on their kids…With intensive mothering, everyone watches us [mothers], we watch ourselves and other mothers, and we watch ourselves watching ourselves (2004:6).

As if these expectations were not enough of a burden, women want to be not just a "good mother," but the best mother (Douglas and Michaels 2004). Under these circumstances, is it any wonder that women feel anguished? Or, perhaps the better question is, why aren't all mothers saying that they're depressed? Moreover, new mothers are not only expected to <u>do</u> intensive mothering, but also to *enjoy* doing it.

The concept of "feeling rules" is central to understanding what the women went through. Feeling rules are "rules about what feeling is or isn't appropriate to a given social setting" or for particular roles (Hochschild 1990:122); they tell us how we <u>ought</u> to feel. The women I interviewed felt distressed after the birth or adoption, and distress is not a socially appropriate feeling for a new mother.

In Chapter 1, I address how the women's discrepant feelings in relation to motherhood are implicated in the labels of PPD and PAD. I analyze how women came to take on the label of post-partum or post-adoptive depression. Experiencing such discrepant emotions as sadness or anger, they initially tried to convince themselves that they were not

bad mothers by attributing their negative feelings to hormones or sleep deprivation. After trying to find alternative explanations, the women performed all the work that "good mothers" should. They hoped that doing the work of motherhood would transform their feelings, but their negative feelings endured, moving from discrepant to deviant emotions (Thoits 1985). Eventually, they blamed themselves for their feelings and, after experiencing a triggering event, appropriated the label. Some then sought help from health care providers with varying degrees of success. Others found relief in non-medical solutions and non-mother identities, suggesting that middle-class expectations for motherhood were part of the problem.

Most of the women I interviewed had male partners, raising the question, "How did the men respond to their wives' distress?" In Chapter 2, I analyze the husbands' strategies for alleviating their wives' pain. Doing emotion work, caring work defined as women's work (Bartky 1990; Hochschild 1983), might have threatened the men's masculinity. Middle-class masculinity relies on men "[seeing] themselves as subjects who intend and decide what will happen and to see others as objects to act" (Johnson 2005:27). Control over one's emotions provides a guise of rationality, which in turn, legitimates middle-class men's authority in the workplace (Sattel 1976). Asking men to share in care work and express vulnerability could threaten the gender and class systems that give them privileges.

But, the caregiving strategies the men used ultimately shored up white, middle-class masculinity. Guided by ideas of masculine control (Johnson 2005), the men offered their wives breaks from child care, took charge of the situation, asked their wives to cheer up, and avoided conflict. They did so in ways that allowed them to believe they were good companionate husbands and fathers. The women reported mixed evaluations of their

husbands' efforts. They appreciated their husbands' "help," but their husbands did not ultimately change the women's circumstances or feelings.

During the interviews, I discovered that adoptive parents consistently discussed others' reactions—often negative—to their anticipated role. I was surprised by this finding; I had assumed that adoption was largely an accepted practice. In Chapter 3, I examine how adoptive parents dealt with the complex deviance associated with their adoptive status. Adoption is simultaneously a form of positive and negative deviance. Adoptive parents fulfill social prescriptions to become parents, but do so by means that are still considered dubious or "second best" (Fisher 2003). For instance, one woman was told that she was "taking on somebody else's mistakes." But, adoptive parents are also defined as sacrificial saviors of children who were "doing such a fabulous thing."

Adoptive parents wanted to be seen as a "normal" family and, thus, had to deal with both forms of deviance. They managed the negative aspects of adoption through "biological" rhetorics. They also tried to seek children with similar physical characteristics, and invoked cultural scripts associated with pregnancy and childbirth. The parents managed the positives by rejecting others' comments that they were "rescuing children"; these "compliments" devalued their children as charity cases. Finally, the parents ennobled themselves and their children for having endured more hardships than others in becoming a family.

DATA & METHODS

The data for this project come from 59 semi-structured, in-depth interviews I conducted from March 2002 to November 2003 and from December 2005 to February 2006.

I interviewed women who identified themselves as having experienced PAD or PPD. [1] When I could, I also interviewed their partners.

Because I was interested in how new mothers made sense of—and managed—negative feelings after birth or adoption, I initially planned to conduct a qualitative study of PPD and PAD support groups, but this plan was stymied. After contacting local adoption agencies and searching the Internet, I did not find a local PAD group. I did manage to find a local PPD group, but after trying to gain access for 16 months, the facilitator limited me to three visits when his co-facilitator was on vacation (during which I recorded fieldnotes, which I transcribed after leaving the setting). Consequently, I decided to conduct interviews. I will address recruitment and demographics for biological and adoptive parents.

Biological Parents

In 2001, I identified a PPD support group. As mentioned above, the facilitator allowed me to visit the group three times when his co-facilitator was absent, but would not let me attend on a regular basis. However, he emailed my request for participants to the group's listserv three times in 2002. I was able to recruit nine women, a convenience sample. In 2005, I discovered a newly-created Internet support group for PPD. I contacted the moderator and asked her to distribute my request for interviews to the group. I then was able to recruit six additional women.

I interviewed a total of 15 women who identified themselves as having post-partum depression; seven of these women I interviewed twice for a total of 22 interviews (see

[1] I also conducted three additional interviews with therapists who work with clients.

Appendix for "Interview Guide"). Nine of the 15 women had no history of depression.[2] Each of the interviews was conducted in person either at the women's homes or at local coffee shops. The interviews were emotionally intense (i.e., women often cried, became choked up, or could only speak in a whisper while they held back tears), and I cut interviews short when I thought the participant needed to stop. I asked the women if I could call them with additional questions, and I was able to follow-up. The interviews ranged from an hour-and-a-half to four hours, with most taking an hour-and-a-half.

When applicable, I conducted interviews with the women's partners. Thirteen of the women had male partners; one had a female partner. The remaining woman was not partnered. I asked all of the partners to participate in an interview, and nine of the possible fourteen agreed (eight men and one woman). These interviews ranged from one to two hours, with most taking one hour. Most were conducted in person at local coffee shops or at their homes. Three of the partners preferred a phone interview.

Of the 15 couples, one couple was black, and the rest were white. Interviewees were predominantly middle-class (most of their incomes fell between $30,000 and $75,000, with a median of $50,000; the 2002 national median income was $43,052). The average age of the women was 34 years, and 36 years for the men. Nine of the 15 women were full-time stay-at-home mothers. Two others initially planned to follow that route, but one was getting divorced and needed to return to paid labor; a second tried to be a stay-at-home mother, but found that she needed outside interests and so returned to work. All the male partners were employed full-time.

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[2]Determining "history of depression" as a demographic question was more complicated than I expected. After taking the label of "depressed," three of the women reflected back on their adolescent and college years and interpreted past "teenage angst," as Rhian put it, as possible depression.

Adoptive Parents

To recruit adoptive parents, I located and contacted the social worker who coined the term "post-adoptive depression." After interviewing her, she gave me the names of others who might be willing to help me find women who had experienced PAD. I contacted the two people she mentioned: a nurse who was writing a book about PAD and another woman active in the online adoption community. The latter agreed to post my request for interviews on her listserv, which had a preponderance of international adoptive parents. I received almost 100 responses. About one-third of the women who responded had not experienced PAD but were eager to talk about their adoption experiences. This listserv also had a members-only message board where adoptive parents—male and female—could ask questions, offer advice, and give support; in this way, they had an informal support group.

Again, I primarily used a convenience sample, a limitation of this study. However, within it, I used some selective sampling strategies (Glaser 1978). After interviewing the first group of women who identified themselves as having PPD, I read that a history of depression is a "risk factor" for PPD (Kleiman 2000; Swendsen and Mazure 2000). Consequently, I decided to screen out adoptive parents with that history. Because I could not control for history of depression with my completed PPD interviews, I opted to keep all of those in my sample. Additionally, it was difficult to recruit biological mothers, so I could not afford to cut participants. Because others might argue that a history of depression would explain PAD, it made sense to "control" for it when I had sufficient volunteers. This decision cut the possible number of interviewees in half.

Throughout 2003, I conducted 28 semi-structured, in-depth interviews with adoptive parents (13 married couples and four unpartnered women, one of whom had separated from

her spouse). These interviews included 18 adoptive mothers and ten adoptive fathers. Because participants were dispersed throughout the U.S., I conducted most of the interviews over the phone. This may have impeded rapport initially but also allowed for a sense of anonymity and freedom of expression not available in face-to-face interactions. The interviews ranged from one to six hours. The median was one-and-a-half hours.

All of the interviewees, except for one, adopted internationally. The high number of international adoptive parents was a consequence of the listserv, which offered more information on international than domestic situations. International adoptions comprise the fewest number of adoptions in the U.S., though this number has nearly tripled in the last fifteen years (U.S. DHHS 2004). International adoptions accounted for 13% of all formal adoptions in the U.S. in 2003; the remaining 87% included those by stepparents, grandparents, and other domestic adoptions (Kreider 2003:2). The parents I interviewed adopted children under the age of five with three exceptions (two couples adopted sibling groups of children over five, and the couple who adopted domestically adopted an eight-year-old). This is consistent with national trends. Those who adopt internationally typically opt for younger children. In 1998, 47% of international adoptions were of children under the age of one, and 41% of international adoptions were of children one- to four-years-old (adoption.com 2006).

These interviewees opted for international adoption for several reasons. All of them were white, and many wanted white babies or a child as young as possible. Finding a white baby in the U.S. may take years, so international adoption offered an expedient alternative (Barthelot 1993). Some parents did not want to maintain a relationship with the birth mother. In the U.S., more birth mothers are demanding some level of involvement in the child's life

(Bartholet 1993), and international adoption would minimize that likelihood. The couple who adopted domestically wanted an older child and a less expensive route to parenthood.

Like previous research on adoptive parents, the participants I interviewed were older and had more education than the average parent (Miall 1996). Except for two women, the interviewees had at least an undergraduate degree. The average age was 44 years for the women and 45 years for the men. Adoptive parents tend to be older than biological parents, but these parents were generally older than their adoptive peers (Stolley 1993).[3] Most had yearly incomes greater than $50,000. Because sufficient resources are necessary for international adoption, it is not surprising that the interviewees had incomes greater than the national median ($43,052). The national median household income of adoptive families is $56,138, and the median of this sample is $54,168.[4] Nine of the seventeen adoptive mothers were full-time stay-at-home mothers, but two additional women worked in child care and brought their children to work with them. All of the male partners, except one, were employed full-time (One man had recently lost his job, but his partner was employed full-time).

In sum, the adoptive and biological parents were slightly better off than the national average, and the adoptive parents had a higher median income than their biological peers. Consistent with national trends, the adoptive parents were also older than the biological parents. All the participants (except one) were white, and most were in heterosexual relationships. The vast majority of all participants had at least an undergraduate education.

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[3]Stolley (1993) reports that the age range of adoptive mothers is 25 to 34, but these figures include all formal adoptions.

[4]One of the interviewees, an unattached woman, usually made more than $50,000, but was taking a one-year leave. Her income for the year of the interview fell in the $15,001-$30,000 range.

Data Collection & Preliminary Analysis Strategies

During the interviews, participants and I discussed expectations of family-building, the adoption (or birth) process, family life after the adoption (or birth), household responsibilities, support from friends and family, life with PAD (or PPD), and therapy. I covered each topic, but the order varied, depending on the flow of the interview. Each interview was tape-recorded and transcribed, and after each session, I wrote detailed notes. Additionally, I wrote analytic memos. Analyzing and collecting the data simultaneously allowed me to test my ideas about mothering, depression, and labeling, as well as (re)orient my interview guide to issues that the participants cared about. For instance, in my interviews with adoptive parents, I initially asked questions about social support during the adoption process but was surprised in my first interviews when interviewees told me that family members and friends tried to dissuade them from adopting. These first interviews led me to add questions about resistance (e.g., "Who was the least helpful during the adoption process?"; "Did you encounter any difficulties from others after you adopted?"; "Could you give me an example?").

Throughout the data collection process, I employed an open coding method, which enabled me to approach the data without preconceived codes (Glaser 1978). This allowed me to approach the data inductively; I was able to explore themes that I had not initially considered when I designed my interview guide. This strategy led me to discover that biological and adoptive mothers described similar experiences of sleep deprivation, discrepant emotions, and normalizing strategies.

Likewise, I employed the constant comparative method (Glaser and Strauss 1967), which involved reading the data and, while coding, documenting the common ideas and

themes throughout the interviews. I manually sorted the data into such categories as "emotions after birth/adoption," "definitions of depression," and "emotion management." I also organized the codes temporally onto the progression the women described (i.e., the process by which they came to see themselves as depressed). This enabled me to identify the stages in the self-labeling process.

Insider/Outsider Status

Prior to the interview, I did not divulge that I am childless by choice, but most of the parents asked about my parental status at the end. I suspect that I inadvertently prevented this line of questioning at the outset because I had a lengthy consent form that busied the interviewees while I set up my equipment. "Small talk" before the interview focused on my old tape recorder and questions about the consent form, anonymity, and my graduate program. If a parent asked whether I had children, I said that I had none, but that I became interested in PPD after a friend experienced post-natal difficulty.

One might argue that being an outsider allows me to approach motherhood (and fatherhood) with more distance. As Sharon Hays noted in her study of motherhood, "part of my job…is to take the familiar and make it strange…[by approaching] motherhood as if I were a disinterested outsider" (1996:x). In addition, around the time I started my research, I also began to develop a feminist consciousness and a critique of conventional motherhood and fatherhood. These changes helped me investigate assumptions about "the family." For instance, I probed for more details when an interviewee said that he and his spouse had an egalitarian relationship (e.g., what that meant to the interviewee, who was doing which child care tasks, and how they came to divide up household labor).

I was an "outsider" as a non-parent, but I had extensive experience in babysitting for friends and family throughout my adolescence. In that sense, I knew that child care involved a great deal of physical and emotional work. One evening, I even broke down in tears while babysitting because I did not know how to handle the child's misbehavior. I began this project with a lot of sympathy for mothers because I remembered my relief in knowing that I could leave a difficult child at the end of a babysitting shift. The mothers could not.

I have an "insider" status in terms of the feelings these mothers experienced, having gone through periods of feeling dismal, worthless, and hopeless. This enabled me to be more sensitive at difficult points in the interview. I was more attuned to the women's nonverbal cues—the heavy sighs, long pauses, and glassy eyes that often preceded tears. At times I may have been too empathetic, feeling vicarious pain. This made it more difficult to maintain analytic distance, particularly when interviewing the partners. The interviews with the women left me wondering why the partners had not been more tuned into their wives' distress, and sometimes I found myself sharing the women's resentment towards their partners. To prevent this from interfering with the partner interviews, I scheduled interviews between a woman and her partner at least two weeks apart so that the woman's comments would not be fresh in my mind.

Limitations

These data are based on a convenience sample partly because recruiting emotionally vulnerable participants was a challenge, requiring special Institutional Review Board assurances. I only interviewed women who had completed their therapy or felt sufficiently well to conduct an interview. Additionally, I suspect that finding participants on post-partum (and post-adoptive) depression shortly after the trial of Andrea Yates, a woman who

murdered her children after experiencing "post-partum psychosis" (a psychological disorder physicians relate to PPD), complicated my search. Medical researchers have noted the difficulty in recruiting mothers defined as depressed. Potential participants might have feared that a researcher would judge them as "crazy," have them "locked up," or have Child Protective Services remove their children (Epperson 1999).

My samples are limited in other ways. Respondents are primarily white and middle-class. They have more resources than poor women in navigating the mental health care system and more knowledge about mental health issues. These higher statuses make for different experiences of mental illness and the acceptance of a mental illness identity. For instance, people in subordinate statuses with fewer resources are more likely to report depressive symptoms on surveys, but less likely to seek help or get it (Anderson 1995; Diala et al. 2000; Pescosolido and Boyer 1999; Thoits 2005).

In addition, although the adoptive parents had a message board that offered informal support and advice, the biological mothers were recruited from intentional support groups, and one of the PPD groups was facilitated by a trained therapist. Support groups can provide therapeutic frames for experiences that might shape how and what the biological mothers think about their emotional experiences (c.f., Francis 1997a; 1997b). Because the women participated in these groups, they may share common rhetorics to describe their feelings, contributing to more similarity among the interviewees.

The preponderance of international adoptions of young children is another limitation. International adoptive parents likely differ from parents who adopt domestically. As seen above, international adoptive parents tend to be wealthier and to use formal adoption procedures. Working-class people and people of color often use informal adoption practices

(Kreider 2003; Stack 1974). I do not know how the emotional experiences of the parents I interviewed differ from parents who adopt domestically. The one couple in my sample who adopted domestically shared similar emotional experiences in defining depression, but much of their difficulty arose from struggling to meet the needs of their physically violent daughter with disabilities.

Additionally, people who adopt older children likely face different challenges than those who adopt younger children. However, having parents of young children allowed me to compare people in similar parenting situations.

Finally, three adoptive fathers were not interviewed (one was out of the country, the second was not available because of his work schedule, and the third, suspected of molesting the adopted children, was getting divorced from his partner). Four of the biological fathers declined to be interviewed, and I considered a fifth unsafe, given the animosity between his partner and him. Three of the four biological fathers who declined did not offer a reason, and the fourth had recently experienced a death in the family and did not feel up to doing an interview. All of the men who declined were comparable to the rest of the sample in age and income. However, the only Black father, who was also working-class, did not show up to any of our scheduled interviews. (I do not know if he had to work or changed his mind. I always confirmed the interview the day before).

Despite the limitations of a convenience sample, my data are saturated with stories and experiences that are consistent and comparable; in conducting additional interviews in 2005-2006, I did not generate new or surprising findings.

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II. ON NOT BEING MARTHA STEWART WITH A BABY: SELF-LABELING AND POST-PARTUM AND POST-ADOPTIVE DEPRESSION

Classical labeling theory has focused on the negative implications of labeling, whereby agents of social control impose labels on the less powerful (Scheff 1966, 1974; Szasz 1981). According to this theory, those with definitional power label an individual "mentally ill" when his or her behavior deviates from social norms; individuals in subordinate positions are more likely to be labeled than those with the resources to resist (Becker 1963). Once an individual is labeled, s/he may become the target of discrimination or social distance (Goffman 1963; Link et al. 1987; Martin, Pescosolido, and Tuch 2000). Hospitalization, in particular, marks the person as a social deviant, and others will likely treat him or her negatively. Over time, the labeled person is likely to adopt and internalize others' imputation of deviance, taking on the identity of mentally ill (Scheff 1966; 1974).[5]

Yet, there are cases in which individuals themselves adopt a potentially stigmatizing label. As Taylor (1995) found, women who experienced emotional distress after a birth or adoption assumed the label of post-partum illness to normalize—through a medical label—what they understood as inappropriate emotions for new mothers. In this way, a potentially

[5]Critics have challenged various aspects of labeling theory, but these debates are not the focus of this chapter (see Gove 1970, 1975, 1979, 1982; Gove and Howell 1974; Weinstein 1983). Proponents of labeling theory (Link et al. 1989) have offered a modified version of Scheff's work, arguing that although labeling does not always lead patients to adopt the identity of "mentally ill," they nonetheless feel devalued and perceive discrimination.

stigmatizing diagnosis could still provide relief by redefining negative emotions as a medical problem, not an individual flaw. Thus, a medical diagnosis can "have important implications for [a person's] ability to negotiate [her/his] social responsibilities [and] health care" (Sharpe 2005:270).

According to self-labeling theory (Thoits 1985, 2005), a person who experiences deviant emotions (often arising from stressful circumstances) may come to see those emotions as signs of "psychological difficulties" (Thoits 2005:105). Deviant emotions violate societal feeling rules—cultural expectations for what people should feel in particular situations. Unlike discrepant emotions, which are temporary, deviant emotions are chronic, pervasive, and can implicate the self (Thoits 1985). People initially try to manage these conventionally inappropriate feelings, but if that fails, they may identify the troubling experiences as a mental health problem (Thoits 1985, 2005).

Post-partum depression (PPD) and post-adoptive depression (PAD) are medical labels for emotions that deviate from the feeling rules for conventional (white, middle-class) mothers (Taylor 1995). Estimates vary as to how many women report experiencing or being diagnosed with PPD, though 10% is a common statistic (Epperson 1999; Keshen and MacDonald 2004).[6] I found no nationally representative survey with estimates of women who report experiencing PAD, but one report on PAD suggested that it "has a higher incidence" than PPD (McCarthy quoted in Foli and Thompson 2004:201).

Like Taylor (1995), I use the term depression as a label women apply to the emotions they experience that violate current feeling rules for conventional white, middle-class

[6]Another study estimates 8% to 23% (Andrews-Fike 1999). Still others suggest that 20% to 30% of birth mothers report experiencing PPD (Kleiman 2000), and another study notes that 58.7% of all new mothers report feeling depressed after birth (Kinniburgh et al. 2004).

mothers. However, referring to PPD and PAD as labels does not deny the women's distress; rather, it shifts the focus to how the women interpreted and defined their feelings.

Feeling rules for new mothers are particularly rigid, making emotional deviance more likely (Thoits 1990). Moreover, conventional motherhood can be all-encompassing (Hays 1996) and isolating (Tardy 2000; Thoits 1983), conditions that make distress likely (Brown 2002; Friedan 1963; Thoits 1983). People expect new mothers to feel happy and fulfilled. As Paula Cooey has argued, "Being a good mother by definition precludes acting like an ordinary, mature adult, subject to moral and emotional complexity" (1999:238). The women I interviewed (and the women Taylor interviewed) felt persistently unhappy, angry, anxious, and overwhelmed—feeling-states they recognized as inappropriate for women who have adopted or given birth to a child. Such feelings were particularly threatening because "mother" served as a moral identity for them (Kleinman 1996:5). Their sense of themselves as good people rested on whether they lived up to being good mothers.

Might PPD or PAD result from atypical childbirths, pregnancies, or adoptions? The biological mothers and adoptive mothers I interviewed seemed quite similar to mothers who do not assume such labels (See Douglas and Michaels 2004; Warner 2005). This suggests that we cannot attribute their distress to atypical experiences with pregnancy, childbearing, and childrearing. For instance, among the biological mothers, some had easy pregnancies and deliveries; others had "morning sickness" during pregnancy, or underwent difficult labors and birth experiences (e.g., an unplanned Caesarean). These events and experiences

are relatively common among new mothers, even those who do not appropriate a label or seek medical help.[7]

Likewise, the adoptive parents went through the regular adoption process (see Sandelowski, Harris, and Holditch-Davis 1993 for the challenges associated with adoption). All passed their home visits and filled out the requisite paperwork with relative ease, though some experienced hassles with their adoption agencies and aggravation associated with international travel (e.g., influenza, small living spaces, trouble calling home). Three couples adopted children with "special needs."[8] Adoptive mothers, however, did face more challenges than biological mothers prior to entering parenthood. Many of them had experienced infertility or miscarriages. They reported having supportive friends and family, but all of them encountered people who interrogated or challenged their decision to adopt (see Chapter 3). For instance, Kaitlynne's uncle asked, "What the hell do you want to do that for?" In spite of these negative responses, the couples maintained their resolve to adopt. Their experiences were not easy, but neither were they atypical.

In this paper, I will expand on Taylor's work (1995) by examining how adoptive and biological mothers came to take on the label of PPD or PAD. Drawing on self-labeling theory, I will show the stages that the women went through in taking on the label. These

[7]A range of experiences among women who define themselves as having PPD is reflected in the medical literature. In etiological studies of PPD, findings are mixed (see Epperson 1999 for a brief review). Major life events (e.g., divorce, job loss, death in the family), race, and prior history of depression consistently correlate with diagnoses of depression (Swendsen and Mazure 2004), but labor complications, age, and socioeconomic status do not (Epperson 1999). In fact, some physicians recommend screening <u>all</u> women for depression because "there are no clear-cut predictors of who will develop PPD (although subgroups of women are described in the literature)" (Andrews-Fike 1999:12; see also Keschen and MacDonald 2004).

[8]One child was missing several fingers; one child had no legs. Another had "reactive attachment disorder" and "oppositional defiance disorder," according to the parents.

include: experiencing discrepant emotions, attributing emotions to other problems, keeping up appearances, blaming oneself, experiencing a triggering event, learning about and taking on the label, and finding non-medical remedies and non-mother identities. Having discrepant emotions that lasted for a long while could have signified to the women that they were not good mothers, so several of these stages also served as strategies the women used to avoid seeing themselves as bad mothers. This chapter will highlight similarities and differences between the adoptive and biological mothers and offer an empirical verification of self-labeling theory using qualitative methods. Although my findings largely confirm Thoits's hypotheses, self-labeling theory did not fully account for the women's experiences. I will offer explanations for the differences between my findings and the predictions of self-labeling theory.

My findings also challenge mainstream explanations that attribute post-partum depression solely to hormonal changes following birth. For instance, in a recent *New York Times* article on PPD, Jane E. Brody wrote that "these feelings…are most likely brought on by the abrupt decline that occurs at childbirth in estrogen and progesterone" (June 7, 2005; see also CBC News 2006; Epps 2004; Levy 2002). If that is true, then how do we account for adoptive mothers who lack hormonal shifts?[9] Psychologists Cooper and Murray found that "there is little evidence to support a biological basis for postpartum depression" and "no firm evidence linking [pregnancy-related] hormones to the development of postnatal depression" (1998:1885; see also Swendsen and Mazure 2000). Although the body matters,

[9]Davey, Dziurawiec, O'Brien-Malone (2006) studied fathers who reported postnatal depression, though no fathers in my study reported such an experience. Their findings also challenge hormonal explanations.

the sense that the women make of their bodily experiences is not determined by their hormones.

After examining the stages of the self-labeling process for PPD and PAD, I will briefly analyze how the women dealt with the potentially stigmatizing label, and I will conclude by discussing the constraints and benefits of medical labeling as they relate to women's experiences of motherhood.

EXPERIENCING DISCREPANT EMOTIONS

The women I interviewed experienced a constellation of feelings that signified to them that they might not be good mothers, and this could have threatened that moral identity (Kleinman 1996:5). I asked the women to describe typically good days and bad days during the first week, month, and three months after the arrival of the child, and I probed for what they felt during those times. The women mentioned feeling unhappy, angry, trapped, and as if they were losing themselves. (Most of the women did not feel all of these emotions. For instance, some felt angry and trapped, but not sad.) Because the women saw these feelings as discrepant with feeling rules for mothers, having these feelings created an additional anxiety: they worried about what these feelings indicated about <u>them</u>.

Sadness was one of the emotions the women saw as a problem. Stephanie, a biological mother said, "I was crying probably just as much as he [the baby] was…I was just tears, tears, tears, just so stressed." Faith, an adoptive mother, felt similarly: "Inside of me I wasn't enjoying life, but I was doing all the normal things you're supposed to do with the kids." Brenda, an adoptive mother, remarked that she felt "kinda flat" after the adoption.

Unhappiness was not the only emotion the women saw as upsetting; over one-third identified anger as a disconcerting feeling. Amanda, a biological and adoptive mother, said that she recognized that she was not feeling right when, after spanking her children, she wanted to spank them more and harder (though she did not do so). Becky, an adoptive mother, explained, "In my case it wasn't…that I just felt sad all the time, it was real, real sheer white anger all the time."

All the women said that they had felt overwhelmed and trapped after giving birth or adopting a child. Aidan, a biological mother, said she wanted to parachute out of her life. Over and over, I heard the words "prison," "trap," "jail," "personal hell," or another type of confinement. As Renee, an adoptive mother, explained:

> With all these things—I just had no idea that it was going to be so all-consuming; that it was going to take every ounce of every sweat bead that I had. It just was very draining….It was very difficult. I sometimes felt as though I was in jail. But for me it was—I felt kind of closed in… I wasn't feeling real good about myself. I felt, 'Here I am a mom, and I wanted these kids, and I'm feeling like I shouldn't be feeling these feelings.'"

Having these feelings was not only unexpected, but tied to their identities as mothers. This link induced more anxiety. Rhian, a biological mother, said, "I was feeling bad for feeling bad." Indeed, an identity that "entraps" a person physically and emotionally contributes to increased distress (Brown 2002), and excessive family demands can heighten negative emotions (Mirowsky and Ross 1984).

Middle-class mothers are supposed to use a child-centered approach in which they "cultivate" children (Lareau 2002, 2003). This translates into the mother's intense

involvement in scheduling and planning a child's life.[10] Overseeing this "investment" requires a lot of time, money, and energy. Failure to do so can induce more guilt (Warner 2005). Jana, a biological mother, explained how demanding she found motherhood:

> When she cries, I sweat… But it's an overwhelming sensitivity of harm coming to your child from anywhere. I don't know how to explain it. I guess, just like totally child-centered.

The women's emotions were troubling to them, and they questioned themselves about their unexpected emotions. Cathy, a biological mother, distinguished between what she felt and what she thought that she should feel: "I wasn't as happy as I thought I should be." Gwen, a biological mother, said that she did not expect to feel the way she did:

> I just figured that he would come out, and there would be just this overwhelming, bright light coming down and rays from the sun, like this is the wonderful child that you've always wanted. Your life is now complete and perfect, and it just wasn't like that. It was like we just had this other person here that we had to get to know.

Gwen's statement that she "had to get to know" this other person is a reasonable statement if she were meeting any other person, but new mothers are supposed to feel happy and have <u>instant</u> love for their child.

Gail, an adoptive mother, repeatedly asked herself, "Why was I experiencing this? Why was I so sad and crying and not happy?" Women are not only expected to mother naturally (English and Ehrenreich 1979), but also to enjoy doing it. Failure to have the right feelings made them wonder if they were legitimate mothers.

The women tried to use several techniques to avoid seeing themselves as bad mothers. These strategies were also stages in the self-labeling process. As each strategy

[10]Working-class mothers tend to use an "accomplishment of natural growth" model. They are expected to provide a nurturing environment, but children entertain themselves by playing with other children in the family (Lareau 2002, 2003).

failed, the women came closer to labeling themselves as having PPD or PAD, which, as Taylor (1995) found, can help women normalize deviant emotions.

ATTRIBUTING THEIR EMOTIONS TO OTHER PROBLEMS

One way people deal with discrepant emotions is by changing the label for the existing emotion and renaming it as appropriate. To avoid seeing themselves as bad mothers, the women initially managed their disturbing feelings by defining them as normal for new mothers. Rhian, a biological mother, explained that she "managed and managed and managed…[because she could not] come to grips with the fact that I, there was something, some problem with me." When I asked Rhian how she managed to get through difficult feelings, she responded,

> In the beginning, I sort of anticipate[d]…you don't get any sleep [in the first three months], and you have problems dealing with nursing. I was sort of prepared for a sprint and not a marathon…. That was just about my only strategy sort of in the beginning of dealing with having such a high needs kid [a child with colic and acid reflux]. I think that my problems really began after those first few months. Twelve weeks before colic really goes away, and here's my kid still screaming her head off. [I'm] walking around the house at night holding her, and she's still crying…I think that that's when things really started. Up to that point, although it was hard and I was sad, and I was angry, and I was tired, and all those sorts of things,…I didn't feel sort of overwhelmed by them.

Rather than interpreting her sadness, anger, and fatigue as PPD at the outset, Rhian convinced herself that her reaction was a normal response to having a high needs child. For a time, she was successful at renaming her difficulty.

In addition to defining their feelings as normal for new mothers, both adoptive and biological mothers attributed their emotions to lack of sleep. The physical symptoms of fatigue partly obscured their discrepant emotional experiences and were initially used as an

explanation for feeling angry or distressed. Extended sleep deprivation undoubtedly alters a person's moods and general well-being. Newborn infants require several night feedings, and young children may require months of reassurance and rituals to create a regular sleep pattern.

Two adoptive mothers told me that it took almost a year to get their toddlers to sleep through the night. Elizabeth said that "the typical day with her [daughter] would be, there would be no sleep at night"; her one-and-a-half-year-old daughter "pretty much screamed all the time and did not sleep." The lack of sleep made it more difficult to deal with the challenges of raising a child, especially one who did not show much affection toward her new parents. Contrary to her desires, Elizabeth began to withdraw from her daughter: "Loreena [her daughter] was getting better slowly [showing more affection], but I wanted to be able to sleep at night…And, my wall was starting to build up, and all I wanted to do was love her." As Elizabeth's statement suggests, she longed to have socially appropriate emotions, but lack of sleep, attributed to the child, made that difficult.

Penny, a biological mother, at first attributed her feelings of loss of control to hormonal fluctuations and sleep deprivation:

> And I think that I was tired, and I was experiencing whatever I was experiencing and at that point, it was still hormonal stuff plus sleep deprivation. I was starting to feel like I was losing control of the situation I had never really mastered...I remember feeling really, really anxious. It was bad. She [her daughter] would sort of get upset and that would set me off, and I thought, "I can't be upset because that's going to make her upset." I wouldn't allow myself to kind of feel what I needed to feel. And it just kept building.

Like sleep deprivation, post-natal hormonal fluctuations offered another explanation for their feelings. As Penny's words indicate, she attempted to normalize the feelings not only for herself, but also for baby's well-being. Eve, a biological mother, explained, "I would get

angry over little things, but I thought it was just hormones and lack of sleep, and there's nothing wrong with me." By attributing their emotions to things outside their control, they not only normalized their feelings, but also lifted the burden of responsibility for those feelings from themselves.

When an illness is seen as controllable, others expect the individual to manage it. Those who fail to do so are seen as irresponsible (Broom and Whittaker 2004; Corrigan 2000; Corrigan et al. 2003; Weiner 1995).[11] Conversely, an uncontrollable illness absolves the person of the responsibility for managing it. If hormones and sleep deprivation were the problems, neither the women nor their experience of motherhood, could be implicated.

We might expect hormonal explanations to be unavailable to adoptive mothers, but six of the 17 adoptive mothers spoke of hormonal changes as a source of their distress. Gail, for instance, explained that adoptive mothers also go through hormonal changes.

> I think you do go through changes in the hormones with the advent of the child coming into your life. So even though biologically your body is not releasing perhaps the same hormones that could be causing some mental [problem] or taxing the body physically, the advent of having that change in your life, everything changing in your life, does cause [physiological changes]. You still kind of go through some of the same things that a biological parent goes through.

Pointing to hormones draws upon mainstream understandings about PPD and creates an equivalence between biological birth and mothering (see Chapter 3). Adoptive mothers argued that because biological (i.e., socially valued) mothers experience PPD, then it is reasonable for adoptive mothers to do so as well.

For adoptive mothers, however, reinterpreting negative feelings as "normal" was more difficult to sustain. Corrine said, "Adoptive parents all along worry that things are bad

[11]Controllability of causes is only one aspect of attribution theory (Corrigan 2000).

because they're adopted." Adoptive mothers also saw their decision as a personal choice to parent, and if they felt distress, then they should harden up and face the consequences. Renee explained, "I shouldn't be feeling like I want to run away from home because I initiated all this." Likewise, Kaitlynne said that she initially thought "we [adoptive mothers] should have 'known better,' and we supposedly went into it with eyes wide open. How what we do versus what a birth mother goes through to get pregnant is somehow considered more intentional."

Adoptive mothers may have stricter feeling rules and less emotional wiggle room around cultural expectations than do birth mothers. Biological mothers may choose motherhood, but these adoptive mothers said that because they had more of a "choice" than biological mothers, they should definitely feel happy. Compounding this understanding of adoption as intentional is the idea that adoption is "second best" (Fisher 2003). Thus, in addition to dealing with their discrepant emotions, these adoptive mothers had to manage others' negative or skeptical reactions to their family form (see Chapter 3). Indeed, being seen as deviant means that adoptive parents have to work harder to appear "normal" (i.e., happy).

Like many new mothers, these women expected to face some challenges after becoming a parent, but they did not expect to have troubling feelings. Consistent with self-labeling theory, they tried to explain to themselves that their feelings were normal consequences of sleep deprivation, fatigue, and hormones. They wanted to have the "right" emotions in spite of their exhaustion. As these emotions persisted, the women's attempts to normalize their discrepant feelings proved unsuccessful, and they were unable to convince themselves that those feelings arose only from hormones or sleep deprivation. Increasingly,

their normalizing proved unfruitful. But, they shifted their focus to the next stage, keeping up appearances.

KEEPING UP APPEARANCES

Health researchers have found that mothers with "depressive symptoms" interact less with their children (e.g., are less likely to show the child books and pictures) (McLearn et al. 2006). The women I interviewed, however, worked hard to perform the routines and meet the demands of motherhood. At this stage, they attempted deep acting, trying to make themselves feel what they *should* feel (Hochschild 1983). Ultimately, most of them managed only to do surface acting, "pretending to feel what we do not feel" (Hochschild 1983:33). By keeping up appearances, the women gave the impression that they were doing well, rather than feeling unhappy or angry. Aidan, a biological mother, succinctly described this strategy: "I appear happy, but I'm rallying [emotionally] for the baby. I don't want to have to rally anymore" (fieldnotes). Anne, a biological mother, said that she was "a coper and hider [of her feelings]." Gail, an adoptive mother, spoke of "slugging it out…for a very long period."

Keeping up appearances was not entirely separate from the previous stage (attributing their emotions to other problems). Attributing the emotions to hormones or exhaustion generally preceded this stage, but even when the women were trying to find reasonable explanations for their feelings, they still recognized those feelings as socially inappropriate and tried to mask them through their emotional displays. Explaining their feelings to themselves was a cognitive process, whereas keeping up appearances involved expressive

and bodily emotion work techniques aimed at convincing themselves and others that all was well.

Maria, an adoptive and biological mother, said that after the adoption she "had to perform" and "do things I didn't feel." She explained:

> Yes, I felt like, from the outside things looked like they were going really well. It looked like I was being a good mom to my kids. Like everything was working out great in this little fairy tale story. On the inside I felt like this horrible person that was unloving, and unproductive, and lazy, and tired…I felt like nobody knows that this is how I really feel. I'm letting everyone think that things are going fine. But they're not. And that made me feel two-faced. And I didn't want to be that way, I wanted things to go like they looked, you know?

On the outside, Maria explained, her life looked like "a little fairy tale story," implying that she had met (and perhaps exceeded) people's expectations. The women's accounts—and interviews with their partners—suggest that these women were not identifiable to others as "bad mothers," but performed the carework of motherhood well (see Chapter 2). On the inside, though, the women's feelings continued. Having those feelings and giving the impression that everything was "going fine" created a double burden. Maria not only masked her discrepant feelings, but also had to manage her feeling of inauthenticity in hiding her troubling feelings.

Keeping up appearances differs from self-labeling theory, which predicts that women will turn to significant others in order to help them manage their emotions (Thoits 1985, 2005). By keeping up appearances, these women delayed talking to their partners and friends, creating the additional problem of managing a secret. Because these mothers performed their mothering tasks competently, their husbands (and others) believed they were "doing great" (as one partner put it). The women feared that reaching out for help or making

sympathy claims might have invited rejection; after all, the women did not appear to be in need of sympathy or help (Clark 1987).

What might account for this difference between my findings and self-labeling theory? Women are expected to do take care of others' emotional needs in the family, and admitting their distress would have placed an emotional burden on others (Bartky 1990; DeVault 1991; Hochschild 2003). Penny managed her feelings for the benefit of the baby, and Michelle, a biological mother, masked her feelings to protect others. She said, "I didn't want to ruin [it for] my husband. It was his first child and only child, and I didn't want to ruin his happiness."

The women also defined their feelings as too shameful to share. Amanda, a biological and adoptive mother, said that she was "very embarrassed" and afraid "people would judge [her]." Turning to others meant acknowledging that they had an emotional problem in relation to the performance of a valued identity. Motherhood is a salient identity that carries significant emotional and moral weight (Kaplan Daniels 1987; McMahon 1995). These discrepant emotions began to erode the women's sense of competence and their belief in themselves as good women (Cooey 1999) and good people (Kleinman 1996).

The adoptive mothers' belief that adoption was "more intentional" than getting pregnant and giving birth heightened their need for secrecy. Kaitlynne, an adoptive mother, said she did not deserve sympathy because, unlike biological mothers, she actively sought out motherhood:

> I was afraid to tell my family and close friends because I thought they'd say those things ["you made your bed, now lie in it"]. Not that I deserved what I was feeling, but rather I didn't deserve sympathy. I thought that they'd have less sympathy because I so actively sought it out and said—verbally, often, and loudly—how badly I wanted to be a mom. Kind of like, "Well, you asked for it, now deal with it."

Even when potentially discrediting information slipped through the women's acting, other people still found the mothers' performances of "good motherhood" convincing. Kate, a biological mother, said that when she was feeling her worst, "all I could do along the way was care for [the baby]." Her spouse, Rafael, said she was "dysfunctional for everything else" in her life, but "normal" and "very beautiful" as a mother. Karen, a biological mother, described an incident in which her emotion work failed in front of a friend:

> And I sat right here in this rocking chair, and I was in the dark. My friend Jen came around the door, and I just sobbed and sobbed (choking up) and I said, and she sat right here. And I said, "I cannot do it. I've really given it an effort and I'm going to have to give him away. I really am." And I said, "I don't love him."…she said, and for this I will love her forever, she said, "Karen, it's not what you *feel* but as of right now it's what you *do*. You know, this child is well fed, cared for, everything. You are loving him through your actions even if you don't feel it *right now*." Because I did not love him (my emphasis).

Although Karen said that her friend's comment helped her at the time, it did not change her overall situation. This supportive comment defined Karen's emotions as acceptable for this particular moment because she was meeting the baby's needs. "Even if you don't feel it right now" suggests that "you will, later," implying that if Karen continued doing the care work, her emotions would eventually catch up with her behavior.

The women managed to convince *others* that they were good mothers, but they rarely convinced *themselves*. Hence, their surface acting was unsuccessful, but their deep acting was not. As their emotion work began to fail, the women increasingly turned to themselves to explain their <u>persistent</u> negative emotions.

BLAMING THEMSELVES

The women turned inward to identify the source of their deviant emotions and began to see themselves as bad mothers. They might have said, "I'm having these feelings because I have a new child, and it continues to be hard work." This would have rendered their feelings normal and temporary, a continuation of the previous stages and a possible satisfactory resolution for those troubling feelings. Instead, they began to identify *themselves* as the problem. Women are socialized into valuing others over the self (Rosenfield, Lennon and White 2005), and are members of a subordinate category (woman) (Lennon and Rosenfield 1995). Consequently, they are more likely to experience "internalizing problems," such as anxiety or depression (Rosenfield, Lennon and White 2005). Faith, an adoptive mother, said that she reached a point where she decided "after all I was doing,…I wasn't a good parent anymore…I found it hard not to take it personally." Stephanie, a biological mother, said that "these feelings of failure and disappointment went to my womanhood level, to your mother level…I thought the problem was me, that I couldn't console him [her baby]." Maria, an adoptive mother, said, "I'm not being a good mom to my kids, [and] this makes me feel horrible."

Adoption adds another burden. For adoptive mothers, the (romanticized) mother-child bonding cannot be assumed. Thus, adoptive mothers are expected to work harder to create that attachment (Wegar 1997). Corrine said that she was a "horrible parent" and thought it might be because she adopted the children:

> I felt like I was a horrible parent…I felt like that perhaps some of the way I was reacting [feeling overwhelmed] was different because I had adopted the children, rather than given birth to them…I wasn't going to bond appropriately with my children because I was having this reaction, and somehow this was less permissible when you adopt than it is when you're a birth parent.

In her use of "I" ("I was horrible"; "I wasn't going to bond"), Corrine transferred the blame for her feelings to herself. When blaming themselves, some adoptive mothers, like Corrine, incriminated both themselves and their decision to adopt, as the sources of their negative feelings. Being an adoptive parent also made their feelings even less permissible (much like Kaitlynne's earlier statement that she did not deserve sympathy because she chose to become a mother).

Biological mothers also began to identify the source of their distress as individual and internal (c.f., Rosenfield, Lennon, and White 2005). Amanda, a biological and adoptive mother, spoke in great detail of her breastfeeding ordeal. Her baby would not latch onto her breast (in part because he was "tongue-tied," a condition in which the tongue is attached to the floor of the mouth—a tongue-tied baby can take two or three times longer to breastfeed). She consulted a lactation specialist, attended *La Leche League* meetings, used a breastshield, put ice on her nipples (to make them more firm and easier to latch onto), and tried repositioning the baby. She came to "dread the feedings…[and] was consumed with feeding him [her biological son]…When I wasn't feeding him, I was pumping, trying to get more milk. I was consumed."

Amanda became increasingly angry, frustrated, and overwhelmed. She might have blamed her emotions on breastfeeding or the challenges of raising both an adopted toddler and a biological newborn, but she ultimately shifted the blame to herself. Her feelings made her question her competence as a mother. Though she felt "there's nothing *abnormal* about me, I started to feel like it's me, it's me" (emphasis in original).[12]

[12]Amanda's experience also highlights a difference between adoptive and biological mothers. The adoptive mothers I interviewed did not breastfeed their children, so they could not have this problem. Breastfeeding is not only assumed to be natural, but is weighted with cultural

In this stage, mothers continued to do the surface acting of conventional motherhood, but because their attempted deep acting of the previous stage had failed, they began to see themselves as "bad mothers" and blamed themselves for their pain.

EXPERIENCING A TRIGGERING EVENT

Thoits predicts that deviant emotions undermine a person's ability to normalize them: "In particular, major changes of or recurrent strains in important identities are likely to produce strong discrepant feelings that are difficult to reduce or transform over the long run" (1985:236). For most of these women, their deviant emotions, combined with a dramatic event or a moment of realization, disrupted their earlier emotion work and contributed to their assuming a medical label. Identifying themselves as the problem replaced the valued identity of good mother with "sick mother" (or mother with a problem). Although a sick mother could not attain the standards of "Martha Stewart with a baby" (Jana), at least she was not entirely bad.

Each woman I interviewed described a point at which she recognized that something was wrong beyond what she could manage, and these triggering events were tied to their role as mothers. In most cases, this recognition involved a striking thought, behavior, or event. Penny, a biological mother, spoke of how she entertained—and almost followed through on—a fantasy to flee from her life. Gail, an adoptive mother, said she nearly had a nervous

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baggage. Pro-breastfeeding discourse is dominant and forceful, especially for white, middle-class mothers who have the material resources to "choose" to breastfeed. Failure to breastfeed can translate into guilt (Wall 2001). The women I interviewed even questioned whether they were good mothers when they considered switching to formula; they pointed out that they knew breastfeeding was critical for "mother-infant bonding" and "proper brain development." The believed that opting for formula threatened the closeness a mother and child should have and harmed the child's future prospects and abilities.

breakdown. Carrie, a biological mother, punched a hole in a wall. Maria, an adoptive mother, and Emma, a biological mother, started crying in public. Julie and Michelle, biological mothers, planned on admitting themselves to psychiatric hospitals. Kaitlynne and Maggie, adoptive mothers, asked their respective friends to adopt their children. Anne, a biological mother, ended up in the emergency room; she had urinated on herself and was sobbing uncontrollably. Elizabeth, an adoptive mother, dropped a drawer on her foot and "felt nothing." Brenda, an adoptive mother, and Eve, a biological mother, broke down in tears when a friend or family member asked how they were feeling.

After her fantasy about leaving, Penny, a biological mother, described how she came to realize that her problem required intervention:

> I had this moment when I thought, I really thought that was the rational right thing to do [running away from home]. And then just right after it, I had this thought. I was like, "Penny, that's not okay. You're in a worse place than you realize." In that moment, I knew this is not only a two-week thing that's going to happen [and get better].

Returning from her porch, she told her spouse about her feelings and called her midwife the next day.

These events, compounded by deviant emotions, became the last straw[13] and forced the women to confront their distress. The women defined these instances as beyond normal and redefined their chronic discrepant emotions as abnormal. These events stood apart and signaled to them that they had a psychological problem.

[13]The length of time before assuming the label varied widely for the women I interviewed. Some took on the label about one month following the birth or adoption; others took the label up to eight months after the adoption or birth.

LEARNING ABOUT AND TAKING ON A LABEL

The women felt that something was wrong, but some were unsure how to name their experiences, partially because they learned about the label of PPD or PAD at different times in the definitional process.[14] Some of mothers discovered it while reading baby books or in classes for adoptive parents or in prepared childbirth classes. Other mothers said they heard about it from friends, family, or television programs. Adoptive mothers were more likely to read about it on adoption websites or message boards.

Women who had a history of depression usually learned the label, PPD, in their research during their pregnancies. For instance, Elaine, a biological mother, read about PPD in baby books. In the next visit with her OB-GYN, she asked about her risks for PPD. She thought she would be "more predisposed to PPD" because she had been diagnosed with depression in the past.

More than half the women learned the label through family or friends. Although the women generally guarded their secret feelings, they tentatively sought out information. Penny, a biological mother, described how she found out about PPD:

> I thought, "Something's just not right," so I called Theresa…I said, "I just want to cry, and I'm upset." And so, we have a friend in common who is really her closer friend, and she said, "You know, Claire had a really hard time." So she shared with me Claire's experience, and Claire had a really severe case [of PPD]. "She just did nothing for the child the first two weeks…She is still on medication and had a really, really difficult time." And, Theresa was aware and also as a medical professional, so more tuned in…[and she] was opening the door for me.

Sometimes family and friends did not act in encouraging ways and discounted the possibility that PPD or PAD existed. Michelle, a biological mother, explained that her

[14]Because "learning a label" occurred at different points for the women, it did not fit neatly into the stages. Thus, I combined learning and taking on a label for ease and clarity.

stepmother-in-law considered post-partum depression "a lazy negative woman's problem." Michelle asked her aunt and stepmother-in-law if they had experienced any negative emotions while raising a child. Her aunt replied, "Oh, I was just too happy to have a child to think about that." Her stepmother-in-law responded, "I was just too busy to even *think* about it." After those comments, Michelle "never said anything."

Michelle's relatives' comments are instructive because they reveal common beliefs about the experiences of new mothers. Women who feel low have a "lazy negative woman's problem," and should instead be "too busy" or "too happy" to be low. These labels imply that the woman's experience is merely an attitude or state of mind that can easily be changed or corrected. People who made these statements held the women responsible for their emotions, expecting them to control their negative feelings (c.f., Corrigan 2000).

Post-adoptive depression is a little-known label, even within the adoption community. In a recent *New York Times* story about PAD, Pamela Kruger, an editor of an anthology on adoption, said, "It's like where post-partum depression was 10 to 15 years ago" (Tarkan 2006). As one of my interviewees, Nora, said, "People are like, 'Oh, that's not true,' about people who develop depression after adopting." Brenda noted that "I feel that I probably had a very mild case of post-adoptive depression, which I didn't hear of. I didn't know that anybody else ever felt that way until about six months after I'd been home." By doing research on the Internet, she read about PAD and recognized herself in the list of symptoms posted on the web.

About one-half of the adoptive mothers initially invoked clinical depression as their medical label.[15] I asked Sharon how she knew that she was depressed. She said, "I started crying, all the time. And that to me, I went, 'This is true clinical depression,' and that's when I knew I needed help." Self-labeling suggests that people share general cultural understandings of mental health labels. When the women saw their feelings as similar to those associated with clinical depression, the label seemed to be the one most applicable to them. However, in the medical literature, doctors use clinical depression and maternal depression (e.g., PPD) interchangeably (c.f., Heneghan et al. 2000). This may also explain why some of the adoptive mothers referred to clinical depression in the interview or did not distinguish between the labels PAD and depression.

By and large, the label of PPD or PAD alone did not provide relief, but the label prompted the women to seek out others to help them manage their deviant emotions. The majority of the women sought the aid of professionals. Most did this formally by talking to physicians, therapists, and ministers. Nine of the biological mothers sought help in a support group facilitated by a social worker, and all of the other mothers (adoptive and biological) used online support groups. In addition, most of the women sought help from a person with medical or psychological training (14 out of 15 for PPD; 15 out of 17 for PAD).

[15]I asked many of the interviewees, "When did you know you were experiencing post-adoptive depression?" Thus, I cannot always distinguish if a reference to "depression" meant PAD or clinical depression. Only one adoptive mother used "depressed" in place of sad or the blues in one instance in her interview.

Michelle, a biological mother, had broken down over the holidays and considered hospitalizing herself, but then she saw a special episode of the *Oprah Winfrey Show* on PPD and post-partum psychosis[16] that led her to name her feelings.

> Right before I had seen the doctor, there was this show on *Oprah* that I think every woman in America had to have seen about postpartum psychosis. I could relate with some of the things they said….And, the one thing that got me was the professional that they had on there said that if you are having those [negative or repetitive] thoughts, it was really important for you to tell your doctor. So I thought, "Okay, if other women have had this problem, they told their doctor, and their babies weren't taken away, I'm going to take the chance and tell my doctor."

Michelle contacted her doctor, who gave her a prescription for Prozac and told her, "Well, let's just see if it'll go away on its own." She did not find the medicine or her doctor's attitude helpful, so she researched post-partum depression on the internet. There she found the *Depression After Delivery, Inc.* website, which gave her references for local health care providers who specialize in PPD. She contacted the specialist, whom she came to identify as her "angel…And he was very upbeat and positive, and he let me talk and tell him everything that had gone on. He told me he had talked with many women like me…He was very supportive, and [the psychiatrist he recommended] has been wonderful. It's been a very long road, and I'm still not there, but am getting better."

Self-labeling can also occur in conjunction with labeling by others (Estroff et al. 1991). Gail, an adoptive mother, thought that "it was the depression that I started to feel" when she lost a lot of weight, felt unbearably sad, could not "hold anything in [her]

[16]The Andrea Yates case sparked a national discussion about PPD, psychosis, and motherhood (Hyman 2004). Oprah Winfrey did an episode on PPD (aired 11/7/01), featuring celebrity mothers who had identified themselves as depressed (e.g., Marie Osmond) and mental health professionals.

stomach," and paced at night. Her labeling process coincided with others also labeling her. This solidified her existing impressions about her feelings.

> She [her neighbor] was a counselor, so she said to me, "I've got to tell you, I think you're depressed."…The realization, the dawning on you from little things here and there because you're trying so hard, expending all your energy trying to cope everyday that it was other people telling me, it was the thoughts that I was having, the realizing that I wasn't happy, the doctor saying to me, "I want to send you to a psychiatrist," her saying, asking me questions and then saying to me, "I would say you're mildly depressed."

For Gail, others confirmed what she was already coming to believe; the combination of her understandings and others' evaluations enabled her to publicly assume the label. But, the medical solutions did not give her relief. Her doctor prescribed an anti-depressant and a sleeping aid, which she did not like because she prefers "natural" remedies: "Most of [her] forms of help were outside the doctor's office." After appropriating the label, she researched PAD on the web and read about "positive affirmations" and relaxation techniques, which she found "really helpful… [to get] myself on the track."

People in counseling, ministerial, and medical roles can aid in emotion work by "reducing self-condemnation for deviance" (Thoits 1985:238), whether through drugs or talking therapies. However, the women responded to medical interventions with differing degrees of success. Eve told her doctor that she was experiencing distress after birth and "mentioned Zoloft, specifically, and so he put me on 25 mg of Zoloft…I was a whole different person, even within a week. I was a whole different person. I was in a good mood again. I was able to take pleasure in the new things that [my daughter] was doing." Like Eve, the women who reported that health care providers helped in some way often pointed to medication as the source of their relief. Medication allowed Eve to reinterpret her distress as "just a hormonal imbalance for me, so we [she and her husband] didn't feel I needed

therapy." Because medication improved her mood, she was able to redefine her feelings as physiological rather than as a response to the mothering of two small children.

After assuming the label, some of the women had a difficult time accessing mental health providers. Elizabeth, an adoptive mother, described her surprise: "It amazed me how hard it was to find a psychiatrist who had an appointment [available]. By the time I found one that was taking patients again, it was two months." Julie, a biological mother, called the hospital, and each department transferred her to another. After about an hour, someone transferred her to a chaplain who happened to have seen a flyer about a PPD support group.

Many women also had trouble finding a health care provider who would validate the label of PPD or PAD. During their lowest emotional points, they made call after call to hospitals, psychologists, and OB-GYNs, but found no help, or were diagnosed with something else. Kate, a biological mother, had read about PPD in baby books, and when she finally decided to go to the doctor, she described what she went through:

> Yeah, I just felt so bad I knew I needed help, and I started looking into it and …So, I went to my general practitioner. I hadn't slept in two weeks, I have insomnia, and I was nursing and all that. I've lost all that weight, and I told her all that. She off-the-cuff diagnosed me with bipolar. She just said, "Oh, I think you're bipolar, and here's a prescription kind of thing."… I knew it wasn't bipolar. And I thought, "Okay, I'll try to check out post-partum depression." Then she said, "How old is your baby?" I said, "Seven months old." She said, "Not post-partum depression, that happens right at the beginning. It happens right after your baby's born and gradually gets better."

Kate turned to her doctor to provide confirmation for what she believed to be the problem, but did not receive it.[17] Contrary to self-labeling theory, more than half the women had difficulty finding a medical provider who would offer or confirm the diagnosis of PPD.

[17]Kate eventually found a therapist, a support group, and a psychiatrist who prescribed medication. She "feel[s] that [she is] in recovery" because of these therapeutic interventions.

Similarly, one study found that pediatricians did not recognize and diagnose depressive symptoms in new mothers (Heneghan et al. 2000). PPD is classified in the *DSM-IV-TR* as a mood disorder that occurs within four weeks of the birth. The *DSM* lists sadness, lack of energy, suicidal thoughts, and difficulty concentrating as symptoms (these are symptoms of depression, more generally). Post-adoptive depression is not listed in the *DSM-IV-TR*, but registered nurse Karen Foli and psychiatrist John Thompson say that PAD can occur "within days or years after the child joins the family" (Foli and Thompson 2004:228). Adoptive mothers who sought therapy were diagnosed with depression or some other *DSM*-classified mood disorder (e.g., generalized anxiety disorder) rather than PAD. PAD is not medicalized to the same extent as PPD.

The dissonance between the women's experiences and medical definitions may help explain the difference between my findings and self-labeling theory. The women's descriptions of how they managed to care for their children differed from the medical label, which defined PPD in terms of lack of energy to engage in everyday activities. Moreover, all of the women I interviewed identified themselves as having PPD or PAD much later than the requisite four weeks. In this case, the women's experiences were at odds with what their medical providers knew. Additionally, Ballard et al.'s (2001) study of menopause diagnoses found that doctors may have difficulty applying a medical label to women's experience because of the range of symptoms that overlap with other medical disorders. Given the women's varied descriptions of their feelings, this same process may be at work with PPD and PAD.

FINDING NON-MEDICAL REMEDIES AND NON-MOTHER IDENTITIES

For some women, the lack of availability of medical solutions or disappointment in them led the women to pursue non-medical solutions. The women cultivated identities apart from their being mothers, but in doing so, they responded in ways that did not threaten motherhood as a moral identity. They could fulfill most of the obligations of conventional motherhood without generating additional guilt about not living up to "standards." Renee, an adoptive mother, said she tried to create some space for herself on weekends:

> My husband would get out of bed with the kids. So I'd stay in the bedroom and stay in there by myself as long as nobody would knock on the door. Because when they knocked on the door then I'd get up. But I'd kind of stay in here as long as they'd let me. And then, I guess I would just kind of not really want to participate in the family things. [I was thinking,] "You're here, you're taking care of the kids on the weekends, I do it all week."

Having spent the week doing child care, Renee rationalized that her spouse should do it on the weekend. In her justification, she also drew upon the middle-class ideas that fathers should be involved with their children (LaRossa 1998; Nock 1998).

Some of the women found solace in another salient identity that had gone by the wayside after the birth or adoption of the child. Returning to work or engaging in religious activities helped the women renew non-mother identities. Corrine had made an appointment with a psychiatrist, but found it unnecessary after returning to work. People told her, "Oh, you'll hate going back to work, and [you'll] want to be home," but she went back to work and "felt better." After the second day of work, she "felt even better."

Maggie, who had a background in nursing, "was able to recognize what was going on with me." After she interpreted her distress as depression, she began taking a dietary supplement (St. John's Wort) and found other interests that made her feel better.

> Recently I went back to school, and I'm finishing up a year-long program to become a massage therapist. It's been great, and just in doing that has made huge changes in who I am and how I deal with the world and how I feel about myself…. I joined a club, before that, and just made a point of doing things that would get me out of the house…I learned that I don't have to deny certain parts of myself, and that I don't have to be the suburban soccer mom in the SUV with her latte from Starbucks. That's not who I am. I can still be me and be a mom. For a long time, I was caught up in trying to make myself fit in some kind of cookie cutter that was what I perceived as how a mom should be.

Reconnecting with previous identities and creating new ones allowed Maggie, who "lack[ed] a sense of self, a lack of identity," to find a "purpose" beyond her roles as wife and mother. She found other ways of defining herself as competent that also did away with her isolation. For her, taking on the label of PAD freed her to pursue massage school and join clubs.

Christian mothers, including Carrie, Elizabeth, Maria, and Amanda, spent personal time in prayer and Bible-reading. Carrie, a biological mother, became a leader in her church's youth ministry: "Honestly, finding a church home and getting involved is really what got me through. It gave me something to focus on…It was positive… Feeling like I have things to do, to contribute."

Returning to their paid work, other interests, or religious connections re-established their ties to identities that motherhood had put on hold. Creating personal space and cultivating other identities were not merely adaptations to the situation, but enabled the women to feel like competent human beings. Becoming involved in outside interests might have undermined their sense of being good mothers; for instance, working mothers are often defined as "bad" or lesser mothers than stay-at-home mothers and are made to feel guilty (Douglas and Michaels 2004; Friedan 1963). Yet, the women defined these pursuits as secondary to mothering. Renee found spare time to hide away in her bedroom. In addition

to her massage work and clubs, Maggie, who adopted children over the age of five, volunteered at her sons' school and became a "den mother" for her sons' Boy Scout troop. And, Corrine still spent a lot of time with her babies after returning to work. Prayer and church work could be done after the children went to sleep and are defined as gender-appropriate behaviors. These identities, therefore, did not threaten their identities as mothers.

Eight women came to question, but not challenge intensive mothering. Corrine, an adoptive mother, said, "[Having children] takes a big toll on your life, and I didn't think that I could say that and be a legitimate mother. So, I didn't [think that] for a long time." However, as her words suggest, she came to acknowledge that mothering is difficult, but still learned to accept herself as a "legitimate mother." Jana, a biological mother who felt "like Martha Stewart with a baby," realized that after the birth of her daughter, "Everything else [her health and her relationship with her husband] came second, which was not good." But, Jana also said that her daughter was "100% [her] responsibility." Gwen, a biological mother, said, "It's boring raising a baby. It's like, 'What do you do?' You look at shapes and colors, and there's not much mental stimulation going on…but I am still his mother." Although Gwen acknowledged that "being 100% involved with [her] son" was "boring," she still saw it as important and identified herself relative to her child (i.e., being <u>his</u> mother). Even the women who went the furthest in questioning intensive mothering prioritized motherhood, but allowed themselves to fall a <u>little</u> short of perfection.

DISCUSSION & CONCLUSION

Experiencing significant distress at the birth or adoption of a child can undermine a woman's emotional and physical well-being as well as her view of herself as a good person.

In this paper, I drew on self-labeling theory to examine how new adoptive and biological mothers managed their deviant emotions and came to identify themselves as having PPD or PAD. Initially, they normalized their discrepant emotions by attributing those feelings to factors outside their control, such as sleep deprivation and hormones. They also tried surface and deep acting to give the appearance that they were good mothers in spite of violating feeling rules. Although they convinced others that they were doing well, they did not convince themselves. As their inappropriate emotions persisted, they increasingly identified *themselves* as the source of the problem, and thereby "bad mothers." Ultimately, a triggering event, linked to their roles as mothers, provided the final "proof" that they were ill.

The women's experiences generally supported the self-labeling process, with two important exceptions: 1) the women delayed seeking support; 2) medical providers resisted validating the label. Self-labeling theorists posit support-seeking as part of the self-labeling process, but the women delayed searching for assistance because they thought of their feelings as shameful, did not experience the "right symptoms," and did not have a language to explain what they felt. Self-labeling theory also hypothesizes that medical providers will affirm the label and provide treatment, but many of the women had trouble finding health care providers who were willing to offer assistance or acknowledge their distress.

Biological and adoptive mothers followed the same labeling process, suggesting that PPD and PAD cannot be reduced solely to biological causes (particularly because I screened out the adoptive mothers with a history of depression). The process also held if I screened out biological mothers with a history of depression.[18] The adoptive mothers, however,

[18]For instance, Elaine said, "Before we left the hospital, she [my midwife] was like, 'I know you've been on anti-depressants before, maybe proactively I should just go ahead and write you a prescription.' And, of course, I was like, 'No, I can do it on my own.'"

differed from the biological mothers in one way: they felt more personally responsible for choosing motherhood, which meant that they should be able to deal with any negative emotional consequences of that choice. Because adoption is still considered suspect, adoptive mothers felt even more pressure to live up to the feeling rules of conventional motherhood.

This chapter also shows how the women enacted emotions that reinforced gender inequality. As Hochschild (1983; 1990) has argued, emotion work strategies arise from—and reinforce—patterns of stratification. The emotion work these women used unintentionally perpetuated the same standards of motherhood that support unrealistic feeling rules. Trying to follow the feeling rules for new mothers maintains conventional white, middle-class motherhood. Attributing their emotions to hormones or sleep deprivation, keeping up appearances, and blaming themselves reinforced unrealistic expectations of mothers and took motherhood off the list of possible sources of the women's distress. But, challenging those standards can be costly. As Hays summarized, for mothers, "the methods of appropriate child rearing are construed as *child-centered, expert-guided, emotionally absorbing, labor-intensive,* and *financially expensive*" (1996:8, italics in original). If new mothers refuse to do (or cannot do) intensive mothering, others might see them (and they might see themselves) as "bad mothers."

Appropriating a medical label can be complicated, especially if it is tied to a romanticized identity bolstered by a powerful ideology. Previous mental health research has generally focused on how labeling has a negative impact on an individual (Link et al. 1987; Link and Phelan 2001; Link et al. 2004; Scheff 1966), but the label of PPD or PAD might have eased one part of the women's distress by helping them normalize their discrepant

emotions (Taylor 1995). Being a "sick mother" might be preferable to being a "bad mother." Rhian, a biological mother, suggested that her experience "to sort of come to the self diagnosis, might not have been so difficult had I sort of arrived at that [diagnosis] sooner." Maria, an adoptive mother, said:

> I think it's better to be prepared, and then be surprised when it does go really well...I was prepared for so much struggle there [with attachment issues], and that [if her daughter had experienced attachment troubles] would have seemed totally normal to me because of the research I had done. There is tons of research about attachment disorder…so that wouldn't have shocked me so much. It's this other issue [depression] that shocks me, so I think it needs to be available to people.

A label can function to normalize feelings (Taylor 1995), and as Thoits (2005) argued, appropriating a medical label also can mobilize those in distress to find ways to get help with their emotions rather than engage in extensive emotion work on their own. However, a diagnostic label would not have changed their situation: having to mother "intensively" (Hays 1996; Sayer, Bianchi, and Robbins 2004; Tardy 2000) while dealing with a medical system that devalues the challenges new mothers face (Taylor 1995). The labels of PPD and PAD do not eliminate the expectations of intensive mothering and less involved fathering (see Chapter 2).

Would attributing their distress to a medical cause have relieved the women from the burden of a moral label? According to attribution theory, a medical diagnosis decreases stigma because the cause of mental illness is presumably out of the individual's control (Corrigan 2000).[19] However, the medicalization of problems does not necessarily eliminate stigma. Some physical ailments, such as diabetes (Broom and Whittaker 2004) or HIV

[19]However, Phelan (2006) found that ascribing a mental illness to genetics did not support attribution theory's hypothesis that stigma would be reduced.

(Sontag 1978), carry moral baggage in spite of medical validation. They are sometimes seen as the fault of the bearers, especially for those perceived as having the class privilege to "take control." The diabetic should have exercised more or eaten better; the person infected with HIV should not have engaged in risky sexual behavior or used intravenous drugs.

The women I interviewed applied a medical label to their deviant emotions, but the label of PPD or PAD has moral implications: a woman so labeled might still be seen as an unfit mother. All of the women felt well enough to participate in the interview,[20] but one mother commented that she did not like taking on the label. Karen said, "I really rejected the notion that I could be depressed. And, I just didn't want it to be true….I thought I was inadequate and unfit." Similarly, losing their children was a possibility for assuming the label. For instance, Michelle (above) feared talking to her doctor because she worried about losing her children.

For disorders with contested medical statuses (e.g., chronic fatigue syndrome), a medical label still might not provide relief (c.f., Looper and Kirmayer 2004). Similarly, PAD is not in the *DSM*. Friends, family, and even medical providers did not always affirm the women's claims. A contested medical label tied to a moral identity may not fully absolve people from the guilt of having deviant emotions.

Future research could also move beyond the limitations of my predominately white, middle-class, heterosexual sample. These women had material resources to do emotion work and eventually seek medical intervention. Differential access to medical intervention or other forms of social support matters (Swendsen and Mazure 2004; Thoits 1985). Although the data are mixed, some evidence suggests that poor, young, and/or minority women report

[20]In order to protect vulnerable populations, the Institutional Review Board required that I only speak to women who felt well.

higher rates of post-partum depression (on surveys)[21] than white women and women with more financial resources (Herrick 2000; Kinniburgh et al. 2004; c.f., Thoits 1990). As self-labeling theory predicts (Thoits 1985; 2005), those with fewer resources and education are less likely to self-label in part because of a fear of stigmatization, a distrust of institutional authorities (Diala et al. 2000; Pescosolido and Boyer 1999), and less knowledge about what is considered a mood disorder (Horwitz 1982). Future work could examine how women with fewer resources define, understand, and label depression after birth or adoption.

Because conventional femininity defines women as more sympathetic and empathetic, we might hypothesize that a women in a lesbian relationship would turn to her partner sooner, rather than maintain secrecy and perform individual emotion work. However, this was not the case for the lesbian birth mother in my study. She also struggled to hide her emotions from her partner until she ended up in the emergency room. Her case speaks to the pervasiveness and power of conventional expectations for mothers.

In addition, although mainstream explanations for post-partum depression center on hormonal explanations, health researchers have begun to investigate fathers' discrepant emotions following the birth of a child (Davey, Dziurawiec, O'Brien-Malone 2006). Like researching adoptive mothers, studying fathers' post-natal experiences and emotions could challenge biomedical explanations of post-partum depression and provide a gendered comparison. Because men and boys are socialized into valuing the self over others, men are more likely to experience "externalizing problems," such as antisocial behavior and substance abuse, whereas women are more likely to experience "internalizing problems"

[21]These studies, based on the Pregnancy Risk Assessment Monitoring System (PRAMS), asked, "In the months after your delivery, would you say that you were a) not at all depressed, b) a little depressed, c) moderately depressed, d) very depressed, or e) very depressed and had to get help?"

(Rosenfield, Lennon, and White 2005). Men who are diagnosed with an internalizing problem are deviant cases, and one line of research could investigate how men come to be labeled (or self-label) with an internalizing problem.

Warner (2005) interviewed mothers of children under four who did not identify as having PPD or PAD. They, too, experienced motherhood as arduous and described similar stories to those I heard in my interviews. For instance, one woman said, "I've been tired for years and years and years;" yet another added, "Anxiety is just accepted…It's not something that is openly acknowledged, it's just subtly brought up in conversations as we talk about busy schedules and coordinating events" (Warner 2005:126). This stress is taken-for-granted. As one mother explained, "I think that mothers often believe, as I did, that it [anxiety/depression] simply goes with the territory" (Warner 2005:126). These women had similar feelings to the mothers I interviewed, but they normalized them successfully. Future studies could examine how women who do not define themselves as depressed manage the emotional challenges associated with new motherhood. These could be compared with those who do take on the labels of PPD or PAD.

"Depression" is more than a biomedical problem. For the women I interviewed, it became a label for disturbing feelings that arose from the way motherhood is constructed and organized. Using a label of PPD and PAD individualized and psychologized emotional deviance for what may be a widely shared experience of mothers in the U.S. Because motherhood is seen as natural and as an identity that signifies one's goodness (or lack thereof), women suffer by holding themselves responsible for something rooted in the social world rather than in themselves.

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III. "NOT A WHOLE LOT I CAN DO": MIDDLE-CLASS MASCULINITY AND MEN'S CAREGIVING

Caring work refers to "attending, physically, mentally, and emotionally to the needs of another and giving a commitment to the nurturance, growth, and healing of that other"; it involves a "fusion of labor and love" (Davies 1995:18-19). Thus, caregiving requires both instrumental and emotional effort. "Emotion work," according to Hochschild (1979, 1983), includes what people do to suppress or evoke particular feelings in themselves or in others. In the context of caring work in the family, emotion work would affirm and enhance a family member's emotional well-being (Erickson 2005).

Studies (Brines 1994; Craig 2006; Coltrane and Adams 2001; DeVault 1991; Hochschild 2003; Sanchez and Thomson 1997; Sayer, Bianchi, and Robbins 2004) have documented the gendered division of instrumental work associated with caring, such as preparing meals, tending the children, cleaning the house, and shopping for groceries. Emotion work is also split along gender lines. Women are expected to—and do—more of it (Bartky 1990; Erickson 2005; Hochschild 1983). In addition, it is seen as natural and common for women (Davies 1995; Kaplan Daniels 1987), but optional and exceptional for men (DeVault 1991; Hochschild 1983). The women who fail to do this work are often seen as unnatural or selfish, while men who do the work often receive extra points (from women).

The emotional care women provide is often "shadow work"—invisible, yet essential to the functioning of home and family (Hochschild 1983). As Erickson (2005:pars. 2) put it: "Women themselves often discount the time and effort involved in caring work not only

because it is expected to be a spontaneous expression of love but also because the illusion of effortlessness is part of doing the work well." Indeed, many women do it so well that other family members learn not to do it (DeVault 1991; Deutsch 2004); when men are called upon to contribute to housework and child care, they find ways to avoid it. Deutsch (2004) found that men resisted doing care work by ignoring requests for help, feigning incompetence, adhering to lower standards, and praising their wives' better performance of housework.

The emotion work required of women and men differs. Women in heterosexual relationships generally show more deference to men than the reverse (Hochschild 1983; Bartky 1990). As Hochschild (1983:163-165) explained,

> Women are more likely to be presented with the task of mastering anger and aggression in the service of "being nice." To men, the socially assigned task of aggressing against those who break rules of various sorts create the private task of mastering fear and vulnerability…Especially in the American middle-class, women tend to manage feeling more because in general they depend on men for money, and one of the various ways of repaying their debt is to do extra emotion work—*especially emotion work that affirms, enhances, and celebrates the well-being and status of others* (italics in original).

Women spend more emotional energy in service of relationships, often trying to meet their husbands' emotional needs (Bartky 1990; Coltrane 1998; Hochschild 2003; Sattel 1976), but this emotion work is largely unreciprocated and potentially disempowering (Bartky 1990). However, when women are unable (or unwilling) to do emotion work, this taken-for-granted work emerges from the shadows, and the division of emotion work is called into question. Under those circumstances, men are put in a position where they may be asked to act as caregivers and do conventionally feminine emotion work. The husbands I interviewed found themselves in a potential role reversal when their wives experienced distress after having or adopting children.

Research on male caregivers has given us some insights into the ways that men offer care and deal with caring work. Skaff and Pearlin (1992) found that men adopt a managerial style of caregiving; they delegate tasks to family (often daughters) and friends. They are technically the primary caregiver of their wives, but they draw on their networks for a lot of the work (Stoller 1990). In contrast, women tend to assume most of the carework themselves when their husbands are in poor health (Russell 2001; Stoller 1990). When men do take on care work, women often organize it. For instance, when men cook (a form of care work), their wives create the menu and buy the ingredients. Cooking often means reheating what their wives have prepared (DeVault 1991).

In his study of predominately white elderly men providing care to their wives with dementia, Russell (2001) found that the men blended "masculine" managerial styles of caregiving with "feminine" nurturant ones. Similarly, Risman (1987) found that fathers adopted "mothering" styles of care for their children when they lost their wives to death or divorce. The men I interviewed took on some of the activities expected of mothers (e.g., watching the child occasionally), but unlike the men Russell (2001) and Risman (1987) studied, these husbands did not perform full-time care and had little need for taking on the tasks of mothering. Despite the wives/mothers' major distress, they continued to do much of the housework and child care.

Some caregiving men have experienced tension between their roles as caregivers—what they thought of as feminine work—and their masculinity (Kirsia, Hervonen, and Jylha 2000). In recounting their caregiving for their wives with Alzheimer's disease, the men saw themselves as sensitive caregivers but felt embarrassed when they cried in front of others and ashamed when they felt hopeless about their wives' condition. Elderly men have lost major

signifiers of masculinity: they are seen as "roleless" following retirement, and as persons in physical decline (Russell 2001). For them, becoming a caregiver created another threat to their compromised masculinity. In response, they reasserted their masculinity by positioning themselves as those who were in charge of the situation. They described themselves as "[men] on a mission," believing that "'a man's gotta do what a man's gotta do' and take good care of what belongs to him" (Kirsia, Hervonen, and Jylha 2000:pars. 5). Thus, they reinterpreted their caring as an obligation that a "real man" would meet. This interpretation prevented their caregiving from undermining their sense of masculinity.

The men studied by Kirsia, Hervonen, and Jylha (2000) compensated for the threat to their manhood, but the husbands I studied did not feel the same threat. Caring emotion work was not central to their identities as men, and their wives' distress only partially and temporarily disrupted the status quo in the family. The men I interviewed were employed in professional careers, and all but one had at least an undergraduate degree. Because work is integral to men's identities, their work and the good family wage they provided assured their sense of masculinity. As I will show, doing some caring work bolstered the men's sense of themselves as good middle-class husbands and fathers.

Previous studies have taken masculinity into account, but they have not examined how the men's class position plays a part in caregiving and the kind of caregiving/emotion work they do. Middle-class men's familial roles "[emphasize] sentimentality toward children, and a more companionate marriage with one's wife…[Beginning in the 19th century], a new romantic sensibility urged greater masculine involvement in the lives of their family" (Mintz 1998:13). In light of the "companionate marriage," middle-class women expect emotional engagement in their marriages (Rubin 1992, 1994).

The "new [middle-class] father" is also supposed to be "intimately involved in raising [the] children" (LaRossa 1998:379). But, LaRossa (1998) found that the new father is more of a folk belief than a reality (see also Pleck 2004). Father involvement in child care and house work has slowly increased since 1970, but women continue to do most of both (Brines; 1994; Craig 2006; Coltrane and Adams 2001; Sayer, Bianchi, and Robbins 2004).

Working-class men tend to hold more traditional and authoritarian views about men's and women's roles in the family (Rubin 1992, 1994), but these ideas do not preclude working-class men's participation in housework and child care. Working-class white, Latino, and Black men contribute more to child care and housework than middle-class white men (Peterson and Steinmetz 2000; Pleck 2004; Roopnarine 2004). Hochschild (2003) found that working-class men with traditional attitudes did more work at home than middle-class men because they felt guilty about not being sole breadwinners.[22] The middle-class men she studied maintained a guise of egalitarianism, but dodged housework and child care (see also Deutsch 2004). As Gerstel and Gallagher found, men with more egalitarian ideas (often associated with the middle-class) are "less likely to provide child care than men who hold more traditional ideals" (2001:211). For the men I studied, their provision of a secure family wage—a signifier of white, middle-class masculinity—freed them from having to do more work at home and from feeling guilty about their lack of participation.

[22]However, these findings are for men who are employed full-time and make more money than their wives. Brines found that "dependent husbands do less housework the more they depend on their wives for income" (1994:682). Men who have been unemployed for longer than three months "do no more housework than their fully employed counterparts, and…they may do less" (1994:677).

Middle-class ideas about a husband's and father's role guided how the men I interviewed responded to their wives' distress. Consequently, they used both gender and class strategies. Hochschild defines a gender strategy as:

> a plan of action through which a person tries to solve problems at hand, given the cultural notions of gender at play. To pursue a gender strategy, a man draws on beliefs about manhood and womanhood, beliefs that are forged in early childhood and thus anchored to deep emotions. He makes a connection between how he thinks about manhood, what he feels about it, and what he does (2003:15).

The wives' distress created a problem for the men. They found themselves in a position of giving emotional care rather than receiving it. I discovered that the men, in doing emotional repair work, used caregiving strategies that reflected and reinforced straight middle-class masculinity: they offered their wives breaks in child care, giving the impression that they were "new fathers" who participated in childrearing. The husbands also tried to take charge of the situation and change their wives' perspectives. These strategies established themselves as "strong, rational men" who were in control of the situation. Finally, they avoided conflict with their wives by emphasizing their role as breadwinner or escaping the scene by doing conventionally masculine tasks. The men gave the appearance that they were contributing more than a paycheck to the family, even if they were not actively engaged in caring.

Because women do most of the caregiving, we have less data on men as caregivers. This chapter will help fill out that picture. We also know little about how the recipients of care interpret their caregivers' efforts. In the second part of the chapter I will discuss how the wives responded to their husbands' strategies. This chapter also explores emotion work within the family, an arena that has been neglected in the family literature (Coltrane 2000; Erickson 2005).

In the next section, I will expand on the ideas that informed the men's gender and class strategies for dealing with the problem. I will discuss how their wives' distress placed these husbands in an uncomfortable position that required emotional intervention. Then, I will examine the emotional repair strategies the men used to alleviate women's pain, followed by an analysis of the wives' reactions to the men's emotion work strategies. In the conclusion, I will discuss how the men benefited from doing emotion work and how these strategies reinforced male privilege. I will also consider how structural constraints and cultural understandings make these strategies more likely.

MIDDLE-CLASS, HETEROSEXUAL IDEAS OF FAMILY

Rubin argues that middle-class marriages are no more egalitarian than working-class marriages, but "the [belief system] of equality is more strongly *asserted* there" (1992:97; italics in original). In the 1970s, the idea that the father should have "coequal responsibility for parenting" (Pleck and Pleck 1997:45) came to the fore as the ideal for middle-class men. However, numerous studies have shown that the gendered division of labor in housework and child care persists, even when women work full-time outside the home (Brines 1994; Coltrane and Adams 2001; Craig 2006; Hochschild 2003; Sayers, Bianchi, and Robbins 2004). For couples who live out the breadwinner/homemaker model, the male breadwinner is expected to provide a good family wage, while the homemaker takes care of the house and children. Under this division of labor, female homemakers often believe that they do not have the right to expect the male wage earner's participation in household labor (Rubin 1992; 1994).

The breadwinner/homemaker arrangement comprises about 25% of marriages, but the beliefs surrounding this model undergird many dual-earner marriages (Tichenor 2005). As Tichenor explained:

> Men are entitled to perform as "ideal workers" in the marketplace, unencumbered by the demands of family life. Women, whether engaged in paid labor or not, are marginalized in the workplace by their domestic responsibilities. They continue to be seen and treated by employers as mothers or potential mothers, which limits their options and opportunities at work…The underlying contract that delegates breadwinning responsibility to men and domestic responsibility to women remains largely unchallenged (2005:12-3).

The continuing division of labor mirrors the identities that are most central for women and men. For many women, motherhood remains a significant identity (McMahon 1995). For white, middle-class mothers, children and the home became measures of success as a person (Hays 1996; McMahon 1995). For men, breadwinning continues to be important to the definition of good fatherhood and manhood (Pleck 2004; Roopnarine 2004). Being a breadwinner is a moral identity for men (Kleinman 1996:5); living up to the good provider role means that he is a good person. The idea of good fatherhood is also coded as middle-class. Implied in the models of bad fatherhood (e.g., the "deadbeat dad") is a man who cannot or does not provide for his wife and child—often poor and working-class men (Pleck and Pleck 1997). The breadwinner/homemaker model itself depends on having a middle-class wage that enables one person (usually the woman in a heterosexual couple) to exit the paid labor force. In this way, poor and working-class men's masculinity and fatherhood are deflated by their constrained ability (or inability) to "provide."

The majority of couples I interviewed established the traditional male breadwinner/female homemaker arrangement for their families after the arrival of the child. Of the 27 couples (adoptive and biological parents), 18 had this arrangement at the time of

the interview (which generally was within 2 ½ to 3 years after the birth or adoption), but all of the women, except one, held a full-time job prior to the birth or adoption. None hired a nanny, though probably less than half of the couples could have afforded a full-time nanny (12 couples made over $75,000 annually). Biological mothers and fathers often attributed this traditional arrangement to the fact that only women could breastfeed, and both adoptive and biological parents told me that the woman had "chosen" to stay home with the children. Women who returned to their paid jobs took a month to four months more leave time than their spouses.

By and large, the men anticipated that their stay-at-home wives would take care of household tasks. Vince reported what Eve did in the household.

> She's a strong woman … and [she] takes care of the family, takes care of a lot of routine stuff that has to be done, since she's stay-at-home, with scheduling and coordinating and things like that. So I don't have to worry about those issues, and that's something I really appreciate.

Like other men who share the breadwinner/homemaker model, Vince justified all that Eve did by pointing out that she was a stay-at-home mother. The stay-at-home mothers sometimes reluctantly came to accept this division of labor because their husbands provided a good family wage. Jana, for instance, said:

> What I've learned basically, and what I've grown to accept is, when you have a baby, no matter what, no matter if I'm not home, if I'm sleeping, if it's his turn to watch the baby, it is always my responsibility no matter where I am. That child's always my responsibility 100%...But at the same time, I mean he's our livelihood. He's what supports us. He's what gives us food.

It was Nate's paycheck that made her solely responsible for the care of their child.

Women also perform the majority of the housework and child care when they work outside the home (Brines 1994; Moen and Roehling 2005). The dual-earning couples I

interviewed often claimed they had egalitarian arrangements, but on closer examination, their division of labor was not egalitarian. Mark was a graduate student, and his wife, Karen, worked full-time prior to the birth and part-time afterwards. Mark proudly told me that he and Karen split child care "50-50"; he took care of their son in the morning after Karen left for work. Karen took over in the afternoon, and into the evening and night. After he described a typical day, I learned that he spent two hours in the gym in the morning. The gym offered child care, and the baby napped for at least one of the hours. Even in his four-hour child care shift, Mark had about one hour of active engagement. Similarly, one dual-earning couple Hochschild (2003) studied created what they saw as an equitable "sharing arrangement" of the household labor. The husband was responsible for maintaining "the downstairs," and the wife, "the upstairs." But, the upstairs included almost all of the house, and the "downstairs" included the garage and the husband's hobby areas. Hochschild called this a "'family myth': "A modest delusional system [that prevented] conflict over the second shift [and got rid of any] tension between their versions of manhood and womanhood" (2003:46-7).

Mark's pride in his contribution is illustrative of the culture of the new father, whereby the ideal contradicts what fathers do. Fathers are often "technically present, but functionally absent" (LaRossa 1998:379). They mostly serve as back-up parents, and when involved with their children, their attention is often directed at another activity, such as watching television (LaRossa 1998). Comparatively, mothers are more involved in all aspects of child care, including active engagement, accessibility (being available, if the child has a need), responsibility (accountability for general child welfare, such as doctor's appointments).

For middle-class families, a companionate marriage creates an interactional expectation for both partners (Rubin 1992, 1994). Companionate partners are supposed to share equally in emotion work, mutually express vulnerability, and affirm each other's well-being. But this, too, is largely a folk belief. Women are expected to do emotion work for their spouses, their children, and the family as a whole (Bartky 1990); when they fail to do so, they often feel guilty (Erickson 2005). Men are not expected to do caring emotion work and thus are unlikely to hold themselves accountable when they fall short (Erickson 2005; Kaplan Daniels 1987). In the next section, I will analyze the emotional repair strategies these husbands employed while their wives experienced extreme distress.

INCONVENIENT EMOTION WORK

The men whose wives saw themselves as depressed after giving birth or adopting found themselves in the position of having to do conventionally feminine emotion work. This interrupted the usual male privileges white middle-class men receive in heterosexual families. First, their wives' needs disrupted the emotional status quo, whereby men receive emotional services rather than provide them (Bartky 1990). Second, the emotion work the men were called upon to do sometimes interfered with their roles as breadwinners and could make them look bad at work. But, overall, the kind of emotion work the men did only inconvenienced them and did not undermine their masculinity.

The men expected things to run smoothly once the children arrived, but their wives' distress cut short that sentimental vision of family life. Roger said, "I thought everything would be downhill and a piece of cake, but Renee is pulling her hair out." Bryan felt baffled by—and angry toward—his partner when he noticed that Corrine "was not coping well"

about a week after she had been home alone with their twin daughters. She called him at work several times a day, saying, "'I think I'm going crazy.' She told me she was going crazy, [and] she was bored out of her mind. The kids are driving her crazy. She would cry and be upset about stuff." Her feelings were incomprensible to him. Bryan said:

> It was very hard to sort of confess it, that there are difficulties… I wanted to keep believing this is going to be absolute, pure unadulterated joy for the next 21 years!...It was beyond my understanding. How she could be depressed? I [thought], "I don't understand. You can't be depressed about this." Because I'm just coming home every day going "oh, ah, oh, ah!" [goo-gooing over the children], and I think I was angry at her for being depressed because I just thought it was so inappropriate...I remember feeling angry somewhat about this...You've got months off from work, these new children, and it's supposed to be a wonderful time of your life. This is the time that ought to be just special memories, greatest times that you remember forever. And it was very unpleasant for us, and I was really angry that she was somehow making it unpleasant for us all.

Bryan's anger at Corrine's failure to have the appropriate feelings reinforced the idea that women are responsible for the emotion work in a relationship. Corrine's distress "was somehow making it unpleasant for us all," implying that he expected her to maintain a happy face for the family. Her unexpected negative feelings and cries for help disrupted the expected emotional tone at home and the division of emotional labor. Women who are unable to assume housework, child care, and emotion work call into question male entitlement for domestic and emotional services (DeVault 1991; Hochschild 1983). As DeVault (1991) argued, within the heterosexual family, women usually cater to men's preferences, and men expect to have their needs and claims met.

Bryan's comment also hinted at an expected division of labor in child care. Bryan had returned to work two-and-a-half months before Corrine did. In the meantime, Corrine stayed home with twin babies and soon felt overwhelmed. He "helped" with the twins when

he came home, but Bryan's main contribution during this time was cooing at the babies and watching them when he could. His particular tasks may have given him the impression that taking care of children was easy work. His statement that she should feel happy because she has "months off from work" equated her child care work with vacation time. Stating that her experience should provide "special memories, greatest times" idealized caregiving.

The men overwhelmingly reported feeling "powerless" and "helpless" in the face of their wives' distress. This powerlessness could have been a threat to their masculinity because masculinity is characterized by control (Johnson 2005). Yet, for the most part, these feelings, and the men's strategies for dealing with them, did not disempower the men. The emotion work of caring does not carry the same moral force for men as it does for women (Erickson 2005; Kaplan Daniels 1987). The responsibility for and performance of emotion work are central to what is means to be a woman, and thus can have a greater impact on women's sense of self (Ferree 1991; Shelton and John 1996). For men, caring emotion work is not integral to their identities, but only a minor requirement of a marital relationship (Erickson 2005).

Victor exemplified this attitude toward emotion work. He said that he didn't want to "dismiss my wife's feelings" or "shame [her] for it [her negative feelings]," but he felt

> a kind of helplessness because you want to be able to help, and there's not a whole lot I can do other than be careful about when and how I say stuff…I mean, you've got real, intentional, direct things you do. At the same time, you wing it. You kind of make it up as you go along…adjust your game plan as you go along.

How women and men respond to their own failed emotion work is gendered. Women, but not men, feel guilty and critique themselves when their caregiving fails (DeVault 1991). Victor's comment suggested that he did what he could, but did not express guilt about it and

did not take it personally when his emotion work was ineffective. "Winging it" implied that Victor was not fretting over how to manage the next incident. He could have been distancing himself from feeling powerless, an emotion work strategy for himself. But, because emotion work is "women's work," he could also feel less threatened about his inability to transform his wife's emotions. Victor pointed out that he did things "intentionally" and had a "game plan," implying that he is strategizing to deal with a challenge (akin to sport). His masculinity is not in question here as he asserts control and makes new moves.

The only time that caring emotion work might have put their masculinity at risk was when it jeopardized the husband's role as breadwinner or made him lose face at work. Several men told me that their wives called them repeatedly at work and asked them to come home, even when the men felt they could not. During a hurricane watch, Jana called Nate and asked him to come home. He explained how he made that decision:

> Jana got upset and called me and basically was kind of like, 'I really want you to come home." And I was saying, "You're overacting. I will be home [later]. This isn't a problem." When she gets stressed out about something like that, that's when her reason is completely lost. In an ideal world, yes, I should have gone home and comforted her and done that. But at the same time, not one person was leaving [work] to go home. I couldn't see how I was going to explain to everybody, "Hey guys, I'm leaving. My wife's a nervous wreck." So, it puts me in this position of do I want people at work mad at me, or do I want my wife mad at me?...At the same time I look at it as the job is what keeps you eating.

Nate saw leaving work to comfort his wife as potentially humiliating, and he was willing to upset his wife rather than lose face with his coworkers. He justified his choice by highlighting his ability to provide for the family and defining his wife as unreasonable ("a nervous wreck"). Opting to do emotion work at that time could have undermined his masculinity.

Nevertheless, the men found themselves in an uncomfortable and unpleasant situation at home, and they had to deal with it. One alternative, to leave the relationship, would have threatened the men's identities as providers for their family and good fathers to their children. To provide emotional care for their wives, they used several strategies, shaped by middle-class ideas about men's roles in the family.

EMOTIONAL REPAIR STRATEGIES

The women managed to give such convincing emotion displays that all of the husbands thought their wives were doing fine until the women made it clear that were not (see Chapter 1). Like the other partners, Dan told me that at first he thought his wife's distress was "normal." Rafael elaborated on his observations of his partner:

> At the time I didn't know she was depressed. I could see something was wrong, but I thought it was normal… I knew that Kate wasn't feeling good or something. I was hoping it could solve itself.

After the women defined themselves as having PPD or PAD, the men could no longer ignore their spouses' distress, and all of them tried to do something about it. They undertook several emotional repair strategies, which I will address in turn. Each of the men I interviewed relied on one or more of these strategies.

Giving Her Breaks

Taking care of children remains "women's work," and many middle-class men find ways to avoid it. As Deutsch points out,

> Women's ambivalence alone certainly doesn't account for the unequal division of labor at home. The unequal men are hardly fighting to do an equal share of the work. In part, they feel entitled to pursue unfettered careers, and entitled to relax after their day at the job. Yet, they don't feel as entitled as their fathers did (2004:469).

The men I interviewed offered their wives breaks from what is defined as women's work. This contrasts with what female caregivers tend to do. Badger (1996) found that predominately female caregivers for those who are depressed took over the work and roles of the ill person.[23]

Almost all of the men thought that they could be helpful to their wives by offering to give them "breaks" in housework and child care. Many of the men I interviewed said they also recommended that the women get mother's helpers or babysitters. In doing so, they offered support by changing the circumstances to reduce stress or removing the person from the stressful situation (Thoits 1986).

Chad explained his strategy to help his wife, Julie: "When I come home I usually take the kids and take them upstairs with me… and try to get them out of her hair for a while." Roger said that he offered both breaks and a mother's helper:

> Renee's pulling her hair out, so I said, "Renee, get a babysitter over here. We're not the richest people on the block. But [you need] to keep your sanity—*we* need to. Even when you are home and not going anywhere, you need to have a babysitter, a mother's helper…So, I said, "Get that mother's helper, or [take a break] when I come home and on the weekend...See some of your old friends" (my emphasis).

Roger's fathering, as his statement suggests, meant weekend work and "helping out" in the evening. Roger recommended a mother's helper not only to keep Renee's sanity, but to keep both of them sane (the "we" he invoked). Thus, he implied that he was worn out by Renee's distress and doing emotional repair. Presumably, breaks or a mother's helper would relieve her stress, which, in turn, would relieve his unease. Bringing in extra assistance is a logical solution, but it depends on class privilege and relies on other, less privileged women to

[23]Although she does not frame her work in relation to gender, women comprised the majority of Badger's sample (9 of 11 informants).

assume the burden of care (Hertz 1986; Hochschild 2003). It also absolves the husband/father from contributing more.

"Help" and "breaks" signified that child care is not a responsibility that should be shared equally by women and men. "Helping" implied that Roger's contribution was supplemental (and optional) and that he was being generous—giving a gift—by offering assistance. As Hochschild (2003) found, because men's participation in housework is not expected, men accrue a lot of credits for few contributions in the marital economy of gratitude. Women, on the other hand, receive few credits for doing most of the work because it is expected. A gift must transcend the cultural baseline for giving.

Roger might have attempted to co-parent, but in a context in which child care continues to be primarily mother's work (Brines 1994; Sayer, Robbins, and Bianchi 2004), this option did not seem to occur to him—or at least he did not mention it as a possibility.[24] Instead, his partner, Renee, reported that they "jointly decided" that she would be a stay-at-home mother (prior to adopting, she had been a nurse for 20 years). She explained:

> Jointly we decided that I would quit work and stay home with the children for at least a year—which has turned into two-and-a-half now. For me, it was a little bit difficult [to give up my job] because I had always had that outside interest. I had always had something outside; adults to talk to.

Breaks would not have enabled Renee to return to full-time work. She sacrificed a valued identity and likened her new one to "a jail" (see Chapter 1). A break from jail does not

[24]A highly-involved father that Hochschild (2003) interviewed said that he felt embarrassed when he took his child to the park in the afternoon and was surrounded by mothers. He felt like a failed man. Hochschild added that with the increasing numbers of nannies who are immigrants, the father may also have found himself resentful about doing the kind of work that upper-middle class women have successfully avoided.

amount to much, and, as Jana put it (above), even when a mother is out, the child is still 100% her responsibility.

In addition, Roger was a sole breadwinner, so taking on a reduced workload would have meant less money for the family. For families with the breadwinner/homemaker model, men are likely to pursue more hours at work after the arrival of a child to make more money or to ensure job security (Moen and Roehling 2005). Other constraints hinder the possibility co-parenting. Real wages are declining, and the cost of living is increasing. Thus, maintaining a secure household income is even more pressing (Moen and Roehling 2005), and in light of the wage gap, men's employment would likely garner more income than women's. Additionally, many companies informally discourage and penalize men for using paternity leave (Hochschild 2001; Moen and Roehling 2005). Finally, breadwinning remains central to men's identities as good providers, and thus as good men (Pleck 2004). Taking on a reduced workload with less money for the family could have undermined Roger's feelings of success as a man.

Men in dual-career couples (9 of the 27 couples) also used the strategy of giving breaks. Both Elaine and her partner, Jerry, worked full-time jobs, but Jerry thought that he was easing Elaine's struggles by giving her time off:

> A couple of times, I'd be like, "I'm gonna take the baby with me. We'll be back in a while." Give her a little time to herself. So, I also recognized that that's important that she have time to herself…Like now, mom is out at lunch with all the women from the Bradley class [a child birthing class] that we took. So, I take [the baby] to the park and make sure she gets some lunch and whatnot, and I do a lot when she needs time off.

Consistent with ideas about the companionate marriage, Jerry tried to tune into Elaine's emotional needs, but his contribution was not substantial ("a couple of times"). In dual-

career couples, caring work still falls heavily on women even when women earn more money and work longer hours (Brines 1994; Coltrane and Adams 2001; Moen and Roehling 2005). Women's income is defined as supplemental to men's (Hertz 1986), even among purportedly egalitarian couples. Moreover, the husband's salary establishes a family's social class, regardless of who earns what (Hochschild 2003; Tichenor 2005). As Tichenor argued, "Within most U.S. families, the income that the husband earns is the most highly valued asset" (2005:13).[25] Elaine found Jerry's contribution at home a "real help," but she did much more of the second shift than Jerry. Nevertheless, he credited himself for helping Elaine and taking care of the baby.

Because fathers are expected to contribute to the care of children and housework in white, middle-class, heterosexual families (Pleck 2004), offering breaks made sense to the men and reaffirmed their sense of themselves as good husbands and fathers. They were acting like "new fathers" while still maintaining their role as providers of a good, middle-class family wage. The men performed some of the instrumental tasks in order to alleviate their wives' distress, but did not take into account how isolating and exacting the standards of motherhood are and how deeply it can hurt women who fail to live up to those standards.

Household tasks and child care have different meanings for men and women (DeVault 1991; Kroska 2003). When the mothers I interviewed fell short of their high expectations, they felt like "failure[s] as mother[s]" and "totally inadequate" (see Chapter 1). The men's offering of time away from child care would not necessarily fix those feelings of

[25]When wives earn more, couples redefine "provider" to include other instrumental and emotional tasks for the family. In so doing, wives collude in preserving their husbands' masculinity (Tichenor 2005).

inadequacy. Offering breaks may have given the women temporary respite, but did not change the women's isolation, sense of responsibility, and distress.

Taking Charge

Control is central to masculinity (Johnson 2005), and the men I interviewed applied what one might think of as a control model to their caregiving. According to Johnson, control "takes men away from connection to others and themselves and toward disconnection. This is because control involves a relationship between controller and controlled, and disconnection is an integral part of that relationship" (2005:27). In his study of elderly male caregivers, Russell found that the men took charge of their wives' care. As one man he interviewed said, "I took matters into my own hands" by arguing with a social worker to have his wife, who suffered from Alzheimer's disease, hospitalized (2001:361). The caregiving women that Badger (1996) interviewed took a different approach. They researched health care providers, went to doctor's appointments, and tried to find alternative activities that might make their husbands (or mothers, in the case of daughters) feel better. These women gave their loved ones attention, options, and suggestions. One woman "insisted" that her husband get help, but she felt guilty about being too assertive, and did not want to be seen as controlling (Badger 1996).

The men I interviewed tried to take charge of the situation by being "strong" and taking control of family decision-making. Doing so, at least gave the appearance that they had the situation under control. Mark succinctly explained how he reacted to his spouse's distress: "When she's frightened, I feel like I need to be strong." Chad said that he was "the stabilizing force" in the relationship. This differs from women's emotion work: "offering

encouragement, showing appreciation, listening closely to what [he] has to say, and expressing empathy" (Erickson 2005:pars.3; see also Bartky 1990).

Some men took control of the situation by giving their wives lists of things to accomplish during the day, deciding whether the women should quit breastfeeding, or pressing them to take medication. Dan said:

> It was draining, I think, emotionally for me. It was frustrating. I just kept on telling myself, "Push through. Push through. Be strong for her." So, I just kept on pushing through.

Being strong refers to maintaining calm and being decisive during turmoil—a conventionally masculine expression of rationality (Sattel 1976). Dan wanted to "be strong for her," but doing so may have created emotional distance. "Pushing through" suggests that he needed to suppress his own emotions in order to manage whatever situation might arise. Being strong and decisive gives the impression of emotional stability, but may lack emotional availability. Like a conventionally masculine hero, Dan situated himself as a source of security for a damsel in distress.

James discussed how he responded when Nancy came to him with concerns:

> I tried to listen…and validate her feelings, [but]….Nancy tends to harp on the same thing over and over and over and over again, and it wears me down after awhile. That's where my thoughts and my rationalizations end up saying, I'm not going to play "what if" games anymore…I always have the view that it's not going to accomplish anything by harping on the negative. You could focus on the positive and just enjoy existence more…Somebody might cross the double yellow [line on the highway], what if. You just can't live your life being depressed about the "what if," and my approach is you might as well take advantage of the joys in life because of the "what if" [i.e., what could happen].

Consistent with the expectations of the companionate marriage, James "tried to listen" and take her feelings into account, but he took charge by doing the emotional equivalent of

putting his foot down. He refused to continue with what he saw as unproductive "harping," thus setting the terms and boundaries for the conversation. He may have intended to mitigate her distress by interrupting her negative thoughts and encouraging her to relax more. However, interpreting Nancy's concerns as "harping" and "what if games" also could have been trivializing. His solution, telling her to relax and enjoy life, did not address what was bothering her.

James also said that Nancy's repetitive negativity interfered with his well-being ("wears me down"). Cutting off the "harping" suggests that he was unwilling to do emotion work for her, but instead preserved his own emotional needs. Men maintain control in a relationship by refusing to support what they see as "irrational" (i.e., emotional) expressions in others (Rubin 2004; Sattel 1976).

Taking charge demonstrates that a person is firm in his or her convictions, but an executive decision distances the one who makes the ruling from those who are expected to comply with it. It also may distance the person on the receiving end. Thus, "taking charge" could undermine communication between the partners and hurt the relationship (e.g., two men who used this strategy were, at their wives' request, seeking marital counseling). Instead of discussing the problems and possible resolutions with their partners, the men failed to explore what their partners needed. They did not affirm their wives' well-being or provide emotional support.

Changing Her Perspective

One way to provide support is by changing a troubled person's view of the situation and defining it as normal, temporary, or inconsequential (Thoits 1986). Some men defined their wives' distress as a problem with "perception" (Marty), or something that could be

overcome with "mind over matter" (Chad). This strategy reduced the challenges their wives faced to a skewed perspective and allowed the men to see themselves as apart from the problem. In their responses, however, the men positioned their view as rational, contrasting it with their wives' irrational perception. In Western thought, rationality is conventionally defined as masculine (and good), whereas emotion, associated with women, is defined as a problem (Rubin 2004). As Johnson has argued, being rational "is actually a controlled emotional flatness that is no less an emotional state than hysteria, rage, or grief…In truth, being masculine is…about acknowledging or expressing only those emotions that enhance men's control and status, and it's about renaming or explaining away the rest" (2005:64).

For instance, Marty attempted to remedy Elizabeth's suffering by telling her to look on the bright side:

> [Elizabeth] would say something about, "Well, Loreena keeps doing this and this and this." And I would say, "Well, think about what she was doing six months ago, and yeah, she does still do this, but she's not doing this anymore. Look at the progress we've made." You could accuse me of being a little too straightforward with that and less welcoming and supportive. And more just sort of, "Come on! Get your head out and look! It's right there, just look at it." That's the important thing. You've got to step back and take a look every once in awhile.

Marty intimated that Elizabeth's perspective was muddled and required intervention from a more objective observer. Identifying his approach as "straightforward," he established it as devoid of emotions (thus, rational). To deal with her strain, he asked her to toughen up for the sake of the children. He recognized that his approach could be interpreted as "less welcoming and supportive," but he emphasized that he did "the important thing."

Marty's encouragement is reminiscent of a coach's pep talk. His use of "we" implied that he was on the same team as Elizabeth, but they were not doing the same work.

Elizabeth, not Marty, did the bulk of the tasks associated with child care. She took care of the two children full time. In addition to children's usual needs, their children had health and behavioral problems. Elizabeth researched their children's problems, found specialists, and took them for treatments. Her perspective represented the daily activities of child care, arguably not a skewed perception.

When Julie, who had been depressed after the birth of her first child, told Chad that she did not want to give birth to her second child (born 1 ½ years after the first), he reminded Julie that her talk "shouldn't be taken at face value" because "this was the depression talking." Chad said,

> I remember her saying things about how this child is not wanted, and then my response to that was, "Certainly, you know, that's crazy. We definitely both want this child. I mean I certainly do, and I know you do as well." I honestly didn't know the best ways to respond. When you're told something like that by a spouse, that this child is not wanted, you know she doesn't mean it, and it's hard to figure out the right way to respond…I tried to tell her that it was just kind of the way she was feeling at the time that was causing her to think that she didn't want this child.

In his efforts to comfort Julie, Chad defined her thoughts as arising from inappropriate feelings. Lillian Rubin found that the "rational-man-hysterical-woman script" is common among heterosexual couples (Rubin 2004:387). In disagreements,

> He falls back on his best weapons: He becomes more rational, more determinedly reasonable. She cries for him to attend to her feelings, whatever they may be. He tells her coolly, with a kind of clenched-teeth reasonableness, that it's silly for her to feel that way, that she's just being emotional…But that dismissive word "just" is the last straw (Rubin 2004:387).

Likewise, Chad's approach perpetuated the idea that women are more emotional and that emotion cannot be trusted. Not wanting to give birth and be a mother is taboo among white, middle-class women (Park 2002); few "sane" women would make such a claim. However,

the anguish Julie felt after the birth of her first child made it understandable that she would worry about a repeat experience.

Detachment and rationality characterize conventional masculinity in both the public and private spheres (Johnson 2005; Sattel 1976). The husbands I interviewed attempted to convince their wives that they held the rational perspective, and their wives were "crazy." Sattel (1976) argued that middle-class men and boys learn to suppress their emotions and maintain a rational façade to prepare them for positions of power, but doing so emotionally separates men from others. He explained, "To effectively wield power, one must be able to both convince others of the rightness of the decisions one makes as well as guard against one's own emotional involvement in the consequences of that decision" (1976:471). Invoking rationality established the men as those who should define the situation, and reinforced the men's authority in the immediate situation and in the family as a whole.

In middle-class companionate marriage, spouses are supposed to share thoughts and feelings, and see things from the other's perspective. The women confided in their male partners, but only after a while. They felt ashamed of their feelings about mothering, which is why they initially tried to mask them (see Chapter 1). However, the couples' "dialogue" could be described as the wife shares, and the husband reframes. Yet, the men's willingness to participate in the dialogue established the men as good and caring husbands in the women's eyes.

Avoiding Conflict

Finally, the men tried to deal with the situation by avoiding conflict. Thoits (1991) found that men tend to take direct action when they see a problem as resolvable. Otherwise

they tend to withdraw from the situation and do nothing (Veroff, Kulka, and Douvan 1981). Among the men I interviewed, the same was true for caring work.

Mark came to the point where he acted as though he accepted Karen's feelings and thoughts. When Karen said she wanted to put the baby up for adoption, Mark said,

> Oh, I was just thinking, "She's not being reasonable, but I'm not going to reason with her, I'll just say that [we can put him up for adoption]." And the next morning she was like, "Mark, thank you for saying that 'cause that's exactly what I needed to hear. Just agree with me, and let's go to sleep." And, because I knew that's not what she wanted, but it's just accepting that she felt that way and it was okay to feel that way was something that we eventually got to. But it took a long time.

Giving a person space or just listening can also provide social support, but avoidance may indicate support burnout: spouses will offer support until they believe their efforts have no effect (Pearlin and McCall 1990). Mark realized that arguing with Karen would not help. He thought Karen's thoughts were too unreasonable to merit discussion, but he pretended to agree. After Karen thanked him, he reinterpreted his response as coming to terms with what she felt. Yet, his description of the night before suggests otherwise. Mark's resignation suggested that he withdrew emotionally from the situation, but he gave the appearance of being sympathetic or even empathetic.

Other men evaded their wives altogether, especially when their partners got angry. Mike said his wife was either "on auto pilot" or "snapping at him." He shared how he avoided his wife when she was "snapping":

> I would get through, mostly by avoidance…Make sure all the dishes are done, all laundry is done just so I wouldn't get her mad at me…Real avoidance would be, I'd bury my head in a project. I'd go off to build something, tear open a wall, and re-plaster it—something that I could then justify why I'm not doing everything she is expecting me to. "Why isn't the laundry done?" "Well, I've got the wall open here." [Or,] "I'm out in the garage doing stuff." I'm not always sure what I do out there, but I'm out in the garage doing stuff.

Mike's statement implied that he was supposed to do laundry at least some of the time, but Becky told me she made sure that "all the laundry was done, all the housework was done" and "wished he would do a little more laundry." This suggests that most of the time, Becky was doing the housework and child care (in addition to running a small day care center from their home).

Mike found ways to escape his wife's grousing (and avoid doing laundry) by engaging in conventionally masculine construction projects or absconding to conventionally masculine domains (the garage). In doing so, he positioned his mystery projects as more pressing than household tasks. By concocting projects for the house, he could see himself as actively participating in meeting the family's needs.

As an emotion work strategy, this technique circumvented direct conflict (Pearlin and McCall 1990), but Mike's partner ultimately was left to cope on her own. Certainly, few people want to deal with a grouch, but Mike could have addressed the cause of her frustration and considered his place in it. He noted that she did not get upset when the dishes and laundry (his main household obligations) were done. That might have offered an alternative.

Providing emotional repair is difficult in situations that lack clear ways of responding (Badger 1996; Karp 2001). The men, overall, did what they thought was right and genuinely wanted their spouses to feel better, though some of their attempts were clumsy and misplaced. This raises the question: How did the women interpret and respond to the men's emotional repair strategies?

THE WOMEN'S RESPONSES

The women described their spouses as supportive in general, but when I asked them to identify what their spouses did to be helpful, many spoke in abstractions. Maria said, "I think my husband is unusually supportive and unusually accepting. [Interviewer: How so? Like, what does he do?] He is very loving. … He's just a very, very unusually tender guy." Nancy was a bit more specific, but still spoke in generalizations. She said that her husband "tried to listen" to her and was "just offering sympathy and support." However, when I asked her what things she found most supportive or encouraging, she offered details about how her therapist had "changed her cognitions." Taylor and Turner (2001) have argued that the emotional bonds linking the support provider and recipient matter more than the actual support given. Thus, the men's presence may have made a difference, rather than anything specific that they did (Jackson 1992).

Nevertheless, many of the women I interviewed also expressed resentment or resignation and eventually turned to friends, family, or therapists for emotional repair. Messeri, Silverstein, and Litwak (1993) noted that people choose forms of support based on their needs. Finding other forms of support suggests that the women I interviewed may have appreciated that the men were present, but found their husbands' strategies lacking (Peters-Golden 1982; Thoits 1991).

Giving Breaks

Bernard (1982) has argued that men and women experience marriage differently. The men I interviewed expected "21 years of unadulterated joy" (Bryan), but their wives felt overwhelmed by their responsibilities and isolated from others. Offering breaks only temporarily relieved the women before they had to return to "jail" and their "personal hell"

(see Chapter 1). The men did not fully comprehend the women's frustration, so this technique was less than effective in transforming the women's feelings. Despite the men's lack of understanding, the women regularly praised their partners' efforts. For instance, Eve said that she was "lucky…when he started taking the kids off my hands and telling me to go out and take a drive."

Eve's remark about being "lucky" suggests that she suspected that other husbands might have offered less. Glass and Fujimoto (1994) found that women who perceive equity in the housework and child care report fewer depressive symptoms. The perception of having social support matters more than whether a person has it or uses it (Wethington and Kessler 1986; Ross and Mirowsky 2002). Thus, some of the women may have been grateful for any help their husbands provided.

Amanda appreciated her husband's assistance, which included helping with child care and verbal support, but she said he did not understand her feelings:

> He was right there with me. He'd wake up cup feeding him [their biological son who had trouble breastfeeding], and… he was very supportive. He couldn't understand; he doesn't understand depression…My husband was a great support and just being very, "It's going to get better." But, I'm like, "Yeah, right. You work. I'm with her [their adopted daughter] all day." And, I was trying to get him to stay home and me [to] go back to work.

Amanda's appreciation is mingled with resentment. She congratulated him for being "right there," but Dan did not empathize with the challenges Amanda faced. Amanda's desire to return to work suggests that she wanted more than short breaks from the children. When home life is stressful, work can be a more relaxing alternative (Hochschild 2001). Dan's lack of empathy and unwillingness to relinquish the breadwinner role may have undermined his support of Amanda (Thoits 1986).

Getting a break was particularly unhelpful if the wives had to provide extensive instructions to their husbands (DeVault 1991; Hochschild 2003). It created an additional burden. As Jana explained:

> By the time I'll say, "Nate, can you, can you take her for a minute? I just need to go change, or I'm gonna go take a shower or something." He'll say to me, "When does she need to eat? Does her diaper need to be changed?" By the time I explain all that, I might as well just do everything myself and then take a shower.

The break was hardly worthwhile when her husband was (or pretended to be) incompetent at child care. "Strategic incompetence" is one strategy men use to avoid doing child care and housework, thus "[allowing] men to justify the gender-based distribution of domestic labor" (Deutsch 2004:470). The need for extra guidance on each task of child care implied that some of the men were not intimately involved in those daily instrumental activities (and ensured that they would not be asked again for help).

Taking Charge

The women had mixed responses to this strategy. Some of them found it helpful; others felt as though they were being controlled and that their needs were not being met. Renee said that Roger supported her by "jump[ing] right in and tak[ing] over":

> He was being very supportive of how I was feeling. I think he was being very strong. He said, "'I know we can handle this. Everything will be okay.'" He was just being very reassuring, just kind of a rock.

Renee felt secure in having a husband who was as strong as a "rock," but Kate experienced Rafael's decision-making differently. Kate admitted that she had been indecisive when she was at her worst. Rafael recalled, "She couldn't decide, even for small things. [When] we had to decide something, I decided. But then she would be angry [about his decision] for the next month."

In her interview, Kate discussed two decisions that had greatly affected her. The first involved a month-long trip to Italy to visit Rafael's dying father, and the second was a move to a new apartment. Kate was suffering, but she and Rafael consulted with her therapist about the trip. The therapist said that the trip was not a good idea, but that she could do it (that "it wouldn't kill me," as Kate put it). Rafael noted that they "had a huge discussion about it," but he "pushed to go to Italy." They went, but Kate explained, "I just started Zoloft, and I wasn't sure if it was the right medication for me…I didn't know my therapist very well. I didn't want to go to Italy. There was just so much [going on]."

The move that Rafael had decided for the family upset her more. Kate spoke at length about how this affected her:

> Our lease had been up in December for the apartment, and Rafael thought, "Well, we really could use a bigger space." At this point I really couldn't make any decisions. I went back and forth and back and forth. He wanted to move into the apartment across from us because it had one more bedroom. I didn't want to go. I said I did, and I said I didn't. [We] ended up moving…I wasn't participating in the move at all, and I just felt awful about it, totally out of control …You see, I wanted stability. I didn't want any more changes in my life. I couldn't explain to Rafael how important it was for me to stay there…I had a voice in my head that would say, "No, I really don't want to do it that way, but it just wouldn't come out. I just would talk myself out of it…I am sure this is like the super mom, super wife, super daughter, super everything.

Amidst Kate's wavering, it made sense that Rafael might take the lead. However, a viable alternative might have been to step back and make no decisions until later. Then, the two could have made a joint decision.

Rafael interpreted Kate's behavior as indecision, but Kate was not indecisive. She knew what she wanted, but feared she could not say it without losing the title of "super mom, super wife, super daughter." His taking charge may well have undermined her sense of

competence as a wife and mother: "To be sure, support transactions may often involve costs to the recipient (such as decreased self-efficacy or increased feelings of indebtedness)" (Collins et al. 1993).

Other women also found that having their husbands take charge was unhelpful. Francis's work (1997) on coping assistance showed that therapists tried to transform support group participants' emotions by transforming their beliefs about themselves as (weak) grieving people into strong people who were liberated from pain. Unlike the therapists, the men I interviewed did not redefine the women's identities in this way. Rather, taking charge unintentionally defined the women as incompetent in the roles they valued—wife and mother. Perhaps this strategy worked well for Roger and Renee because Roger accompanied "taking charge" with reassurances that Renee had the fortitude to endure. Thus, he may have helped her feel less incompetent and less weak as a mother.

Changing Her Perspective

Few of the women mentioned that their partners used this strategy. Elizabeth, whose partner told her to "look on the bright side," did not mention this as a form of support. Instead, she said that getting massages and having time alone helped her the most. Sara said that her husband used this strategy, but she found it "stressful": "He was just like, 'Well you have nothing to complain about. Just go upstairs and look at that baby, and you'll snap right out of it.' Well, of course I didn't."

Other studies show that comments reminding sufferers to cheer up or look on the bright side are ineffective forms of support. In their study of social support for the bereaved, Lehman, Ellard, and Wortman (1986) found that comments that encouraged recovery were

unhelpful and detrimental to sufferers. This was true as well for the few wives in my sample who talked about their husband's use of this strategy.

As mentioned above, Chad told Julie that her feelings about not wanting to continue her second pregnancy resulted from "the depression talking." She resented his approach:

> He's a very logical guy, but he just doesn't get it. I don't think he'll ever get it. He's not really a touchy-feely kind of man. He's read articles and things about depression, post-partum depression, and he thinks mind over matter. You should be strong enough to overcome it. He's really at a loss, and he would say, "What can I do to help?" And, I'm like, "Just forget it."

Julie's take on the matter suggested that Chad did not empathize, which is critical for social support (Thoits 1986). Instead, she experienced his attitude as a demand to suppress her emotions. Because she had already tried deep acting and had even considered hospitalization, stifling her emotions and trying to realign them were no longer options (see Chapter 1).

Men who used this strategy unintentionally trivialized their partners' emotions. Chad was at a loss for an appropriate cultural script and failed to understand what was going on with Julie. This created emotional distance in their relationship. To Julie, her partner became one more person she could not fully rely on emotionally. Chad and Julie talked about divorce and were going through marital counseling at the time of her interview. As Julie's comment illustrated, she did not want his kind of help. She refused his "logical approach," which branded her and her feelings as abnormal (Peters-Golden 1982).

Avoiding Conflict

Like the previous strategy, conflict avoidance came up only occasionally in the women's interviews. Among the women who did mention it, some found it positive, others negative. Its absence makes sense. When the husband was successful in his attempts at

evasion, his partner might not have noticed, or found his disappearance legitimate. For instance, Mike, as mentioned earlier, sneaked away to do mystery projects, but Becky did not mention his excursions to the garage or holes in the wall. Instead, she said that Mike was not around because "he worked incredibly long hours. It was typical to work 60 to 70 hours a week, so I didn't see him. I was home with two small kids, and he was never around."

Pearlin and McCall (1990) found that among the couples they studied, giving space at the right time was a useful form of social support. This was the case for Mark and Karen. In her interview, Karen described the same situation that Mark did, and she appreciated that he had humored her:

> Mark and I were up with him once in the night when [Cole] was just newborn, and I said, "Mark, I'm going to have to give him away for adoption. I really am. I can't do it." And, the best thing he's ever done is (chuckling) he said to me, "We will call first thing in the morning." He didn't say, "Hey, that's ridiculous. You're being stupid." 'Cause he knew I didn't really mean it, but he just said, "That's a good idea, and we'll take care of it." So, by the next morning I felt better but, at the time, it helped me relax immeasurably because he just wasn't judging these feelings that I was having. He was just accepting, period.

Though he found Karen's feelings unreasonable (see above), Mark acted as though he agreed with Karen and affirmed her feelings as real in that moment. By not arguing, he relieved Karen of the guilt of her deviant emotions. Mark's surface acting convinced Karen that she was not alone, thus giving the appearance that he understood what she was going through.

However, avoiding conflict at the wrong time can increase conflict (Pearlin and McCall 1990). Jana hinted at her resentment toward Nate's hands-off approach. Prioritizing his sleep over sharing in the late-night feedings, he had her take care of the baby:

> So I've kind of just accepted that you know what, I can't blame him for having to have his sleep. I can stay awake. I can't promise that I'm not going to be overtired and snippy and irritable and what kind of

> consequences it's going to have on my health, but I can stay awake and take care of our child. I still resent him for it. I don't understand why you can't stay awake if your baby's screaming or if your baby needs you. I don't understand it. I don't think I ever will but, he can't, so that's it.

Jana felt resigned to her situation but resented Nate's lack of participation in child rearing. Their different responses illustrate the dual experiences of "his" and "her" childrearing. Conventional understandings of motherhood and fatherhood enabled Nate's behavior as well as Jana's acceptance of and resignation to it. For women, child care carries moral weight that can translate into guilt if not done properly (Douglas and Michaels 2004; Hays 1996; McMahon 1995; Sanchez and Thomson 1997). Because Nate was the male breadwinner and occasional helper, his sleep and health became priorities in the family. As Jana noted earlier, child care is <u>always</u> her responsibility, and by fitting into the model of white middle-class motherhood, she is likely to continue subsuming her well-being and needs to that of the baby (Hays 1996; Kane and Deeb-Sossa 2004).

DISCUSSION & CONCLUSION

Men generally do less emotion work than women, and their lack of practice may leave them less skilled at, and less willing to do, emotional repair. Nevertheless, the men I interviewed used several strategies shaped by their gender and class. Informed by the cultural expectations for the involved father, all the men offered their wives breaks from child care. In addition, they stepped up to the situation by taking charge, maintaining a stoic façade and making decisions for the family. These husbands also tried to change their wives' perspective, telling them to cheer up and look at the situation "rationally." Finally, some of the men escaped interactions with their wives in the hopes of dodging confrontation.

The majority of the women appreciated the men's help, but said that the men could not understand their distress. Some of the women resented their partners' efforts and thought the men did not take their feelings seriously. When the men required extensive child care instructions, excluded the women from decision making, and refused to leave work early, the women reported feeling hurt and angry rather than supported.

When men are placed in conventionally feminine roles, they may look for ways to compensate for the loss of their masculinity. This has been the case among male temporary workers (Henson and Rogers 2001), male school teachers, social workers, librarians, and nurses (Williams 1995). Doing conventionally feminine emotion work could have compromised the masculinity of the men I studied. But these men did not have such a problem because they had middle-class signifiers of masculinity (e.g., professional success). In addition, the men responded to their wives' distress in ways that fed their masculinity. They defined themselves as rational and strong relative to their wives, and affirmed their identities as good, middle-class husbands and fathers (i.e., as good men). Offering breaks meant that the man was an engaged father (in spite of how little time he may have spent with the child). Taking charge and changing the woman's perspective reinforced his sense of control and established his perspective as the rational one. Conflict avoidance allowed the men to prioritize their needs while giving the appearance of being engaged in the conversation or in family responsibilities. Finally, Bartky (1990) argues that women's unreciprocated emotion work is disempowering (and under some circumstances, morally compromising), but men who do care work can get bonus points for their work (e.g., Eve was "lucky" to have Vince's help).

These men thought that making any effort to do emotion work was sufficient for living up to expectations for the companionate marriage (Rubin 1992, 1994). They managed to hold that belief while failing to do intensive caring work. As Victor said earlier, he did what he could. Some of the men made use of the term "we" to suggest they provided emotional and instrumental care to their partners. Chad told Julie, "We're in this together," but Julie did not believe him. Nick said, "We can handle this." This suggests that the men believed they were doing their part as companionate partners. Vince remarked that he "tried to be understanding about it. Sometimes I wasn't as understanding as I could have been by making her feel worse about the whole thing. And, maybe [I] got a little frustrated that I ended up dealing with the kids more because of it...I really tried." He was not successful, but at least he had made the effort. Men's lack of success at caring work did not harm their sense of competence as men because success at emotion work is not a signifier of masculinity.

The men's strategies may have reduced their own anxieties more than their wives,' thus feeding their sense of control over a difficult situation. As some of the men's comments hinted, they felt put out by having to do emotion work. Their wives' feelings were potentially embarrassing and stigmatizing to the men (Davey, Dziurawiec, and O'Brien-Malone 2006). In the face of their wives' disturbing feelings, the men may have needed to mask their own emotions. Emotion work can be used on the self and others simultaneously. Performing emotion work allowed the men to "just get through" (Bryan) a difficult time. This suggests that these husbands' strategies for supporting their wives also served as coping strategies for the men (Thoits 1986).

Many of these couples set up a traditional male breadwinner/female homemaker relationship. In doing so, they established the circumstances that could increase women's

isolation as mothers while making it financially difficult for the husband/father to leave work or work part-time. This is true not only for traditionally-organized families, but also for dual-earners, who usually do not have the luxury of quitting or taking a leave from work.

Structural constraints and strong beliefs about motherhood/fatherhood create the conditions that made the men's strategies likely. Declining wages, increased costs of living, the wage gap, and a consumerist culture contribute to prioritizing men's paid work over family life (Moen and Roehling 2005). Yet, calls for care work to be "shared by all those who are able to do it, must be made against powerful beliefs about the naturalness and importance of family life, and about men's and women's dispositions and roles" (DeVault 1991:163). These powerful gender beliefs translate into women doing most of the housework and child care whether women earn more or their husbands are unemployed (Brines 1994; Hochschild 2003; Tichenor 2005). In either situation, the wife does more of this work to protect her husband's self-esteem as a man.

Likewise, these same calls for equity should take into consideration a capitalist system that demands an unrelenting work ethic and makes false promises of rewards for that hard work. As Moen and Roehling (2005) have noted, trying to create co-parenting arrangements while both women and men climb the career ladder masks the inexorable demands of capitalism on families, and especially on women. Having a so-called successful career requires 110%, and being the perfect mother requires 110%. It is under these conditions that people work out individual solutions to pain, and solutions that often fall short under much larger social strains.

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IV. "DOING SUCH A FABULOUS THING": ADOPTIVE PARENTS MANAGING POSITIVE AND NEGATIVE DEVIANCE

In the popular imagination, deviants are seen as unsavory characters, but research and theorizing on positive deviance have challenged the idea that deviance consistently indicates a negative or devalued identity (Ben-Yehuda 1990; Dodge 1985; Heckert 2003; Heckert and Heckert 2002; 2004; Irwin 2003; West 2003). Although proponents of positive deviance have defined it differently (see Heckert and Heckert 2002; Hughes 1984; West 2003), they generally agree that some social deviants receive accolades, while overconformists may be reprimanded. For instance, Merton (1968) argued that criminals in one historical period could become present-day heroes, while Heckert and Heckert (2002; 2004) showed that "rate-busters," such as overachieving gifted students and zealous workers, were negatively evaluated by peers. Katz (1975) points out that an exceptional attribute (which he calls charisma) can operate like a negative one, and charismatic individuals, such as priests, are "set apart from ordinary people" (Weber 1968:48) and isolated as special.

Depending on the audience, history, or context, a person or act can be evaluated positively or negatively (Durkheim 1995; Heckert and Heckert 2002; 2004; Irwin 2003; Weber 1968). Parents and teachers of overachieving students adore them while their classmates seldom share that sentiment (Heckert and Heckert 2002; 2004). As Irwin (2003) found, elite tattoo collectors and tattooists fall outside mainstream behaviors, but within their world, they occupy a celebrity status and even draw upon their fringe identity to elevate themselves. Heckert (2003) also found that in Western societies, blonde women meet, and at

times exceed, conventional standards for beauty, but are often seen as unintelligent and sexually promiscuous. Hughes argued that "the saint's saintliness should be contagious, but only slightly, so that only a few should catch it as badly as he, and the rest of us…should catch it only in its lighter form" (1984:104-5). Too much saintliness can become heretical (Hughes 1984).

Similarly, Katz theorized that charisma and deviance are "two sides of one moral coin" (1975:1384), and Durkheim contended, "An impure thing or an evil power often becomes a holy thing or tutelary power, and vice versa, without changing its nature, but simply through a change in external circumstances" (1995:414). The degree of deviance from the expectation and context of the deviation inform how others will interpret it; little is intrinsic to the act or object.

In this chapter, I will expand upon this line of inquiry by showing how adoption is simultaneously evaluated as a positive and negative deviant act. People alternately praise adoptive parents for "rescuing" children but also comment on the "horrors" of adoption (c.f., Fischer 2003a; Miall 1996). How do parents manage an identity that is held both in favor *and* disregard? How do they come to understand themselves as a legitimate family in the face of such a challenge? First, I will examine the ambivalent context surrounding adoption, including the beliefs about adoption the parents encountered—beliefs that the parents themselves held prior to adopting, and I will analyze how they negotiated the positive and negative charateristics. In the conclusion, I will discuss how the case of adoption can expand our general understanding of deviance and deviants' responses to apparently contrary attributions.

Adoption occurs in a larger context in which the traditional, biological family is the valued family form (Dalton and Bielby 2000; Miall 1987). Many people still contend that biology makes a family (Bartholet 1993; Miall 1987; 1996), with the traditional nuclear family construed as white and middle-class. Relative to the biological family, adoption is still treated as second best (Fisher 2003a): About half of the respondents in a 1997 Evan B. Donaldson Adoption Institute Survey agreed with the statement that adoption is "not as good as having your own child" (1997:i). This fear of adoption may indicate that nature remains the conventional explanation for individual character and behavior.[26]

Adoptive parents experience their status as deviant and continue to encounter remarks about their children not truly being their own. Negative stereotypes pervade representations of adoption. As March and Miall (2000:362) note, "A focus on the potential negative outcomes of adoption, based on preconceptions about the importance of biological ties, has cast adoption as a problematic family form." Depictions of adoption in the news media (Waggenspack 1998) and college textbooks (Fischer 2003b) are overwhelmingly negative. Clinical studies on adoption focus on problems or deficiencies in adoptees or adoptive mothers (Wegar 1997). For instance, stories of "adopted child syndrome," a psychological label of "antisocial behaviors and personality traits among adoptees" (Wegar 1997:82) are overrepresented in discussions of adoption and defines adoption as inferior. The parents I interviewed had to deal with hurtful comments such as, "What's wrong with those kids? [because their biological mother placed them for adoption]" (Mike); "What do you know about their *real* mother?" (Renee); "After all, he's not their *real* kid" (Becky).

[26]I thank an anonymous SI reviewer for this insight.

Some surveys, however, demonstrate that people also hold positive views about adoption. In the National Adoption Attitudes Survey (2002:5-6), sixty-three percent had a "very favorable opinion of adoption," and Freundlich (1998) notes that forty percent of the U.S. population has considered adopting. In spite of reported positive attitudes, adoption is not considered equal to building a family through biological means. Only fifteen percent of women treated for infertility seek out adoption as an alternative (Hollingsworth 2000), and the number of adoptions has not grown substantially in the last twenty years (U.S. DHHS 2004). According to the National Adoption Information Clearinghouse (U.S. DHHS 2004), 127,407 children were adopted in 2001 (15% internationally; 39% public; 46% private, independent, and kinship), as compared to 118,000 in 1987.

Despite negative representations of adoption, the adoptive family, like the biological family, is romanticized and sentimentalized (Power and Eheart 1995). The cultural myth about adoptive families involves two loving parents (usually white and middle-class), saving a poor orphan from a life of deprivation. The appreciative child completes the family, and the parents instantly fall in love with the child. Moreover, adoptive children are not always smiling, grateful orphans. They sometimes have developmental delays, physical and mental disabilities, and other health issues. This feeds the view of adoptable children as "damaged goods," or even products of "fallen women" (Solinger 2001; Wegar 1997).

Adoption also occurs against a backdrop of racism, class privilege, and even imperialism. International adoption has had an especially checkered history. Because of the low supply of white babies available for adoption after the 1970s,[27] married, wealthy, white

[27]Post-1970s propaganda urged pregnant white women to keep the child at all costs, which made the socially-valued adoptable children almost nonexistent (Bartholet 1993). This

Americans went abroad to find other white (i.e., socially-valued) children. These couples from Western countries could afford the travel, paperwork, and translation expenses. (Currently, an international adoption's costs range between $12,000 to $30,000, and the majority fall in the $15,000 to $25,000 range [NAIC 2001].) They also had the class and heterosexual privileges required to become parents. They often find children in materially impoverished, war-torn countries, whose citizens have endured social, economic, and political upheaval. However, in the 1980s and 1990s, baby-snatching and baby-brokering stories headlined, making international adoption suspect, and stories of baby-snatching continue to surface. A recent article in the *Washington Post* reported on baby-snatching in China, which has become a popular country for international adoptions (Goodman 2006).

In the next section, I will discuss how adoption consists of both positive and negative characteristics and will then analyze how the adoptive parents managed both. They dealt with the negative aspects by passing as biological parents, claiming parity with them, and invoking cultural scripts associated with pregnancy and childbirth. They managed the positives by rejecting moral superiority and creating positive alternatives. Finally, I discuss how the adoptive parents management strategies expand on the positive deviance literature.

ADOPTION AS NEGATIVE AND POSITIVE DEVIANCE

In this section, I discuss how adoptive parents experienced adoption as a deviant act, partially because of outsiders' resistance and partially because "the stigmatized individual tends to hold the same beliefs about identity that ['normals'] do" (Goffman 1963:7). Among my participants, adoption as a family-building option usually arose as a last resort. Couples

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occurred at the same time unwed mothers were offered fewer resources to provide for their children (Solinger 2001).

tried to have biological children first and considered adoption only when the biological route became unavailable. For one couple, the alternative to adoption was opting out of having a child, or trying to conceive and risking the woman's life. As this woman put it, "[My inability to get pregnant] sort of put the nail in the coffin for us" (Corrine). Her partner added, "Okay, she's going to have a 75% chance of dying if she gets pregnant. So, that's like, Oh. Okay. I guess we're going to have to adopt" (Bryan).

Nearly all of the adoptive parents had experienced infertility, and most couples had tried fertility treatments before considering adoption. Women and their partners described the painful and time-consuming treatments in detail. Many women were willing to endure daily hormone injections and doctor visits as well as regular ultrasounds to conceive a biological child. These daily injections could be administered at home, or women could go to their physicians' offices and sometimes wait two or three hours for their injection. Others experienced several miscarriages before pursuing adoption. Infertility is stigmatized (Wegar 1997), but when it precedes adoption it can become a defining part of the adoption process, framing it as the second choice, rather than one choice among many.

In a context where biological parenthood (especially biological motherhood) signifies normalcy, infertility can translate into shame, embarrassment, and self-blame, especially for women (Bartholet 1993; May 1998). Unresolved fertility issues are gendered; they are generally seen as stemming from a woman's physiology (Wegar 1997). For many white, middle-class women, becoming a mother is equated with being a "real" woman (Cooey 1999; McMahon 1995). Nancy said that her infertility made her "think things like, 'I can't have a child, so I'm a failure.'" In addition to personal feelings of failure, adoption workers often see unresolved issues around fertility as a problem and believe that potential adoptive parents

should give up the idea of biological children altogether before entering the adoption process (Wegar 1997).

Each adoptive parent told me about their encounters with negative reactions from family members, co-workers, and strangers. These ranged from ignorant questions to blunt statements. Outsiders told them "horror stories" about adoptive children who went bad (Becky). What is telling in these statements is that family, friends, co-workers, and acquaintances felt free to utter these hurtful comments. For example, while Elizabeth was undergoing fertility treatments, her father-in-law pointed out that biological children were preferable to adoptive children:

> But I will also never forget the comment that Marty's dad made, my husband's dad made, when we were going through our infertility stuff, and we were talking about how we were going to pay for it. And we had stocks we were going to take some money out of. And he was like, "Yeah, it's much better to do this than to take on somebody else's mistake."

His statement impugned the biological mother's behavior as a mistake, resulting in a child who was also a mistake; unwed mothers continue to be seen as less desirable and less capable of raising a child (Wegar 1997). This condemnation of birth mothers is a carry-over of earlier views. Solinger (2000) explained that in the post-WWII era, pregnant, white, unwed women and girls were characterized as "fallen women" who could be redeemed by giving up their child for adoption to a white, middle-class, married couple. Black, Hispanic, and Native American women were criminalized for their pregnancies, and white doctors, as late as the 1970s in some states, forced them to undergo sterilization (Solinger 2001).

Other interviewees discussed how acquaintances and even family members would differentiate biological from adopted children by denoting biological children as one's "real kids" or one's "own children." Both adoptive mothers and fathers reported anxiety about

being able to love an adopted child. Becky "was concerned about the issues like a child not attaching to us," and Bryan explained, "I mean I went through a period where I thought, 'Gee, would I actually be able to bond with a kid who is not biologically mine?'...[I was] worried that it somehow wouldn't feel right." Jack noted that one barrier to adoption for him was "how I would deal with the child not being my own flesh and blood." These fears are grounded in a general belief that "blood is thicker than water" (Modell and Dambacher 1997:10).

Being a single woman compounded the stigma. The single women I interviewed felt generally encouraged and supported by friends and family but occasionally encountered resistance:

> And, I think my father was very supportive, my mother was not very supportive initially. She just wasn't supportive of the concept of my being a single parent. She wondered why I wanted to do it. Even though she knew that I always wanted to be a mom. It just seemed, I think somewhat to her, unnatural…an unnatural thing to do to adopt a child as a single person (Kaitlynne).

Kaitlynne's mother's concern reflects heteronormative beliefs about parenting and adoption (Wegar 2000). White, middle-class, married women receive higher marks in the adoption process (Solinger 2000; 2001) and are more likely to get referrals to the more valued children (Bartholet 1993).

In addition to negative evaluations, adoptive parents encountered positive attributions. Others identified them as saviors of unwanted or undesirable children. Parents remarked that people would say, "You're adopting; you're saving a child" (James), or "You'll be blessed for doing this someday" (Ruth). Maria complained:

> But all these people who have supported us and loved us so much are looking at us and putting us up on this pedestal because we have done this thing. We've gone to Russia; we've adopted this disabled child,

> "Oh, aren't we wonderful people."…"Oh, you are just incredible," things like that.

Yet, these remarks framed adoptive parents as do-gooders who, in taking on "somebody else's mistake" (Elizabeth), rectified the wrong committed by the biological parents, especially the biological mother (Solinger 2000).

MANAGING NEGATIVE AND POSITIVE DEVIANCE

Dealing with the Negative Aspects

Because of the continued supremacy of the traditional family, adoptive parents wanted to have "normal families" (Bryan) and be "just like any other family" (Marty). One way to deal with negative placements is to try conforming to what is considered "normal." Using this strategy, adoptive parents tried to pass as normals (Goffman 1963; Park 2002). They tried to pass as biological parents, claimed parity with them, and invoked cultural scripts associated with pregnancy and childbirth. This strategy allowed adoptive parents to avoid dealing directly with the negative evaluations, especially when adoption was not evident to others. However, parents who used this strategy unintentionally accentuated the devalued aspect of their identity (and adoption more generally) by holding the biological family as the norm. Avoidance strategies, such as passing and claiming parity, are reactive. Reactive strategies "attempt to avoid its [stigma's] impact, but they do not challenge it" (Siegel, Lune, and Meyer 1998:10). However, when adoptive parents invoked the cultural scripts associated with pregnancy, they also used an intermediate strategy because they tried to expand the meaning of those scripts (Siegel, Lune, and Meyer 1998:10).

Passing as Biological Parents

Goffman (1963) points out that stigmatized people often hold the same views as normals; thus, the adoptive parents I interviewed could anticipate others' negative reactions. They used passing as a strategy to head off possible comments. For example, adoptive parents must decide whether to adopt domestically or internationally, and if they opt for the latter, then they must decide on the country. Both women and men reported that many factors went into that decision, including how long the process would be, which countries had established programs, and which countries their adoption agency worked with. Some interviewees expressed concern about having to deal with racism and selected their country based on skin color so that their children would be seen as white:

> As I thought about it and was thinking internationally, I said to myself, and I said to Renee, too, "Where can we go to find a child that would look most like us?" And my thought there being that the child being adopted was going to probably have issues with other kids, and at some point possibly having kids tease them or look at them differently for being adopted, and I didn't want to give extra ammunition, whether it was to other parents, other kids, whoever, to be walking holding hands with an Asian child and have people right away raise eyebrows (Jack).

> We had chosen Russia because we didn't want to have to deal with racial issues, really. I'd never had to deal with racism in my life, and I wasn't sure how I would teach someone else how to cope with that, so we agreed to do Eastern Europe (Maggie).

In a context that devalues interracial families (c.f., Rothman 2005), the parents' strategy was an understandable response to racism. Members of a dominant group do not have to deal with racism, and some adoptive parents "didn't want to deal" with it and did not know how to do so. Supposing that these parents would defend their children, raising children of color would force them to encounter racial conflict, thus diminishing some of

their privileges as white people. Having a white child would alleviate this potential problem. Additionally, their class privileges enabled them to use international adoption as a tool for passing.

Some parents remarked that a particular child fit their family (or was "their" child) because they saw a "family resemblance" in the referral pictures. Marty explained, "There was one particular child that stood out in both Elizabeth and I's mind just from the picture, partly because she looked in the picture so much like Elizabeth's mother." Another mother, Kim, reported:

> I don't know how I decided [that Sebastian would become her child]. I just saw it. There were a few things, maybe it was wishful thinking, but I saw family resemblance to people. He had blonde hair, and that runs in my family in the younger kids. And blue eyes, and he was left hand dominant in the video, and I thought, "That's a sign."

Historically, adoption in the U.S. has depended on matching the child to the adoptive parents in an "as-if-begotten" model (Modell and Dambacher 1997:10). Matching, as Modell and Dambacher point out, "affirms the genealogical model guiding American adoption, …[and] exposes the 'essentialism' underlying adoption policy (you are what you appear)" (1997:6). Through matching, these parents tried to curtail potential problems. Using race and family resemblance lessened the visibility of the adoption by controlling how much information strangers could discern, thus strategically avoiding negative and inappropriate comments. A child who did not match them physically might lead others to wonder whether they had adopted. In passing, the parents intended to protect their families, but they also reinforced the superiority of the white, middle-class, biological family.

Matching and finding family resemblances served another function: It positioned them as a "real family" and established ties to their adopted child by creating the appearance

of a biological connection. In this way, it confirmed their claim to the child and proved that s/he was meant for them (Sandelowski, Harris, and Holditch-Davis 1993).

When physical matching was impossible, parents found alternative forms of matching. For example, although they initially wanted to adopt a child from Russia, one Jewish couple adopted an Asian child because the wife, a developmental psychologist, wanted the youngest baby possible in order to control her/his developmental benchmarks. She wanted to avoid fetal alcohol syndrome associated with adoptions from former Soviet Bloc countries. The child did not match the parents physically, but she had what they perceived as cultural similarities. James explained:

> Then the next part of the thought process was ethnicity, really. We were pretty close at one point of deciding to go through a Russia program, but then we started to do more research on the preponderance of fetal alcohol syndrome, and that really scared us…the children are institutionalized for long periods of time, neglected, poor health and so sure, a Caucasian child is easy, and so deciding to have a child of another ethnicity is kind of a big step. We had some really close friends that are Asian. We're Jewish, and there are certain Jewish philosophies that we felt are very much aligned with a lot of Asian philosophies, whether it's Buddhism or just cultural.

As James pointed out, shared appearance was their first choice; choosing a child of a different race was a "big step." Even though their second choice seemed to undermine biological primacy, he nevertheless, essentialized Jewish and Asian cultures by implying that cultural practices were rooted in biology—an Asian child will "naturally" have Asian philosophies. His statement also unintentionally rendered interracial adoption as a third best option.

Claiming Parity with Biological Parents

Problems with adoptive children have historically been attributed to unwed mothers, infertile adoptive mothers, or psychological issues of adoptees (Wegar 1997; 2000). When

adoptive parents had difficulty with what would seem like mundane childrearing problems (e.g., the child would not behave well), they and their children were told by friends and family that the child's problems arose from their adoption status. As a response, most of the adoptive parents I interviewed emphasized that neither adoption nor biological birth mattered when it came to parenting:

> Because whether you're having children biologically or adopting children, they're all going to come with their unique set of little problems that you're going to have to handle. So, it really isn't whether you adopt a child or give birth to a child, it's how flexible you are in your ability to parent that child and accept those differences that you don't expect (Ruth).

These adoptive parents strove to reduce the negative assumptions people made by suggesting that they were no different from biological families, thus upholding biological families as the norm. Yet, unlike the previous strategy, this also functions as an intermediate strategy in that it offers some resistance to the biological construction of family. Ruth's explanations showed that both adoptive and biological parents face unexpected challenges, and both adopted and biological children cause problems or have bad behaviors. Though the biological family is held as the primary reference group, adoptive parents challenge birth as the marker of what constitutes a family. Parenting, rather than birth, is what matters.

Some of the women used PAD as a resource to show they were just like biological mothers. This is surprising given the stigma of mental illness (Karp 1996). Faith explained that PAD is "clinical" and "mothering of any kind triggers it [depression]." Kaitlynne also equated her experience with PAD to post-partum depression (PPD):

> [Having PAD] is like someone with post-partum depression. They don't want to admit that they've now delivered this beautiful child that they want nothing to do with. It's exactly alike. But people don't expect it to occur in adoption, because you don't, you're not supposed to have those hormonal changes. But my doctor told me that in fact

> you do have those hormonal changes. I've read about this quite often since then, that there are some people who say that …physiologically your body can also change. I've heard of people who stop having periods for nine months while they adopt. Who gain weight, whose breasts get tender, who do experience a lot of motherly, maternal things during that process.

Through this comparison, Kaitlynne suggests that adoptive mothers experience the same physiological indicators of pregnancy and post-partum depression as biological mothers. In a context where biological motherhood and blood ties are paramount, the shared experience legitimizes adoptive mothers as real (i.e., biological). It creates a biotemporal order that adoptive mothers, like pregnant women, can follow (Sandelowski, Harris, and Holditch-Davis 1993).

Using PAD as a resource was also gendered. Women's reproductive capacities and motherhood define them as women (Cooey 1999; Wegar 1997). Experiencing the physical symptoms of pregnancy along with the post-natal depression created a biological tie that not only made them mothers, but "real" women. Suffering was viewed as a badge of honor that proved and naturalized their motherhood. No men used PAD as a resource, possibly because post-adoptive depression was seen as located in women's biology, or at least as a woman's problem.

Invoking Cultural Scripts about Pregnancy and Childbirth

As mentioned above, one general assumption that adoptive parents and others hold is that adoptive parents, especially mothers, have difficultly bonding with their children. Under this logic, the mother-child bond depends on biology, and adoption presumably disrupts this bond (Miall and March 2003). One way to manage this belief is to use the very language of birth in order to naturalize adoption and equate the adoption bond with the (presumed)

biological bond. Donia compared receiving a picture and video of her child to "being pregnant and seeing your ultrasound." Marty described the first time he met his adopted son:

> I would equate it to the moment when a doctor hands you the baby for the first time and you just look down and … you just know [that you love them]. When you hold them they feel like a part of you, and you look at them and you see something and you just make a connection. And I don't know that I can describe it other than associating it with other things I would imagine it to be like, but you just know, you just look at 'em and go, "I came here to get you, and now we're going to go home together" (Marty).

Since few scripts exist to capture the powerful emotional experience associated with adoption, Marty invoked birth and its culturally-associated feelings. If cultural resources for describing adoption were readily available, the parents might have described their experiences differently. Invoking pregnancy and delivery also legitimizes adoption as an event that is as powerful as birth. Because Marty and Donia experienced the same feelings as biological parents presumably do, they must be "real" parents.

All of the interviewees referred to an extraordinary experience or supernatural power in talking about the adoption of their child. They "just felt [it]" (Elizabeth, Nick, and others), had "a sign" (Kim), or "had an immediate connection" (Bryan). These signs helped them know that these were the right children for them. Not only did this strategy establish their adoption of a child as a sacred event (like birth), it also affirmed that adoptive parents had similar experiences to biological parents. Adoptive parents described their children as "amazing" (Bryan). Some noted that they chose their children by "relying upon fate" (Mike) or with "a God-given sense of wisdom" (Nick).

Because adoptive families face mainly negative images of adoption, positive cultural scripts and models are not as readily available. As such, the parents drew on culturally-acknowledged and established forms of family and family-building to validate their

experiences. By using an intermediate strategy, adoptive parents attempt to expand the meaning of cultural scripts to include adoption, but these scripts have the effect of upholding the biological family as normal and normative.

Managing the Positives

Adoptive parents also managed the well-regarded aspects of adoption. Drawing on the cultural myth of deserving parents saving deprived orphans, non-adoptive people complimented the parents. The parents, in turn, negotiated the positive aspects by alternately rejecting claims to moral superiority while creating their own positives. Parents resisted others' accolades by pointing out that adoption was a normal way of building a family, but they at times claimed the specialness that adoption conferred on them. They rejected compliments that framed adoption as charity work (Wegar 1997), but they also cultivated an alternative positive identity as superparents and superchildren.

Rejecting Moral Superiority

Many adoptive parents spoke of talking to people who regarded them as saviors of disadvantaged children. Ironically, adoptive parents rejected these compliments by saying that they were "selfish" because they "wanted to grow [their] family" (Mike). Because adoption is also negatively evaluated, why would they disidentify with positive statements? James explained his position:

> Then there were some people that thought it was just an amazing thing to adopt a child and that they're just so excited for you. I think that those people are often saying that, they say that in a way where they think it's great for you to be saving a child's life. That's true, … In typical situations the child is typically in a much better position than where he or she might have been…So people, they say, "Oh that's great, you're adopting a child, you're saving a child." They don't understand that we're doing it selfishly as well.

Others' comments are positive on the surface, but they imply that the child is inferior to biological children because s/he needs to be saved (and could be permanently damaged by "bad" biological mothers). Comments such as these establish the parents as aid workers, different from "normal" parents who have biological children.

James' explanation also reflects the privileges of class and nation implicit in U.S. adoptions. Most of the parents expressed that when they were traveling to developing countries, they felt bad, but "lucky to be an American" (Nick). Traveling abroad brought to life the advantages these parents had compared to the biological mothers. The U.S. is materially wealthy relative to most countries, and these parents do have financial resources. The children will have better access to education, health care, and nutrition than they would in the orphanage. Some of the children also have developmental delays from institutionalization and fetal alcohol syndrome; these parents have more resources to provide access to medical and therapeutic professionals. However, these apparently positive remarks are negative in light of the children; in the context of U.S. hubris and hegemony, the "saved" child is a damaged or deprived charity case rescued from a "Third World" country.[28]

Like some parents of gay and lesbian children, these adoptive parents both normalized their children and normified themselves (Fields 2001; Goffman 1963). Normalizing involves making a deviant other "normal," and normifying involves making oneself "normal" (Goffman 1963). The compliments the parents heard were similar to

[28]Solinger (2001) questions adoption as a form of help to children and women. Childless people with resources can choose to adopt children from disadvantaged women. Rather than helping by establishing programs that give poor women a real choice about mothering, adoption, she contends, advantages the wealthy.

others' negative attributions, in which people assume something is wrong with an adopted child. By rejecting others' compliments, adoptive parents normified and normalized:

> A lot of people look at it like you've rescued them somehow which is not even remotely close to how it is. We're a normal family, which means we have good days, bad days, and we have days where we're going to pull our hair out. But people on the outside say, "How could you be unhappy about this? You did this great thing." Ninety percent of the people who find out our kids are adopted and at what age, they go, "You did such a fabulous thing; [it's] so wonderful that you could save them like that." But, no, we didn't do it for them, we did it for us. It was a truly selfish thing. We wanted kids. And my [adopted] kids will tell you, they did this because they wanted to do this, not because they were trying to be nice (Maggie).

Saying "we're selfish" implies that "we are normal and have a normal family life." Being a "normal family" would not require accolades and adulation. The praise outsiders lavish on them highlights the view that adoptive families are *not* normal, something was lacking.

Claiming selfishness is also surprising in that those who choose to remain childless are usually seen as selfish (Hays 1996; Park 2002). Saying "we're selfish" inverts that belief. On the one hand, these parents could have invoked selfishness as the opposite to the attribution of virtue, thus distancing themselves from the compliments. Many of the parents adopted after experiencing infertility; thus, circumventing biological limitations by adopting. Because they desired something that they could not have biologically and found a way around their physical constraints, this may have framed their family-building method more selfish.

Such praise kept these parents from being a "normal family" because martyrs who save children are not supposed to have "bad days" and "days where we're going to pull our hair out." Hughes explained that "those who deviate from the expectation in the direction of the angels through no wish of their own…are in the position of having to be better than they

would like to be, or better than anyone has a right to expect them to be" (Hughes 1984:102-3). If adoptive parents have unhappy days, it can be construed as their fault for having adopted (an irony, given that biological parents presumably also choose to have children). As Maria explained, the compliments:

> [Put] pressure on me. I just caved. It's like I am just a person; this isn't on my own strength. I prayed about this [adopting]; this is God's strength that enabled me to do this. And stop acting like I'm some great person and, and stop paying all this attention to her…but I found that all that attention and all that pressure was just about to drive me insane (Maria).

White middle-class women are already expected to live up to an idealized standard of motherhood, but adoption adds another dimension to the perfection. Maria's quote illustrates that adoptive families receive more surveillance than biological families, and it can limit the range of emotions adoptive parents are allowed to show. If a mother shows a shortcoming, her mistake or the child's misbehavior can be interpreted as arising from their adopted status, rather than as a part of mundane family life (Waggenspack 1998). If an adoptive mother seems at all unhappy ("How can you be unhappy?...You did this great thing," as Maggie said), outsiders question her mothering skills or blame the adopted child.

Creating a Positive

The adoptive parents sometimes used their status as a resource to fashion themselves as better than biological parents. The parents I interviewed generally did not describe this strategy as a response to a particular comment or event. But, in reflecting on the adoption process, they would almost "sermonize" on how wonderful adoption was and how it made them into better people. This suggests that they may have felt judged or believed that their children were being judged. In fashioning themselves as better parents, they were not saying that biological parents are bad; however, unlike parents of biological children, they had to

work harder. Sandelowski, Harris, and Holditch-Davis found that preadoptive couples "emphasized the similarities and *advantageous differences*" between adoptive and biological families (1993:483, emphasis added).

Cultivating a superior identity is a common response for deviants or stigmatized groups (Fields 2001). Goffman (1963) theorized that stigmatized individuals may manage their stigma by adopting superior identities and trying to convert "normals" to their position. Warren has argued that stigmatized groups recognize their status and attempt to destigmatize themselves by "[defining] themselves as better than normals" (1980:67).

Like "supernormal" recovering patients who strained themselves beyond what healthy people might accomplish (Charmaz 1987), these adoptive parents said that they had to be twice as qualified to become parents, and their children, having endured hardships, were better children. Similar to the straight parents of the lesbians and gay men Jessica Fields studied (2001), they claimed that they were "superparents," better qualified than biological parents who could give birth without any knowledge of parenting or proof of qualifications.

Surviving the adoption process was an accomplishment that made them special and more prepared. Going through an adoption, whether domestic or international, is an emotionally and financially arduous process. Potential parents undergo intense scrutiny to determine if they are "fit." Obstacles adoptive parents face include invasive procedures: having a home study, in which a social worker examines the home for health and safety concerns (e.g., "cleanliness," pets, and so on); undergoing intensive interviews about parenting beliefs, family histories, and medical history (including blood tests for STDs and other diseases); getting fingerprinted by law enforcement; and filling out mountains of

paperwork, much of which requires visits to public offices and notaries. Depending on the state in which they adopt, parents also must attend a certain number of hours of parenting classes (ranging from 0 to 24 for my interviewees). They then wait up to two months, sometimes without hearing from the agencies. International adoptive parents also must travel for an extensive period to the country from which they plan to adopt (the average time in my interviews was three weeks). Even at a late stage, an adoption can fall through, leaving the parents-to-be devastated (Sandelowski, Harris, and Holditch-Davis 1993).

Elizabeth joked that when she baby-sits or hosts sleepovers, she assures other parents that she is qualified, even exemplary, because federal, state, and even international (Ukrainian) officials have certified her as a "Good Parent." Like leprosy patients who became "career patients" (Gussow and Tracy 1968), Elizabeth served as a charismatic spokesperson for adoption.

Sometime this strategy was aimed at culturally "undeserving" parents, particularly women. Nancy explained, "thirteen year-olds, [and] all these people that didn't want children, couldn't care for children, were trying not to get pregnant, and got pregnant" could be parents, but she could not become pregnant. James expressed anger at these undeserving women and frustration about the amount of work adoptive parents must undertake:

> Does every crack whore in the street have to go through some sort of burden of proof that she is worthy of bearing a child? Of course not. So the paperwork, you have to go through all these criminal background checks, you have to get your notarized birth certificates….And then the social worker [does] a home study…First of all, I think the adoptive parents learn a lot from that because it's part of the requirements that the adoption agency imposes on the adoptive parents. They require that you sit through a certain number of training sessions, courses, kind of classes to learn about lots of issues (James).

The parents I interviewed expressed a range of frustration, but James' comment highlights the sexist, racist, classist, and heterosexist undertones in the rhetoric wielded

against birth mothers (Wegar 1997). James invoked what he saw as the worst kind of mother, "the crack whore," to prove that adoptive parents are above average. In doing so, he drew on the raced and classed trope that only certain kinds of women—white, married, and middle- and upper-class—deserve to be mothers (Solinger 2001). James failed to take into account that he and his partner had the monetary and educational resources to navigate the adoption process; adoption gatekeepers were more likely to view James and his wife as "good potential parents."

In addition, by leaving out the biological father, his comments impugn the mother and draw on the cultural image of the much maligned "welfare queen." "Crack whore" elicits images of a poor black woman (see Collins 2000) who is undeserving of raising a child. Poor, Black, neglectful, and drug-addicted, she is antithetical to what motherhood is supposed to represent in the contemporary U.S. This shows that birth alone does not signify a positive act; white, middle-class, educated, and married parenting are the legitimate markers of parenting. Compared to the "crack whore," who could disagree with the argument that adoptive parents are "superparents"?

Other parents argued that their children's initial disadvantages made them into superchildren. For example, Ruth and Nick's two- and three-year-olds, having suffered, were apparently grateful for being adopted. Ruth remarked, "Even these tiny babies appreciated shoes. They would admire things we'd buy for them," and Nick added,

> They [his children] are proud; they are happy to have anything you give them. They cherish it. Where these, I guess I'll say American kids, they expect all this. I mean if they get a new pair of clothes or anything, they are just so proud and so happy to have something (Nick).

The parents' descriptions make the children into hearty survivors, consistent with the rhetoric of pulling oneself up by the bootstraps. Tim even noted that even if he would have been able to have biological children, he still would have adopted. Adopted children, he argued, would teach his imagined biological children to learn gratitude:

> So, I always thought that even if we had our own biological children I would still like to adopt. Just a number of reasons to remind me that I often want people to give me a second chance and a break, to remind my own biological children, if I had them, that, "You know what? Not everyone's as fortunate."

The parents' statements also implied that U.S. adoptive parents had saved the children, despite having downplayed or rejected outsiders' missionary language. In this instance, they, rather than outsiders, give themselves the credit for having done a good deed. In addition, because children are seen as reflections of their parents, having "superkids" reinforced their image of themselves as "superparents."

Finally, parents sometimes invoked religion to set adoption apart from biological families. As seen earlier, parents used supernatural language to create parity with birth, but religion also functioned to show that adoption was a special or religious calling. Parenting a "child of the world" was a divine responsibility, not merely a biological drive:

> To me it is a responsibility to be a parent, and once I accepted that responsibility from God, that He had this greater plan for me to be parent. And this is going to sound arrogant but to be a parent of a child of the world. It just felt awesome. It is an awesome gift and an even more awesome responsibility (Elizabeth).

God wanted a superparent, not just a regular parent, for this "awesome gift." A "child of the world" was a "more awesome responsibility" than a child of the womb. Elizabeth also talked about her adoption as a religious calling or vocation; someone answering a divine call is set apart or consecrated. To give birth is human, but to adopt is divine. This rhetoric of God's

will also helped them to accept their specialness without seeing themselves as arrogant or inappropriate. Their specialness is not self-proclaimed, but God-given. Invoking religion and fate not only "[challenged] the primacy of the blood tie" (Sandelowski, Harris, and Holditch-Davis 1993:475), but also validated the child as a divine gift in which the supernatural was directly involved. Many people refer to biological children as gifts from God, but adopted children are not received as passive gifts. They enter the family through divine intervention.

DISCUSSION & CONCLUSION

Adoption is responded to as a positive and negative deviant act, and adoptive parents learn to manage those responses. Adoptive parents face a double burden in having discrediting and elevating attributes merged into a single identity, and they negotiate both. Challenging these attributions is difficult for adoptive families because adoption has a checkered history, bound up in race, class, and heterosexual privilege. In addition, biological families continue to be valued as *the* legitimate form of family; few symbolic resources and cultural scripts for positive family alternatives exist.

Adoptive parents dealt with the negative aspects by passing as biological parents, claiming parity with them, and invoking cultural scripts associated with pregnancy and childbirth. They rejected the attributions of moral superiority when others' compliments unintentionally implied that their children were charity cases. At other times, however, they identified themselves as especially qualified parents with superior children.

It would make sense for adoptive parents to emphasize the enhancing attribute and to de-emphasize the negative evaluations. In their study of lesbian mothers, Hequembourg and

Farrell found that some of the mothers played down their marginal identity while accentuating their revered one (1999:551). However, adoptive parents sometimes did the reverse. By talking about their families in ways that approximated biological families, they used biology as the benchmark for normalcy and emphasized one source of their marginalization. They also rejected enhancing attributes when those implied that their children had some original deficiency.

My work sheds light on deviance more generally and expands the debate about positive deviance. Opponents of positive deviance as a sociological concept see it as a confusing oxymoron (Goode 1991; Sagarin 1985). They argue that deviance is not interchangeable with deviation from norms and that positive and negative deviance cannot be seen on a continuum (Goode 1991; Sagarin 1985). However, other theorists (Durkheim 1995; Weber 1968; Katz 1975; West 2003) note that the sacred and the profane, charisma and deviance "are two sides of one moral coin" (Katz 1975:1384).

Multiple, ambivalent, and contradictory understandings can comprise some forms of deviance in a single setting. For adoption, its history and complicated ideals about family intersect to create a complex deviant identity. My findings on this ambivalent deviance, therefore, might extend to theories about the sacred, which Durkheim describes as ambiguous (1995), inspiring reverence and fear. People are instructed to approach the sacred with "respectful precautions" (1995:415). An object can transform from impure to pure, and vice versa: "The possibility of such transformations constitutes the ambiguity of the sacred" (1995:415). Adoption functions similarly: It alternately arouses respect and distaste from others.

Unlike the sacred and profane, however, adoption is largely a mundane phenomenon, yet it simultaneously evokes these complicated and contradictory evaluations. Similar processes occur among others facing status contradictions. For example, Hughes (1984) found that representatives of groups historically excluded from a profession find themselves in a status dilemma when they break through. The first women and Blacks who entered medicine were revered as physicians but still seen as members of their subordinate groups. Those in these circumstances struggle to balance the positives and negatives: "Positively, they represent someone's ideal conception; negatively they take care not to shock, astonish, or put doubts into the mind of a public whose confidence is sought" (Hughes 1984:144).

Because many people report positive attitudes towards adoption on surveys, one might not expect adoptive parents had to validate their family form. This demonstrates that positive attitudes, even widely reported ones, do not always constitute a valued identity and do not prevent someone from being stigmatized.

Finally, previous researchers have pointed out that having resources impacts the person's ability to counter stigma (Link and Phelan 2001). The parents I interviewed share a privileged position, which shaped their ability to manage the attributes. They were able to draw on their race, class, national, and (sometimes) heterosexual privilege to demonstrate that they were just like—and sometimes better than—other families. They were not like the undeserving mothers who did not want, or could not care for, children. As U.S. citizens of socioeconomic advantage, they could provide for children materially and culturally. Outsiders sometimes questioned their decision to adopt, but they seldom faced questions about their ability to parent. (Only a single woman had such problems: she said a social worker had reservations about her decision to put her adopted child in day care while she

worked.) Being white, middle-class, and (usually) married, their credentials as parents were legitimized by gatekeepers.

Adoption takes different forms based on socioeconomic position, and adoption may arise as a response to group or individual needs. The poor, rural Black families Carol Stack studied used and defined "adoption" in a distinctly different way from the families presented here (Stack 1974). Stack found that women in The Flats relied on the practice of "child-keeping." Child-keeping involved "temporarily [assuming] the kinship obligation to care for a child, fostering the child indefinitely, [and acquiring] the major cluster of rights and duties ideally associated with 'parenthood'" (1974:62). Future work should compare the meanings and practices of adoption across contexts. How do socially devalued parents, who have fewer resources to resist stigmatization, define and build a family? What strategies do they use to legitimate their family form?

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V. CONCLUSION

When I tell someone that I have been studying post-partum and post-adoptive depression, I usually hear the question, "How can it be cured?" That question makes me uncomfortable because 1) I imagine the listener wants a quick solution that I can't provide, and 2) the recommendations I would offer are probably the ones she or he would not want to hear. My "answer" is bound up in eliminating gender and the social construction of motherhood (and fatherhood). Motherhood is romanticized, sacred, and sentimentalized in U.S. culture, particularly among the middle-class, and any critique of (intensive) mothering makes me look like a non-empathetic, childless woman, at best, or a mother-hating ogre, at worst.

So, where do we go from here? I'd like to turn to the women I interviewed for their solutions and suggestions. These women wanted their husbands not only to contribute more to household labor, but to offer the "right kind of help." This meant a man who would not rely on his partner for instructions (e.g., Where's the laundry detergent? Where's the frying plan?). Other women longed to have a housekeeper.

Some of the women had help from other women in their family, but those women (often mothers, grandmothers, and mothers-in-law) held their own opinions on how mothering should be done. They questioned the new mothers' choices, compounding their feelings of inadequacy. Having a more experienced mother judge their child-rearing choices discouraged some of the new mothers from asking other women to be around. The women I interviewed managed to cobble together individual solutions. These included: finding some

personal time away from the children, joining clubs or Bible study groups, and returning to their jobs. These strategies may have worked for individual women, but not for women as a group.

Some women made the connection between their private pain and public troubles and recommended social solutions. For example, a few women said that companies need to offer more flexible schedules and more time off from work after a birth or adoption. Two women pointed out that in some countries, new birth and adoptive mothers receive governmental-funded follow-up services from a doula so that they can ask questions about taking care of a child. Several of the women I interviewed mentioned that they wished they could activate the "village model" of raising children, in which multiple people are responsible for raising a child. Another woman thought that we should bring back the historical model of the baby shower. In this model, the guests took care of the new mother and child for several weeks.

Hochschild's (2003) policy recommendations echo some of the women's suggestions. To promote gender inequality in the home, she proposed that fathers contribute equally to household labor, and that the nation provide support for families, such as flexible leave time and affordable child care.

When the women I interviewed envisioned getting help, they typically imagined employing another woman to provide housework or child care. The "village model" meant shared care by <u>women</u>. Likewise, bringing back the old-style baby shower depends on other women coming in to do the work. The solutions of flex time and affordable child care, while important, fail to address how motherhood is constructed as women's work and is bound up in powerful beliefs about white middle-class femininity. Parents do not use flex time; mothers do. Women are the ones, by far, who take advantage of these policies if the

company has one (Moen and Roehling 2005). Less privileged women do the caring work when middle-class women do not, so "affordable" child care can mean hiring a poor or working-class woman of color at a low wage.

Offering a few social policies that enable white middle-class women to better balance work and family places a double burden on women. For the women I interviewed, their identity as good people relied upon how well they performed as wives and mothers. When the "career mystique" (Moen and Roehling 2005)—the idea that a woman can advance in her career by sacrificing and working hard—confronts the demands of intensive mothering, women feel as though they are compromising on both fronts (and feel guilty about it).

Hochschild's recommendation that men contribute more to household work conflicts with the reality that men are not invested in caring tasks. Providing a secure family wage ensures that they are good men, participating at all in housework and child care becomes a gift. By doing a little work at home, men receive bonus points from their wives. Their wives feel consider themselves "lucky" to have such a caring husband, and in some cases, also feel indebted to him. Change on this front will not come easily. As DeVault explained,

> There are not terms within which men think of [caring] as service for women, no script suggesting that husbands should care for wives through domestic work. Some women are beginning to insist on more equal relations, and some husbands are beginning to struggle at taking equal responsibility for family work. But these attempts are made without a cultural imagery to support them, and in opposition to established understandings about appropriate activities for men and women (1991:162).

Eliminating gendered expectations of care work are critical to changing the conditions that make motherhood isolating and overwhelming, but doing so means that men not only need "scripts" but also must be willing to give up some of the invisible privileges that they receive from women's caring work. Many men do not want to give up these privileges:

> On some level, of course, both women and men know how men depend on the domestic and caring work women perform. Men eat the food that women buy and prepare for them; slide into bed and feel the clean freshly changed sheets that have been laid out for them; accept caring when they're sick, grieving, or in despair; take emotional support when they feel doubt or fear; and benefit from countless other things that sustain them…But when men acknowledge need, they make themselves vulnerable, which under patriarchy is a threatening thing for men to do (Johnson 2005:148).

The white, middle-class fathers I interviewed have much to lose. As we have seen, they have the best of all worlds: the benefit of being seen as egalitarian (i.e., good husbands) without actually contributing as much as their working-class counterparts.

In addition to challenging sexism, eradicating the intensive model of mothering and uninvolved fathering also means confronting capitalism. Women's care work costs employers and taxpayers nothing, and keeping care work invisible "absolves the public world from responsibility for the values of unselfish care, commitment to the good of others, and willingness to carry out obligations without direct or material remuneration" (Hays 1996:175). Moreover, putting women on the "mommy track," and treating all women as mothers (or potential mothers) can be used to justify the wage gap (Tichenor 2005). To meet the demands of intensive mothering, many women make compromises with their paid labor. As Moen and Roehling (2005) found, women reduce their time in paid labor after the arrival of a child. This reinforces employers' prejudices: why should the company invest in a woman who will not be as committed as her male counterpart?

That brings us back to the question, "Where do we go from here?" How do we change the conditions that create intensive mothering? I do not have a magic solution, and Hays (1996) is not optimistic about an "ideological revolution." She argued that "under current circumstances, our best hope for easing women's burden remains increased public

power for women, higher public status for those involved in caregiving, and greater paternal participation in child rearing" (Hays 1996:176-7). Hays hopes that public power for women might translate into those powerful women demanding more benefits for all women.[29] Increasing the status of caregiving might encourage men to participate more. Like Hays and Hochschild, I believe that fathers should be doing an equal share of housework and child care (for women in heterosexual relationships). Quality day care for all children should be well-funded by taxpayers.

To make those things happen, child care must become valued work. DeVault similarly recommends that we conceptualize the care work women do as "skilled and significant work" and provide institutional support it (1991:240). Although child care is sentimentalized, it is not valued. If it were valued, men would be doing much more of it. Saying that children are miraculous, and then delegating their care to women, belies the sentiment. One way to value child care as "real work" is to pay a fair wage to those who do it.

Undermining the systems of inequality that support intensive mothering and less involved fathering is a massive challenge, but each person can share in that responsibility by refusing to participate in practices that reinforce inequality (Frye 1983; Johnson 2005). Not fawning over fathers who take their children to the park or who change a diaper interrupts practices that allow men to be rewarded for minor participation. For instance, when my mother tells me how wonderful my brother-in-law is by helping my sister with their two children, I respond, "Well, he should be doing those things." Of course, there are

[29]I am less optimistic than Hays about women in powerful positions. We need women who are *committed to equality* to gain powerful positions. Many conservative women believe that a mother's natural place is in the home doing full-time child (and husband) care.

consequences for taking this approach (e.g., arguments, lengthy discussions, or being called a man-hater), but as Tichenor explained, "effectively disrupting the gender structure will require a great deal of commitment and vigilance…[T]o swim against the cultural current, [people] will often have to do what they know to be right, rather than what feels right" (2005:191).

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