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"Either I do the mother thing or I call the police": Childhood Mental Illness and Negotiations of Maternal Identity

A Thesis submitted in partial satisfaction of the requirements for the degree Master of Arts

in

Anthropology

by

Nicole Rochelle Letourneau

Committee in charge:

Professor Janis H. Jenkins, Chair
Professor Jonathan Friedman
Professor Joseph D. Hankins

2017

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ABSTRACT OF THE THESIS

"Either I do the mother thing or I call the police": Childhood Mental Illness and Negotiations of Maternal Identity

by

Nicole Rochelle Letourneau

Master of Arts in Anthropology

University of California, San Diego, 2017

Professor Janis H. Jenkins, Chair

Mothers of children diagnosed with chronic and severe mental illnesses in the United States face many challenges outside of typical mothering expectations, such as problems at school, financial burdens of medical treatment, lack of social services, and difficulties at home. This paper examines the additional challenges mothers with children diagnosed with severe mental illnesses face to negotiate their maternal identities amidst contradictions to the cultural narrative of motherhood that emerges from the dominant intensive mothering ideology and the narrow framework of normality produced by

discourses of "good mothering." Intensive mothering ideology perpetuates a set of beliefs about parenting in which mothers are assumed to be disproportionately responsible for childrearing and are expected to prioritize the needs of their children and the mothering role over all else. Based on interviews with mothers in the Southwest Youth Experience of Psychiatric Treatment (SWYEPT) Study, this paper argues that intensive mothering ideology shapes the patterned ways in which these mothers experience caring for children with mental illnesses. These patterns include (1) susceptibility to both internal and external critiques of their parenting based on their children's symptomatic behavior; (2) contradictions to the primary authority over their child emphasized by intensive mothering discourse, as they must share caretaking responsibility with medical practitioners; (3) constrained parenting choices. As this paper will illustrate, in the context of competing ideologies and confrontations between medical and maternal authority, mothers found ways to defend their maternal identity by utilizing reclassification techniques that modified the boundaries of maternal responsibility.

Title: “Either I do the mother thing or I call the police”: Childhood Mental Illness and Negotiations of Maternal Identity

“A mother is a person who, seeing there are only four pieces of pie for five people, promptly announces she never did care for pie.” - Tenneva Jordan

Introduction

This paper examines the ramifications of the identification of women with child rearing in a specific context: caring for children with chronic and severe mental illnesses in contemporary United States society, in which the dominant ideology of child-rearing involves intensive mothering. First coined by sociologist Sharon Hays, intensive mothering ideology involves a parenting style that is “construed as *child-centered, expert-guided, emotionally absorbing, labor-intensive, and financially expensive*" (Hays 1996, 8, italics in the original). The following questions will be addressed: what challenges to culturally-scripted mother roles do mothers caring for children with chronic and severe mental illness face? How does an ideology of “intensive mothering” factor into the challenges mothers face and the ways in which they deal with these challenges? Does mother blame influence mother’s evaluations of their experiences parenting children with mental illness? How do mothers negotiate simultaneous and competing ideologies of intensive mothering and medical authority when medical professionals become a constant and necessary presence in their lives?

Mothers experience the influence of this dominant ideology in varied ways, from feelings of guilt upon returning to work to paying for expensive toys that promise superior cognitive development. Many experience contradictions to the cultural script of motherhood that emerges from this intensive mothering ideology and the narrow framework of normality produced by discourses of "good mothering." Mothers of children diagnosed with chronic and severe mental illnesses in the United States face many challenges outside of typical mothering expectations, such as problems at school, financial burdens of medical treatment, lack of social services, and tumult at home.

In this analysis, I describe the challenges many of these mothers face to negotiate their maternal identities amidst contradictions to the cultural narrative of motherhood described above. I aim to demonstrate how ways in which they experience parenting a child with a mental illness are patterned and an overarching ideology that shapes these patterns. These patterns include (1) susceptibility to both internal and external critiques of their parenting based on their children's symptomatic behavior; (2) contradictions to the primary authority over their child emphasized by intensive mothering discourse, as they must share caretaking responsibility with medical practitioners; (3) constrained parenting choices. I also aim to illustrate ways in which they negotiate their maternal identities in the context of this ideology of intensive mothering. In the context of these confrontations between medical and maternal authority, mothers find ways to defend their maternal identity by either emphasizing the abnormality of their situation, thus removing their child's behavior from maternal jurisdiction, or by rejecting medical claims to authority. The situations of these mothers also illustrates the double bind produced by cultural discourses that, at once, task mothers with disproportionate responsibility for the

outcomes of their children and tell them they must be "experts on their own children," while simultaneously framing parenting and child development as areas of scientific expertise.

Thus, in order to understand the context of contemporary motherhood in which the mothers in this study navigated maternal roles and psychiatric demands, a brief overview of the overlapping sociohistorical processes that have greatly influenced current conceptions of motherhood, childhood, and medical authority will be useful.

Motherhood in the United States and the Child as Innocent Object

According to a home health manual published in the United States in 1866, "The reproduction of the species—their nurture in the womb, and their support and culture during infancy and childhood—is the grand prerogative of woman. It is a noble and holy office, to which she is appointed by God; and the duty is both pure and sacred" (Cook 1866, quoted in Apple 1987, 5). This idea reduced women to their childbearing and childrearing potential and excluded them from non-domestic areas of society. Since then, women have successfully fought to expand their access to roles historically monopolized by men. Despite the progress women in the United States have made, the idea that women have a unique responsibility for childrearing remains, often implicitly. What evolved from the Euro-American 19th century "cult of true womanhood" is a contemporary intensive mothering ideology characterized by extraordinary maternal effort and accountability and, often, unattainable expectations (Hays 1996; Warner 2005).

In contemporary American culture, intensive mothering is the dominant ideology of child-rearing. Especially important to maternal negotiations of authority is the "underlying assumption that the child absolutely requires consistent nurture by a single primary caretaker and that the mother is the best person for the job" (Hays 1996, 8). Scholars note the importance of intensive mothering ideology throughout a variety of maternal experiences, such as maternal mental health (Rizzo et al., 2012), managing simultaneous employment and motherhood (Johnston & Swanson 2006, Christopher 2012), the work of family leisure (Shaw, 2008), infant feeding (Lee, 2008; Knaak, 2010).

Hallstein notes the interaction between second wave feminist ideas of female independence and neoliberal individualism in contemporary mothering, explaining,

"American mothers find themselves struggling on a daily basis to try to meet their obligations at home and at work and, more often than not, ground solutions in their own individual choices" (Hallstein 2015, 37). Indeed, intensive mothering ideology is more than a continuation of Victorian ideals of female domestication and maternal commitment. Rather, it developed in tandem with feminist movements oriented towards meritocracy and personal freedom that opened opportunities to women. This presented intensive styles of mothering, such as attachment parenting, as matters of female empowerment, while obscuring the accompanying coercion and subjugation. As sociologist Frank Furedi stated, "[attachment parenting] is based upon the idea that, unless you reorganise your life and subordinate yourself to your child, you are, in effect, an irresponsible or even bad parent…Even those parents who kick against it feel guilty because they have internalised its message about what it is to be a good parent" (Furedi, quoted in Henry 2012).

A notion of a special, innate connection between mother and biological child beyond gestation and childbirth accompanies these expectations of intensive mothering. This enduring idea has helped perpetuate the overwhelming responsibility for childrearing placed on mothers. However, recent studies have shown no significant differences between outcomes of children raised by single fathers versus single mothers (Downey et al 1998), outcomes of children raised by male-male partners versus male-female partners (Adams & Light 2015), oxytocin levels of fathers and mothers at various time points after childbirth (Gordon et al 2010), or brain activity between primary caregiving males and females (Abraham et al 2014). Instead, there are prenatal hormone changes in both female and male first-time expectant parents (Edelstein et al 2014). Yet,

the idea persists that mothers are uniquely equipped and responsible for child development. For example, a recent Livestrong.com parenting post advised fathers that "You can influence your baby's social confidence by being the first 'stranger' your baby encounters," [parenting guide author Christine] Langlois suggests.

The historical shift in perceptions of childhood is intimately linked to this child-centered emphasis. The image of children as symbols of innocence is a recent phenomenon. For example, Locke's influential 1693 writings on children reveal his belief that, though an infant's mind was a *tabula rasa*, children were not inherently innocent or kind, as evidenced by their cruelty, which he had observed (Parker 2013). The recent "sacralization" of children's lives that framed them as emotional assets rather than economic ones is a particularly important shift that accompanied the shift towards the idealization of women as full-time mothers (Zelizer 1994, 9-11). Thus, at the same time that "the specialization of women into expert full-time motherhood intensified" and spread, at least ideologically, to the working class (Ibid.), the conception of childhood as a period of protection, insulation, and economic uselessness did the same. Scholars disagree about the primary motivators of these changes, but, certainly, "The increasing domestication of middle-class women in the nineteenth century…'went hand in hand with the new conception of children as precious'" (Degler, quoted in Zelizer 1994, 9). The symbolic association of children with innocence and passivity has important implications for contemporary mothers. Whereas children were previously considered somewhat agentic, the passive, innocent child is now an extension of an agentic mother.

Understanding intensive mothering ideology in the context of historical shifts in conceptions of motherhood and childhood helps emphasize it as a social construct.

Likewise, intensive mothering ideology is culturally situated and is not contemporarily universal. While the identification of women with child-rearing is prevalent throughout the world (Rosaldo 1974), cultural scripts of motherhood vary, as do dominant ideologies of child-rearing. Cross-cultural research has shown significant variation in parental and child-rearing norms and expectations. For example, the use of sibling and non-parental caretakers is widespread globally (Weisner & Gallimore 1977). In a study of 186 societies, Barry and Paxson (1971) found that mothers were the principal caretakers less than half of the time. Korbin (1980) examines cultural differences in understandings of child abuse and neglect, providing cases of culturally normative parenting that would be negatively evaluated in other cultures. For example, initiation rites such as "genital operations, facial scarifications, beatings, and hazings by older members of the group" may be considered abusive to Western cultures. Likewise, "members of a cultural group in New Guinea were appalled that the American anthropologists living in their midst allowed their new-born infant to cry without immediately picking him up" (Korbin 1980, 6). Corporal punishment, while mostly discouraged in the United States, is a common disciplinary technique around the world (Ember & Ember 2005).

Expectations of parenting roles also differ culturally. Bornstein et al. (1996) found cultural differences in Argentina, France, and the United States regarding mothers' ideal expectations of their own and their husbands' behavior. Wang and Fivush (2005) found functional variations in mother–child conversations in European-American and Chinese families that suggested different culturally-relevant socialization aims. U.S mothers "focused more on personal themes and autonomy…, whereas Chinese mothers were more repetitive and focused more on social themes and interaction scenarios" (Wang & Fivush

2005, 488), indicating differing expectations of what a mother should teach her child. Rothbaum et al. (2007) found cultural similarities and differences regarding beliefs about attachment and *amae* (expectations of indulgence and interdependence) in United States and Japanese mothers. These examples support the idea that cultural ideologies, such as intensive mothering, influence how mothers experience parenting and evaluate their children.

Medical Authority

Medical authority is another dominant ideology in the United States. Since the 19th century, American physicians have fought to control health-related information (Trostle 1988).

Through a concerted effort by the medical establishment, legal system, and pharmaceutical industry, medical authority was solidified and, over time, became normalized such that most Americans today unquestioningly accept its assumptions. Trostle describes the assumptions of medical compliance ideology:

> These assumptions about patient-doctor relationships can be summarized as follows: the physician is the proper, ultimate authority over the actions of his or her patients; in exchange for a physician's services a patient owes fees, cooperation, and compliance; non-compliance is usually the patient's fault; and physicians offer therapeutic partnerships to patients, not vice versa. (Trostle, 1988, 1305)

A search for recent medical publications about patient compliance yields thousands of results, the majority geared toward improving patient compliance, with the built-in assumption of medical practitioners' authority. As Trostle explains, "Compliance is successful as a descriptive term in clinical practice precisely because it assumes that physicians legitimately control patient behavior" (Ibid.). Mahowald describes the physician-patient relationship as traditionally paternalistic, "mimicking the father-child relationship in which one party is clearly powerful and autonomous, the other vulnerable and dependent. Because 'father knows best' what is in the child's (patient's) best interest, he has not only the right but at times the responsibility to override the wishes of the child" (Mahowald 1993, 43).

Important in regard to relations between the medical community and mothers, part of the early consolidation of medical authority involved medical interest in infant feeding and a strategy of physician control in which manufacturers removed instructions from formula labels. Mothers were thus forced to seek medical assistance to appropriately feed their children (Apple 1987). What had previously been a strictly maternal task aided by shared knowledge between family and friends became a medicalized procedure. Further, medical attention expanded beyond infant feeding to include a full spectrum of maternal experiences. Apple explains how motherhood became an object of scientific inquiry and expertise, leading to the development of scientific motherhood, which she defines as "the insistence that women require expert scientific and medical advice to raise their children healthfully" (Apple 1995, 161). Scientific motherhood produced an enduring contradiction: "it made [women] responsible for the health and welfare of their families, but it denied them control over child-rearing. In other words, women were both responsible for their families and incapable of that responsibility" (Ibid.). In this context of intensive, scientific mothering and compliance ideology mothers find themselves dealing with the challenging circumstances of parenting children diagnosed with severe and chronic mental illnesses.

Mother-Blame

Intensive mothering ideology, informed by scientific mothering, provides a cultural script for the experience of motherhood and an idealized image of what the result of the mother's labor, the child, should look like at every step of development. Since the child is viewed as the product of mothering rather than an active participant in their own development, deviations from the ideal type are viewed as maternal failures. Mother-blame has a long history in American culture, and mothers have been blamed for a wide variety of ailments and deviances. A study of 125 contemporary articles published in clinical journals reported authors attributed to mothers 72 different kinds of psychopathology (Caplan & Hall-McCorquodale 1985). The study also analyzed articles from 1970, 1976 and 1982, and found few changes over that time period, suggesting the persistence of mother-blaming despite contrary scientific evidence. Though overt mother-blame theories are no longer dominant in today's mainstream medical establishment, replaced by "brain blame" and genetic models, mother-blame ideology has not disappeared, in medical or public spheres. For example, a 2012 article by clinical psychologist Humphreys in *The Irish Examiner* suggested a link between autism in children and their parents inadequately expressing love and affection (Bohan 2012).

Corresponding to both the endurance of mother-blame in American culture and expectations of intensive mothering, mothers in the SWYEPT study were confronted with critical evaluations of their mothering ability as a result of behavior relating to their children's mental illnesses. [PB49's mom], the mother of PB49, a 16-year-old girl diagnosed with psychotic disorder, faced criticism from PB49's father, Jim:

> And the first time she was put in the hospital, it was World War III between me and her dad. World War III. Oh, I was the worst mother in the world, I was a piece of shit, my daughter's piece of crap, she's making all this shit up, that… I'm like, um, your daughter's mental state needs to be your priority. He was pissed because I had put her in the hospital, and she had one interrupted school week.

Jim's criticism demonstrates how an outcome outside of expectations, such as missing school, is often attributed to the shortcomings of the mother. Jim's reaction also shows that, not only did her ability as a mother come under intense scrutiny, [PB49's mom]'s character as an individual came under attack, as well, because of PB49's behavior. As discourses of motherhood present intensive mothering as the natural role of a women, perceived failure in this role presents the woman's entire identity as open to moral evaluation.

In [PB49's mom]'s case, criticism came from PB49's father; but as cultural ideals of good mothering are widespread and often taken as moral facts, criticism may come from a variety of sources beyond the family. Indeed, it is not uncommon to hear the question "Where was his/her mother?" exclaimed in response to reports of child or adolescent misbehavior. For [PB41's mom], the mother of PB41, a 14-year-old boy diagnosed with Asperger's Syndrome, ADHD, and OCD, an unsolicited, negative assessment of her mothering came from a police officer after her son ran away:

> And he ran away, and he was very sad, I am sure. And he went to Target, I think it was Target. And some woman there, who is the social worker, apparently, felt very sorry for him. And so she called the police, and they brought him home. And then the police came in and started to berate me about what a bad parent I was and how I had kicked my child out of the house…I just wanted to freak out on those people. I was like, 'You can look, we called the police, like, three weeks ago, and they have record of

> us calling the police when he ran away.' I said, 'I, if he had not come back by the end of the evening, I was going to call you. It was not like I was happy that he was gone and, you know, don't want him here.' I said, 'But we are not safe. He is violent.' And I showed them how he had destroyed, like he had threw something one day, and it had broke up the wall over here. And, um, that was the first time we called the police. And I tried to explain to them. They just believe PB41 at that point, because he is this little boy and at this point, he is not angry, he is just sad and feels like he has been kicked out. You know?

[PB41's mom]'s interaction with critical police officers demonstrates how, despite unfamiliarity with the family, other adults feel entitled to openly evaluate her mothering ability. As [PB41's mom] points out, the officers believed PB41's version of events over [PB41's mom]'s "because he is this little boy" in a culture in which children are assumed to be innocent and truthful.

Yet, although demonstrating resistance to outside assessments of her mothering behavior, [PB41's mom] described her own feelings of guilt and self-blame in regard to PB41's symptomatic behavior:

> About every six months to a year, he has to have an increase [in medication], so it is often enough that it is very disruptive for the family. And then all of the emotions that go along with that. I mean, you know, I started feeling like, what did I do wrong? And even though, even though I know I didn't do anything wrong, and I would totally tell one of my clients they didn't do anything wrong. I am a mother and I have all of the stuff that goes along with being a mother. And it is just natural for you to feel guilty and like what could I have done differently? And what did I do wrong? And did I eat the wrong thing when I was pregnant? And now I just eat whatever I want, because I did everything perfect: I didn't eat chips, I didn't eat pop, I didn't eat chocolate, I didn't drink coffee. I didn't do any of those things that they say not to do. And I did, like, wanted it to be a perfect pregnancy…

[PB41's mom], a licensed therapist herself and active consumer of expert-guided mothering instructions, such as diet during pregnancy, knew better than to blame herself. Yet, she experienced guilt and self-doubt, which she accepted as a natural part of the mothering experience. Asking herself what she could have done differently and what she did wrong, [PB41's mom] exemplifies the internalization of a mothering ideology that considers the child to be the observable product of maternal effort. Entangled with the conception of children as non-agentic, completely malleable beings, this ideology places enormous pressure on mothers, who are led to believe that the slightest parenting error could have an irreparable effect on the person their child will become. That [PB41's mom]'s expert knowledge regarding mental illness failed to alleviate her own nagging feelings that she had somehow failed as a mother illustrates the power of intensive mothering ideology and persistence of mother-blame.

Confrontations of Care: Mothers and Medicine

Data for this analysis were drawn from the Southwest Youth Experience of Psychiatric Treatment (SWYEPT) Study. The SWYEPT study was an NIH-funded, interdisciplinary research project on adolescent mental health carried out from 2005–2011 across the State of New Mexico.[1] Over a span of six years, a team of researchers conducted multiple interviews with patients and their guardians in homes and inpatient facilities. The adolescents in this study experienced a wide range of serious mental health problems, often carrying multiple, simultaneous diagnoses. For further description of the study, see Jenkins (2015, 220).

For the present analysis, thematic analyses of ethnographic interviews of mothers of the adolescent children were conducted. Because the aim of this analysis was to examine how typical mothers negotiate their expectations of mothering versus the reality of caring for a child with a particular type of special needs, cases were excluded in which the mother-child relationship was marked by particular contextual features that precluded frequent face-to-face interaction, such as situations in which the mother was not present in the home or the mother's presence was unstable, such as being in and out of prison.

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[1] This collaborative project was funded by National Institute of Mental Health Grant # RO1 MH071781–01, Thomas J. Csordas and Janis H. Jenkins, Co-Principal Investigators. Data collection for the study took place across the state of New Mexico, with major sites of research in the Albuquerque and Las Cruces metropolitan areas (2005–11). The team-based study involved ethnographic interviews and observations of many youths from all parts of the state. As for all such university- and government-sponsored studies, informed consent was obtained, and in this case it involved both a parent or guardian and the adolescent

Cases were also excluded in situations in which primary caregivers were adoptive parents or grandparents or the child assumed a caregiver role.

While temporary negotiations of authority between mothers and medical practitioners regularly occur without incident, sustained confrontations between these forms of authority occur when a child is diagnosed with a severe and chronic mental illness. Caregiving, which Kleinman describes as "one of the foundational moral meanings and human experiences everywhere," becomes a shared "moral act" (Kleinman 2012, 1550). Medical care becomes a regular part of life, as described by [PB14's Mom], the mother of PB14, a 15-year-old girl diagnosed with bipolar disorder. When asked when she was told of PB14's diagnosis, [PB14's Mom] responds:

> Um, when she was about nine and a half…And, um, we immediately, you know, went to [a receiving home] which is a, you know, they have a whole program for the family, and that's where we started with that. And then her behavior began to deteriorate, with school and socially and we had her going to a therapist at the time. The therapist said 'you know, I think she's bipolar. She should see a psychiatrist. She's going to need medication' and we've been seeing psychiatrists ever since.

Thus, interaction with psychiatrists had been a part of [PB14's Mom]'s mothering experience for over a third of PB14's life.

Dealing with severe mental illnesses of their children can also conflict with norms of maternal authority by restricting the choices a mother is able to make. In some of the SWYEPT cases, mothers were given the option between sending their children to jail or to mental health facilities as a result of illegal, symptomatic behavior. In one such case,

[PB41's mom], described an altercation with a policewoman that led to PB41's hospitalization:

> She said he tried to hit her. Hauled off and try to hit her. He said he was just trying to get his arm away. So who knows? I wasn't there. But she was not very happy with him. Basically, she said, you have two choices. Because I have explained to them, he's been having this illness since he was born. They said that you want him to go to detention because we can take him to detention, or do you want him to go to the hospital? And I said go to the hospital. And so that's what we did. They escorted him to the hospital, and then I met them at the hospital.

In many cases, the decision to seek medical attention was made my police officers following emergency calls made by panicked mothers. [PB15's mom], the mother of PB15, a 16-year-old boy diagnosed with psychotic disorder, described how calling 911 led to a such a choice:

> So I did call 911 because… I had gone there and I think….um, that's when he had broken his glasses and, you know, he had thrown [unintelligible] and his glasses broke. So I called them in the night cause I didn't know what to do…Then, they said, OK, the police officer will be right there and I go, WHAT, I don't want, that would just freak my son completely out and she goes OK, she goes, would you rather have the ambulance, I said, yeah, I said I don't want the cops showing up. The cops showed up anyway… I just felt like they were treating him like, he was a criminal or something. And I don't want to do that, because I don't, I don't want to do that to my son and he was, you know, he was, emotional as it was, so, so they just checked if he had weapons, and then they said, well, you know, if we take him by ambulance we're gonna charge you but if you don't, you know, um, …the people in the ambulance said well, are you willing to go in the car, and he goes yeah I'll go, so, so, my sister drove me, him and my nephew down … So anyway, that's when he was first admitted, and we stayed in emergency all night long.

Similarly, PB21, a 14-year old boy diagnosed with ADHD and PTSD, described his mother's constrained choice to send him to a treatment facility:

> Well, because [mom's boyfriend] had to restrain me. And that she—mom called the cops and ev—and she didn't mean [to have me arrested] but she just needed someone to come out to the house. They said they were gonna arrest me, but then my mom said, No, send him to the hospital. So basically my mom just saved my butt for going—from going to six months in jail. Because it's either [hospitalization] or six months in jail. I'd rather go to [the hospital] and get it over with. Get my treatment over with.

Thus, in these cases, the choice to seek medical care for their children was constrained by the presentation of only one other alternative: jail.

Maternal Expectations, 'Abnormal' Responsibility, and Reclassification

As previously illustrated, many mothers' experiences caring for children with mental illness involved disruptions to culturally-scripted expectations of maternal authority, such as shared caretaking responsibility with a medical provider or constrained choice, and these disruptions present challenges to maternal identity in the context of the demands of intensive mothering ideology. Perhaps the most common method of negotiating maternal identity observed amongst the mothers in the SWYEPT study was emphasizing their perceived abnormality of the parenting experience caused by factors outside of the mother's control. These mothers also correspondingly emphasized how unlike other children their child was in a way that distanced their child from the idealized image of the passive, innocent child whose behavior directly reflected maternal action. At the same time, they expressed deference to medical authority in the care of their children. Altogether, these emphases worked to reclassify the clinical child in a role outside of that of the typical child and the child's behavior as the object of medical, rather than maternal, intervention. Many mothers also cited differences between other children they knew, including other children of their own, and the clinical child in order to convincingly explain their inability to privately handle the situation. In alignment with Warner's assertion that contemporary American mothers have "been bred to be independent and self-sufficient. To rely on their own initiative and 'personal responsibility.' To *privatize* their problems" (Warner 2005), these mothers felt it necessary to explain why they could not handle the situations on their own in a way that made clear that the burden went beyond typical mothering responsibilities. In this way, mothers were able to maintain their own self-identification as good mothers despite the undesirable behavior of their

children, as the mother had done everything correctly; it was the child who failed to properly maintain his/her role.

[PB14's Mom], for example, repeatedly emphasized the abnormality of parenting PB14. Referring to caring for PB14, she stated, "It's just … I mean, I have three children. She's just, always been just different. Her needs are just a lot different." [PB14's Mom] even stressed the difference between PB14 and other children with her same diagnosis:

> I go on the internet. I'm on a couple of support groups, bipolar support groups. But the only problem is nothing specifically relates to PB14. PB14 is just, seems to be just a little more intense than the atypical fifteen-year-old bipolar kid. Do you know what I mean?

Owing to this irregularity, [PB14's Mom] justified her inability to handle PB14's behavior within the home and the necessary intervention of a medical team and treatment foster care:

> Well, after PB14's last admission, the, um, the deal was, or the reality was either you make the effort and do what you have to do or your parents won't be able to maintain you at home. Well, we had the … community family team, C-F-T, and they came to the house and we were getting nowhere and we discussed that treatment foster care is probably the next step. PB14 understood that and she deteriorated and wouldn't make an effort. Also, I'm at the end of my rope. I can't do it. I cannot maintain her at home. I cannot do whatever she needs to get her to function. I'm not equipped for it.

[PB14's Mom]'s language makes clear the difference between being unable to meet the excessive demands of caring for PB14 and being unwilling to engage in the intensive

mothering expected of American mothers. That she is "not equipped" suggests the necessity of something beyond the natural abilities of a mother. She needs more than maternal ability and the laborious effort of intensive mothering; she needs equipment.

[PB49's mom] also described a situation in which the parent-child relationship with PB49 was abnormal:

> It's just… it's been a battle. It's been… and I think I am just tired, 'cause I've been doing this with her since she was… 13. And I am just done. After these many years, I can't… ran away from home already… you know, last year this time, from last year to this year it just, it just seems unreal. Everything that she has put me through.

Contrary to conceptions of childhood innocence and passivity, [PB49's mom] characterizes PB49 as the agent and herself as the passive victim of "everything that she has put me through." [PB49's mom] is not, then, the extension of her mother; she is positioned against her mother, who describes behavior as outside of her influence.

[PB41's mom] described how, despite textbook good mothering, PB41 reacted in unexpected ways that were different from other children:

> I would always tell him how great he was, and that would stress him out, because it would make him feel more pressure to do better. Whereas most kids would love their parents to say they're doing great, it would stress him out. It took me years to figure out that that is why he would get mad at me. I would just cry, and be like, 'What am I doing wrong? I just cannot please this kid.' At everything that I learned about parenting, I've been around kids my whole life, babysat since I was 10, and none of it did me any good. I just was…. stumped.

Like [PB14's Mom], [PB41's mom] also compares her child to other children with his condition, presenting PB41 as exceptionally challenging:

> Yeah, they wanted to release him after three days and we all knew that PB41 was not manageable at home at this point, and he is not like other kids where just because he is good for three days means he's stable, which I am sure that there are other kids like that, too. Because for PB41, he can even go for a week or two and then, you know, try to kill somebody. So we were very, once he's, once he's been like that we knew that he was not manageable at home

[PB41's mom]'s choice of words is also revelatory: PB41 is "not manageable at home," indicating unmanageability as a quality of PB41, rather than any failure on her part to manage him. Further, PB41's unmanageability is specific to the private sphere over which [PB41's mom], as mother, is expected to have control.

Describing her son, PB50, a 16-year-old boy diagnosed with depressive disorder and conduct disorder, [PB50's mom] stated, "I always knew he was a different child. I've, I've been around kids all my life and babysitting and having my first daughter. When I had PB50, it was different." She went on:

> I guess when he was like two or three he was just very, he was a mean little boy…um, very hyper, always on the go. Um, I guess it took a lot to get him tired out. Um, he was good with his sister but then yet he was just very mean**…**He'd hit, pull hair, bite, um, throw rocks, um, throw temper tantrums. He used to throw himself backwards on the floor and hit his head on the floor and, you know, um, didn't talk for the longest time until he was about three, three and a half, so just knowing right off the bat something was different.

In describing how she thought her experience with PB50's medical team could improve, [PB50's mom] also demonstrated an elevation of medical authority over her own in regard to PB50's care:

> Um, I guess I would like to see more of, um, how do I help my child…how can I better help, what is it you're doing that I can do in the home…teach me what you're doing to him because whatever you're doing is …and I need it to work at home, you know, …that's what I'd like to see…you know…teach me what you're doing.

Similarly, Beth, mother of Anne, a 15-year old girl with major depressive disorder, PTSD, separation anxiety disorder, ADHD, ODD, and conduct disorder, recalled "I said, I just need help, getting started, on what I'm supposed to do because I'm not a professional, I don't know."

Especially notable in these descriptions is that, rather than relaying a narrative of psychological abnormality in a clinical or biological sense, the focus is on the abnormality of the parenting experience and the child compared to other children, often with simultaneous references to good mothering, such as learning about parenting and experience being around children. Indeed, rather than adopting brain-blame discourse, which maintains the child as passive while faulting the brain, these mothers presented their children as agents, presumably immune to the influence of intensive mothering.

To understand how this pattern of reclassifying their children as outside the boundaries of mothering allows mothers to maintain their identification with the mother role prescribed by intensive mothering ideology, Mary Douglas' work on purity and dirt can be useful. In her discussion of purity and dirt, Douglas presents the concept of

"matter out of place," which is "a set of ordered relations and a contravention of that order" (Douglas 1966, 36). Regarding dirt, Douglas states that "dirt is the by-product of a systematic ordering and classification of matter, in so far as ordering involves rejecting inappropriate elements" (Ibid.). Dirt, then, is symbolic of the ordering and classification from which it is excluded. She explains, "When something is firmly classed as anomalous, the outline of the set in which it is not a member is clarified" (Douglas 1966, 39). Firmly classing their children as anomalous thus clarifies the outline of what a child *should* be, and it is *that* child who can be shaped by intensive mothering, who is reflective of maternal effort. Douglas concludes that "if uncleanness is matter out of place, we must approach it through order. Uncleanness or dirt is that which must not be included if a pattern is to be maintained" (Douglas 1966, 41). Indeed, the emphasis on needing professional guidance helps to order their children's behavior in the category of medical, not maternal, care. [PB50's mom] described the boundary between being a mother and addressing her son's symptomatic behavior bluntly, stating "There is, either I do the mother thing or I call the police."

Rejecting Medical Authority

[PB20's mom]

While some mothers accept the authority of medical providers and seek out their assistance, others emphasize their own authority as mothers and caretakers of their children. [PB20's mom], the mother of PB20, a 13-year-old boy diagnosed with ADHD, conduct disorder, and psychotic mood disorder, was an unusual case amongst the SWYEPT mothers in her almost militant insistence that she was the rightful authority in all matters of PB20's life. While internalization of intensive mothering ideology was apparent throughout the SWYEPT mothers' narratives, [PB20's mom] demonstrated a particularly strong commitment to the culturally-scripted role of the mother:

> I mean, most people will look at him and they'll, like, back off. (laughs a little) I can't do that. If I show him fear or let him think that he has control. Ooooh. That's not a good thing. So I can't do that. I need to show him I'm the boss, you know, you're gonna' do what I'm gonna' say and I'm not afraid of you. You better be afraid of me, but I'm not, I'm not afraid of you. And he could tell from lots of people that, you know, they're afraid of him and he takes advantage of that. And it's like, 'No. I'm your mom and it doesn't matter if I'm eighty or ninety years old, I will still spank you.' I will still be your boss, you're not gonna' do whatever you want. And he's like 'well, what if you're dead?' I'm like 'don't worry, I'll come and pull you from your legs.' You're gonna' listen and you're gonna' do what I say. So, you know, he'll tell people 'the only one I'm scared of is my mom. I'm not scared of you.' You know, he's told the sheriffs and everything. He's like 'I'm just scared of my mom, I'm not scared of you.'

She emphasized her role as the primary decision-maker, even in regard to PB20's medical care, despite having no formal medical training. Expressing dissatisfaction with

PB20's psychiatrist's decision to let PB20 have a role in determining his own medication, [PB20's mom] stated:

> I got into an argument with, um, the psychiatrist's, um, helper about that and told her that I don't care about the law, that he's a minor, and on everything else, I'm responsible for him, so if I am responsible for that and everything, he is going to take the medication that I say he is going to take.

[PB20's mom] was adamant that she knew her children and how to care for them best, better than any of the medical professionals:

> There are some psychiatrists and some therapists that, you know, really, really did listen and try to work with you. And there are some that don't, you know. Thing is, lately I have been bumping into a lot that are, you know, they-- I have had psychiatrists or therapists tell me that I can't keep my kids safe, which I have been doing their whole life. And that's with medication and without medication. With therapy and without therapy. And they tell me that I can't keep them safe and I don't know how to handle them and I'm like, 'You're not handling them,' you know? So, it's like, or they'll come out with, 'I have so many years of experience that I can read people.' And once I told a therapist, 'Can you read what I'm feeling right now?' And she's like, "Anger." And I'm like, "No," I'm just fed up with you. I'm fed up with you and I'm pretty much laughing at you (I: Umm-mm) because you're an idiot. And she just, you know, she got all offended and everything, and she's like, "We need you to work with us" and everything and I'm like, "No, you need to work with me; I don't have to work with you. You do not know them, you do not take care of them, and you are not responsible for them. If they do something out there in society, in the community, I am responsible.

In her descriptions, [PB20's mom] places herself in the authoritative role. It is she who provides information and who is the expert; it is others who need to listen. She counters medical practitioners' claims to expertise with her own claims to expertise: her history of

keeping her children safe. In this way, her children are her embodied credentials, the visible products of her labor. That they are alive and safe is proof of her successful mothering. As she points out her ability to care for her children with or without treatment, presumably at their best and worst behavior, she further elevates herself above the medical professionals who do not experience the full range of her children's behavior.

Unlike many of the other SWYEPT mothers, [PB20's mom] does not attempt to reclassify her children's behavior outside of her mothering jurisdiction. Instead, she subsumes treating her children's mental illnesses, even deciding how much medication they should take, under her maternal responsibilities and expertise. In a reversal of [PB14's Mom], for example, who emphasized being "not equipped" to care for PB14 at home, [PB20's mom] portrays the clinicians as ill-equipped to handle the children whom she, in her assessment, successfully cares for at home. [PB20's mom]'s assessment of the clinic is that it is a place in need of influence by parenting expertise, demonstrating another reversal of expressed desires of other mothers' to import medical expertise and strategies into their homes in order to better fill a supplementary medical role to their children. Yet, although exhibiting a different classification strategy than the other mothers, [PB20's mom] also engages in a reclassification method that redraws the boundaries of maternal jurisdiction to include not just obtaining medical care but providing it herself.

Conclusion

From interviews with mothers in the SWYEPT study, we have argued that an "intensive mothering" ideology shapes the lens through which these mothers view their experiences with children with mental illnesses. Tellingly, mothers in the SWYEPT study were not explicitly asked questions about their mothering ability or feelings of maternal success, yet most felt the need to defend themselves as good mothers. The history of mother-blame in the United States is, of course, an important component of this defensive urge, as mothers are especially likely to be blamed for the mental illnesses of their children. Thus, for example, we would not necessarily expect to see such defenses in the narratives of mothers of children with non-psychological chronic diseases, such as asthma (though this could change in this era of epigenetic discourse). But inherent to mother-blame is a mothering ideology that unduly burdens mothers with all societal evaluations of another human being, their child, in a way that erases the individuality of the mother and the agency of the child.

Mothers in the clinical sample in the SWYEPT study dealt with competing ideologies and expectations by modifying the boundaries of maternal responsibility to either exclude the clinical child or include medical care. These reclassification techniques are consistent with Christopher's findings that employed mothers negotiate simultaneous "intensive mother" and "ideal worker" ideologies by constructing "extensive mothering" narratives that reframe employment within notions of good mothering (Christopher 2012) and Johnson and Swanson's findings that employed mothers engage in "cognitive acrobatics" in order to construct an "integrated worker-mother identity" amidst tension between employment and intensive mothering expectations (Johnson and Swanson 2007).

Intensive mothering ideology is constraining to women, in general, and may be harmful to mental health. Rizzo et al (2013) found that intensive mothering beliefs correlated with several negative mental health outcomes, such as higher levels of stress and lower levels of life satisfaction. In the context of caring for a child with a mental illness, the constraints are even tighter, and life satisfaction may be negatively affected to an even greater extent. For example, the shame that mothers are taught to feel when their child misbehaves may cause mothers of children with mental illness to withdraw from social life. Indeed, [PB14's Mom] discussed her own isolation from extended family in order to insulate them from PB14's behavior. She also discussed her family's ability to take a rare, pleasant vacation while PB14 was in treatment foster care and her accompanying guilt. Thus, under the weight of intensive mothering expectations, happy moments are tarnished by feelings of wrongdoing and inadequacy. Further, as the intensive mother role comes to dominate identity, a woman may evaluate her own life negatively as a result of disappointment with the idealized childrearing experience she expected. As one SWYEPT mother of a clinical child described of her own life, "It's very sad. All I ever wanted to do was grow up and be a mom and have kids, and then my kids—except for Sarah—are the biggest disappointment ever. On mother's day, I wondered why I ever had kids."

In addition to the importance of its impact on maternal wellbeing, intensive mothering ideology may be especially harmful to children with mental illnesses, whose mothers may avoid seeking medical help due to the belief that they should be able to manage the problem on their own. In cases of mothers like [PB20's mom], the need to defend maternal authority and the boundaries of the mother role may prevent them from

seeking help and utilizing available services. Further, in a study of family burden, Jenkins and Schumacher (1999) found that independent of type of disorder, patient's misery was most frequently cited as the most distressful symptom to caregivers. Thus, avoiding care that would ameliorate their child's misery would have the looping effect of making both mother and child more distressed.

I conclude with the extension that intensive mothering ideology is an issue of global mental health. Jenkins and Good (2014) address some of the culturally-specific vulnerabilities of women in regard to global mental health, arguing that "the overall vulnerability of girls and women to mental illness must be accounted for in part by women's greater likelihood of occupying socially subordinate status and being subject to unequal power relations" (Jenkins & Good 2014, 275). The dominance of intensive mothering ideology in United States culture perpetuates the subordinate status of women and unequal power relations between women and men. As long as mothers are unnecessarily tasked with disproportionate responsibility for childrearing, their participation in other spheres, such as the workplace, cannot match that of men without compromising in other ways, such as health. Thus, intensive mothering is indeed a culturally-specific vulnerability deserving of attention, within and across specific social contexts of precarity.

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