

Transitions in Turmoil?
Young Adult Children of Parents with Mood Disorders
and the Transition to Adulthood

by

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Adulthood

Thesis directed by Professor Amy C. Wilkins

ABSTRACT

This dissertation is a qualitative study of the stories young adult children tell about growing up with a parent with a diagnosed mood disorder. Using 50 in-depth interviews with young adults between the ages of 19 and 34, I explore how children of parents with a mood disorder, who describe feeling invisible and/or misunderstood, rely on a specific set of cultural stories that emphasize white, middle-class ideals to make sense of their childhoods and the consequences of their parents' illness. When they compare their own experiences to these narrow ideals, my respondents describe "lost" childhoods and feelings of "growing up too fast." They use these interpretations of their childhood to explain their choices and behaviors as they transition to adulthood. The stories they tell simultaneously empower and constrain my respondents as they seek to emphasize the maturity and independence that they gain, while also discussing the often-negative impact of their parents' illness on their relationship and childbearing decisions. I include data collected from cross-gender sibling pairs to explore how children who grow up in the same household may not only have different experiences but vastly different ways of interpreting them and the role that gender plays in this process. Finally, I discuss the implications of this study for how we understand children of parents with a mental illness and the importance of examining the role that culture plays in shaping how individuals interpret and talk about their families.

Dedicated to my families in Colorado, Maryland, Saint Louis, Virginia and
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CHAPTER ONE

INTRODUCTION

Young adult children of mentally ill parents are a hidden population both in research literature and in the public view. 1 in 17 (6%) of Americans meet the criteria for a serious mental illness in a given year and 1 in 4 (25%) meet the criteria for a diagnosable mental illness (Kessler and Chiu 2005). Many of these individuals are, or may one day become, parents. Even though research detailing the impact of having a mentally ill parent for children and adults is growing, there is limited research that looks directly at the impact on young adults' lives and more specifically on their transition to adulthood. Young adult children of parents with mood disorders (severe depression and bipolar disorder) are an interesting population because their parents' illness can lead to non-normative experiences in child and adulthood. Mood disorders may cause inappropriate feelings. Sometimes these feelings are exaggerated for a situation, such as a person who grows euphoric over a mundane event. At other times, emotional expressions may be limited, such as a person who cannot express affection or feel happiness. Consequently, children who have grown up in households with a parent who has been diagnosed with a mood disorder are more likely to confront chronic disruption to "normal" family life. These experiences can range from a parent who sleeps all the time, to a parent who consistently forgets to pick his or her children up from school, to a parent who has grandiose illusions about what he or she can do. In some instances, the parent's symptoms may be severe and in others relatively mild.

In this dissertation, I analyze 50 semi-structured in-depth interviews, which I conducted with young adult children with a parent with a diagnosed mood disorder. I treat my interviews as an opportunity to explore how young adult children¹ rely on a specific set of cultural stories that emphasize white, middle-class ideals to make sense of their childhoods and the consequences of their parent's illness and how they use these interpretations of their childhood to explain their choices and behaviors as they transition to adulthood.

Children of the Mentally Ill Through the Life Course

Life course scholars have emphasized the importance of examining the transitions and trajectories of individuals' lives and the ways in which these lives are linked to others (George 1999; Moen and Hernandez 2009). Despite some work that examines the lives of those who are connected to individuals affected by mental illness, more research in this area is needed to fully understand the impact of mental illness on all who may be affected (George 1999). A large number of children grow up in households with a mentally ill parent². Using data from the National Comorbidity Study and U.S. Census data, the Committee On Depression, Parenting Practices, And The Healthy Development Of Children (funded by the National Research Council and Institute of Medicine), estimates that over 15.6 million children under the age of 18 are living in a household where at least one adult has

¹ Throughout this dissertation I may refer to the population in question and my respondents as children. I use this term not to refer to their age location or specific expectations about behavior, but instead to mark their relational status to their parent(s).

² Much of the literature on the impact of parents with a mental illness includes a variety of diagnoses, including: severe depression, bipolar disorder, schizophrenia, anxiety disorder, and more. I did not limit my review to only those focused on affective disorders, but do address why I chose only to focus on this population in my methods chapter.

experienced major depression in a given year (National Research Council (US).

Committee on Depression, Parenting Practices 2009). Despite these large numbers, the committee argues that this population remains relatively invisible:

Current screening programs for depression in adults generally do not consider whether the adult is a parent, and therefore they do not assess parental function or co morbid conditions, do not consider the impact of the parent's mental health status on the health and development of their children, and are rarely integrated with further evaluation and treatment or other existing screening efforts (National Research Council (US). Committee on Depression, Parenting Practices 2009).

Despite this persistent invisibility in terms of services and identification, research on this population is continuing to grow. This research generally finds that growing up with a mentally ill parent harms children. The study discussed above found that depression “interferes with parenting quality and is associated with poor health and development (e.g., physical, psychological, behavioral, social development and mental health) in their children at all ages” (National Research Council (US). Committee on Depression, Parenting Practices 2009). Other research has highlighted the negative parenting skills and general household disruption that parental mental illness brings (C. Mowbray et al. 2002; National Research Council (US). Committee on Depression, Parenting Practices 2009; Smith 2004). Adolescent children of mentally ill parents are more likely to face behavioral or interpersonal challenges and to be diagnosed with their own psychiatric disorder, or to have difficulty with psychosocial functioning (C. Foster et al. 2008; Maybery, Reupert, and Patrick 2009; C. Mowbray and O. Mowbray 2006; C. Mowbray et al. 2004; C. Mowbray et al. 2006).

While research has examined the consequences of both paternal and maternal mental illness, more studies have focused on maternal mental illness (see Goodman 2007 for review). Maternal depression has been shown to affect young children's language development, intelligence, behavior, social and emotional development, sleep patterns, and attachment (Smith 2004). This research suggests that growing up with a mentally ill mother is particularly harmful, but it is unclear whether these results represent a general bias in the research that assumes that mothers matter more to children, or if there is a specific relationship between mothers and their children that is particularly affected by mental illness.

Despite the increasing interest in this topic, Gladstone, Boydell and McKeever (2006) argue that many of these studies focus too closely on models of risk and resilience, "in which childhood is considered primarily a critical developmental phase during which children need protection due to their physical and psychological vulnerabilities" (2541). In these models, Gladstone et al. argue that children are only framed as victims and are not given any agency within families. The risk model assumes negative consequences, which means that children who remain healthy are framed "as resilient, invulnerable, and even as 'superkids'" (Gladstone et al. 2006:2543). Just as they critique the risk models, Gladstone et al. (2006) and Mordoch and Hall (2008) argue that resiliency models do not adequately explore how children understand and make sense of their parent's illness on their own terms.

Most of the studies that do address the subjective experiences of children with a mentally ill parent are not located in the United States and instead explore the experiences of children in Scandinavian countries, Australia, Canada, and the United Kingdom (e.g. Aldridge and Becker 2003; Aldridge 2006; Garley et al. 1997; Haug Fjone, Ytterhus, and Almvik 2009; Knutsson-Medin, Edlund, and Ramklint 2007; Trondsen 2011). Despite the diversity of locations, many of the studies point to similar findings in terms of how children and adolescents discuss their experiences. Some of the primary themes that emerge in these studies are the complex relationships that children have with their parents and the emotions these relationships generate, the potential for increased practical and emotional responsibility, feelings of invisibility, stigma, and drawing comparisons to other families. I briefly explore each of these themes below.

Navigating Complex Relationships and Emotions

Growing up with a mentally ill parent can be challenging. Respondents throughout studies discuss the difficulty they have in navigating their relationships with their parents. Children work to both understand and adjust to their parents' behaviors, sometimes with very little information (Mordoch and Hall 2008). Some children report feeling simultaneously ashamed and proud of their parents and try to manage these feelings throughout their childhoods (Haug Fjone et al. 2009). Their strategies vary, but some researchers have pointed to the need for children to develop ways to disengage from a tenuous family life and find other ways to be

successful (Beardslee and Podorefsky 1988; Luthar, Cicchetti, and Becker 2000; Mordoch and Hall 2008).

In the context of the issues discussed above, almost all of the studies that examined the subjective experiences of children with mentally ill parents described the vast range of emotions children encountered. Mordoch and Hall's respondents discussed a range of emotions including: "joy, love, pride, sadness, worry, frustration, anger, guilt, fear, despair, anxiety, grief, hurt, discouragement, embarrassment, relief, hope, and loathing" (2008: 1139). Children struggled to know how to handle these various emotions and worked to try to manage these emotions in an attempt to feel "normal" (Haug Fjone et al. 2009).

Increased Responsibility

Researchers have identified the increased burden that some children face when living with a parent with mental illness because they feel they must provide physical and emotional support (Aldridge 2006; Mechling 2011; Smith 2004). In one study, Aldridge (2006) found that "children who care for parents with serious mental health problems, while undertaking many of the tasks other children do whose parents have physical health problems or disabilities, also take on a great deal of what can be perceived as emotional care responsibilities" (81). Some researchers have referred to this process as "parentification". In these studies, "the child is described as 'precociously mature' and is said to have assumed an 'adult' role prior to being emotionally or developmentally ready to manage it successfully" (Gladstone et al. 2006). Professionals who work with these "young carers" have

found that these children face isolation, invisibility, and marginalization (Gray, Robinson, and Seddon 2007). Gladstone et al. (2006) argue that while a few studies discuss the benefits of this increased responsibility, most frame it as a pathological problem with negative consequences.

Invisibility

The children of mentally ill parents see themselves as invisible to service providers and the population at large and feel unnoticed because of a lack of understanding, stigma, and limited support options. Many young children reported having limited or incomplete information about what was going on with their parent (Garley et al. 1997; Mordoch 2010; Trondsen 2011). In an extensive review, Gladstone et al. (2006) argue that children are invisible due to the individualistic nature of healthcare provision, the inability for service providers to coordinate care for families, and broader understandings of childhood that make it difficult to see children as capable social actors. Regardless of the process through which this invisibility occurs, it is something that children discuss feeling throughout their lives. The few studies that have explored the experiences of children through in-person or online support groups or focus-group methodology found that children benefited from finding someone who had experienced something similar to themselves (Garley et al. 1997; Trondsen 2011).

Stigma

Stigma is “an attribute that is deeply discrediting, but it should be seen that a language of relationships, not attributes, is really needed” (Goffman 1963:8). Thus

it is not simply the presence of a discrediting attribute but the way that it is talked about and understood. There is a distinction between the discredited individual, whose stigma is known or visible, and the discreditable whose stigma is unknown (Goffman 1963). Those with mental illness are oftentimes discreditable individuals who must make decisions whether to share the potentially stigmatizing information.

The concept of courtesy stigma posits that there are two types of people who are the most likely to support those with a stigmatized identity: those who share the identity, and those who are “wise” (Goffman 1963). The wise person could be one of two types: those who work with individuals with stigmatized identity and those who are “related through the social structure to a stigmatized individual—a relationship that leads the wider society to treat both individuals in some respects as one” (Goffman 1963:30). Thus the stigma of one individual is in a sense transferred to his or her connections. Given this conception, children of mentally ill parents must contend with a potential courtesy stigma of their own in which they must navigate whether or not to share this identity and thus risk facing social the consequences. Several authors have addressed the issues of courtesy stigma as it relates to family members of the mentally ill (Angermeyer, Schulze, and Dietrich 2003; Corrigan and Miller 2004; Haug Fjone et al. 2009; Hinshaw 2005; Phelan, Bromet, and Link 1998). In these studies, family members - including children - discussed fears of contamination and social isolation because of their loved one's illness.

Comparison to Peers

Children develop understandings of their own lives and parents through comparison. Several studies point to the feelings of difference and frustration that children of parents with mental illness encounter when comparing their lives to those of “normal” families. In their study, Mordoch and Hall (2008) found that younger children, who had fewer modes of comparison, were less likely to be concerned about how their family deviated. However, the older children, who were able to observe and analyze the family interactions of their friends, were much more critical of their family and frustrated by the ways in which they did not live up to expectations. In an interview-based study with children ranging from age 8-22, Haug Fjone et al. (2009) identify five steps through which children begin to realize that their family differs from the norm. These steps include:

1. The child takes the parents’ behaviour for granted, not comparing it to any standard.
2. The child starts to wonder what is going on, and whether their own situation differs from other families. They make social comparisons.
3. The differences turn into deviances when the child compares him- or herself to peers.
4. The child spends a lot of time wondering whether this is something they can talk to others about.
5. The child is able to verbalize and talk about the differences and deviances (467).

Once the children acknowledge that their family differs, “they strive to show that their lives are similar to their peers’ ‘normal’ lives. This could result in using different actions in order to be looked upon as ordinary children and ordinary pupils at school and not to be associated with their parents’ mental health distress” (Haug Fjone et al. 2009). As children get older they are more likely to interact with a

variety of family forms; in almost all of the studies of children of parents with mood disorders, they often interpreted their experiences to be well outside of the norm.

Young Adulthood

The vast majority of research that examines the impact of growing up with a parent with a mental illness focuses on children and adolescents. Recently, several studies have begun to explore the impact of parental mental illness on young adults. Kaimal and Beardslee (2010) conducted 16 interviews with children of mentally ill parents, starting at age 17 and at three different time points to see how their perspectives on their parents' illness changed over a two-year period as they matured. They found that some respondents were less angry and frustrated at age 19 compared to their feelings at 17. Instead they displayed kindness, compassion, and understanding, while others discussed limited-to-no change, and others continued to manage ambivalence toward their parents and their illness (Kaimal and Beardslee 2010). Abraham and Stein (2012) investigated the experience of caregiving for mothers with affective disorders among children between the ages of 18 and 30. They found that "emerging adults with mothers with affective disorders reported less affection, felt obligation, and reciprocity and more experiences of role reversal in their relationships with their mothers" in comparison to those who had mothers with no affective disorder (Abraham and Stein 2012:546). Many of the experiences that researchers have documented continue to persist into young adulthood.

Adulthood

Researchers have also examined the experiences of children with a mentally ill parent by asking older adults to retrospectively reflect on what it was like to grow up with a mentally ill parent (Karp 2001; Nathaniel 2007; Secunda 1997). However, most “children” in these studies represent a wide range of ages and life experiences and make it difficult to draw any conclusions about the role lifespan stage may play in response to a parent’s illness. Murphy et al. (2011) conducted a qualitative meta-synthesis of adult children with mental illness looking specifically at qualitative research that had explored this issue. The synthesis identified key patterns and found that adult children described the relationships with their parents as difficult and confusing. Adult children struggled with parental absence, feelings of isolation, and lack of support, parentification, and difficulty trusting others. However, at the same time, respondents in these studies also discussed positives, including: increased creativity, resiliency, and personal growth (Murphy et al. 2011).

Finally, the amount of research focusing on those who care for the mentally ill has also increased. The majority of this research focuses more specifically on spouses and parents and emphasizes the increased burden they face in providing care, given the chronicity and unpredictability associated with many brain disorders (Champlin 2009; Karp 2001; Loukissa 1995; Perlick et al. 2007). Karp's (2001) in-depth study of family members of the mentally ill examines the constant boundary renegotiation that occurs as family members work to decide how much

they owe their ill relative and how much they owe themselves. He further argues that mental illnesses differ from other chronic illnesses because “with greater frequency than for most physical illnesses, mentally ill persons will reject medical diagnoses, will refuse to participate in efforts to become well, will be angry and hostile toward caregivers, and will be unable to express gratitude for the care they receive” (2001:68). Families cope with these feelings and experiences through a variety of strategies primarily centered finding ways to feel “normal” (see Rose, Mallinson, and Walton-Moss 2002 for review). While some families are able to set and maintain boundaries and others accept that they will have to loosen or cut ties with a mentally ill family member, very few studies have explicitly examined what it means to be a young adult, attempting to establish independence and identity, while still being connected to a mentally ill parent. Before moving on to explore current research on the transition to adulthood - specifically the role of parents, I will introduce the importance of the concept of stigma for young adult children of parents with mood disorders.

The Transition to Adulthood

Historically, and even today, adolescence and young adulthood have been framed as a time of uncertainty or a “problematic life stage in modern society” (Furstenberg 2000). Recently a New York Times article asked “What is it about 20-Somethings” and explored why it takes today’s young adults “so long to grow up?” (Henig 2010). Both journalists and researchers seem to agree that the transition to adulthood is “ambiguous and generally occurs in a gradual, complex, and less

uniform fashion” than in the past (Furstenberg, Rumbaut, and Settersten 2005:5). Access to jobs and education is shifting, the availability of long-term affordable housing is shrinking, and both men and women are making new decisions about if and when to marry and have children. While researchers in various disciplines have acknowledged and explored these shifts, how they actually conceptualize and measure the transition to adulthood differ. Many studies of youth today look at discrete events or “markers” separately (Furstenberg 2000; Shanahan 2000). In his review of the pathways to adulthood, Shanahan identifies five key markers of adulthood including: “leaving school, starting a full time job, leaving the home of origin, getting married and becoming a parent for the first time” (2000:667). Researchers have also begun to focus on the importance of financial independence (beyond job securement) (see Danzinger and Rouse 2007). According to Shanahan et al. (2005) the field of psychology has emphasized individuals' use of cognitive, emotional and behavioral markers of adulthood such as being able to accept responsibility for one's actions or make decisions independently (e.g. Arnett 2004) while sociologists and demographers still draw on these key family transitions. They find that youth generally feel like an adult at work, home, and with their children and romantic partner, but are also less likely to feel like an adult among their parents and their peers. Those who had “experienced the family transitions— independent household, getting married or cohabitating and becoming a parent— were twice as likely to report feeling like an adult” (Shanahan et al. 2005: 249). In addition, young adults who experienced hardship (differing family structure,

economic hardship, and perceived lack of safety) in childhood or adolescence generally reported higher subjective ages (Johnson and Mollborn 2009).

The majority of these studies rely on large-scale survey data, which is useful in investigating broader patterns and trends, but do not provide extensive information on the processes associated with the transition to adulthood. One exceptional study, which relied on in-depth semi-structured interviews and synthesized concepts from the various disciplines and theoretical approaches above, found that demographic milestones did matter for young adults' perceptions of adulthood and were also used in personal narratives (Hartmann and Swartz 2006). Rather than focusing on any single event, the respondents defined adulthood as an “accumulation” of roles:

When asked to talk about their adulthood in their own terms, young adults used the language of independence, maturity, autonomy, and responsibility, but almost always tied these concepts to social roles and statuses, experiences with others, and involvement in other and often new social positions and relationships (Hartmann and Swartz 2006: 262).

The young adults in this study saw the transition as non-linear. Drawing from large- scale surveys and qualitative interviews with youth (including data from Hartmann and Swartz) researchers have begun to examine the role that local context and normative expectations play in young adults conceptualization of the transition to adulthood (Waters et al. 2011). Even though some of the respondents in the Waters et al. study, which included youth in small town Iowa, Minneapolis/St. Paul, the New York metro area and immigrant children in San Diego, held to “traditional” norms of adulthood, most “young people were far more

creative in the cultural scripts they adopt to think about what adulthood means” (Waters et al. 2011:15).

Social Class and the Transition to Adulthood

Despite a variety of ways to measure and understand the processes connected to the transition to adulthood, many researchers posit the foundational role that social class plays in the transition. Using traditional role markers, young adults from middle to high SES backgrounds are more likely to attend college (see Breen and Jonsson 2005 for review), are more likely to get married, but do so later (Edin and Kefalas 2005) and postpone childbearing (Glick et al. 2006). However, as discussed above, while young adults still rely on these key markers, they also create more subjective understandings of adulthood. Young adults from poor and working class families are more likely to feel as though they have grown up faster, a process that researchers refer to as subjective aging (Benson and Furstenberg 2006; H. Foster, Hagan, and Brooks-Gunn 2008; Johnson and Mollborn 2009). Young adults in these situations take on more responsibilities in their families (Burton 2007; Johnson and Mollborn 2009). Drawing on family therapy literature on parentified children of divorced, chronically ill, and alcoholic parents, Linda Burton (2007) refers to this process as “adultification”. In these instances, children living in persistent poverty who are adultified, “precociously do the “heavy-lifting” in families (e.g., “parenting” one’s parents or siblings) with the intent of meeting a specific family need. In many instances, unlike the hurried child, adultified children receive limited guidance in performing their tasks.” (2007:331). The acceptance of these

responsibilities pushes adolescents and young adults into adulthood at a faster rate than their higher-class peers. Inherent in conversations of social class and the transition to adulthood is role that parents play in this process.

The Role of the Family

Researchers focusing on the transition to adulthood posit that parents may now be “parenting” longer than in the past (Nelson et al. 2010). Much of this literature has demonstrated that a positive relationship with parents can lead to beneficial outcomes for young adults (Barry et al. 2007; Kenny and Sirin 2006; Leondari and Kiosseoglou 2002). During the age of young adulthood (18-34), parents continue to offer both emotional and practical support. In general, this support appears to help young adults either to bolster their current plans or goals (scaffolding) or provide help during times of need (safety net) (Swartz et al. 2011). This support decreases as children get older and would best be described as situational rather than consistent. In addition to continued support, because of increased technology, children and their parents are generally in greater contact than they were in the past (Fingerman et al. 2012). These close relationships continue on into adulthood and are often motivated by affection rather than a simple sense of duty (see Swartz 2009 for review). However, not all relationships are beneficial for children and negative relationships are just as likely to persist as positive ones. Musick and Meier argue that close relationships with both mothers and fathers are important for young adults, but that the mother-child relationships seemed to matter more and persist over the life course, “with specific features of

earlier relationships, that is, closeness, time together, and negative interactions, carrying into young adulthood” (2012:117). Given these variations, Johnson and Benson (2012) argue that researchers must examine multiple dimensions of parent-child relationships and the role these play in supporting or complicating the transition to adulthood. As illustrated above, parent-child relationships are connected to issues of social class. Johnson and Benson’s (2012) findings indicate that adolescents from higher SES families believe they are more successful than their peers, partially because their parents are able to continue to provide financial support (Johnson and Benson 2012:101). Lareau and Weininger (2008) also demonstrated how social class not only affects the material resources that parents transmit to their children, but how parents’ cultural knowledge and approach to parenting can have real consequences for children’s college application process. Class not only matters for the influence it plays in childhood but also as children continue to transition to adulthood.

Stories and Culture: Looking At Young Adult Experiences In a Different Light

Mental health researchers have begun to demonstrate the impact that growing up with a parent with a mental illness has on adults, and life course scholars and those interested in the transition to adulthood are examining the increasing role that parents play during the transition to adulthood. Indeed, exploring the impact of parental mental illness on young adult transitions is important and more research needs to focus on the consequences of this process.

However, as researchers in both fields point out, more research is also needed to explore the subjective experiences of young adults and children of parents with mood disorders. Consequently, the goal of my research is not to simply document the experiences of young adult children who have parents with a mental illness. Instead, my dissertation seeks to explore the stories that young adults tell about growing up with a parent with a mood disorder. As discussed above, the transition to adulthood is viewed as a time when young adults begin to construct lives and identities separate from their families of origin. This process of differentiation can follow a variety of pathways, but one of the main ways in which children create identities is through the stories that they tell. Sociologists and psychologists have recognized the importance of narratives (stories) in the creation and understanding of identities and the self (Bruner 1994; Irvine 1999; McAdams 1993, 2001; Wilkins 2012). Individuals use stories to make sense of experiences and emotions. Even though the content of the stories may focus on the experiences of the individual in everyday life, these narratives are “susceptible to cultural, interpersonal and linguistic influences” (Bruner 2004:694). In other words, stories can be thought of as a reflection of “real experiences” or as tools that individuals use to “entertain, to illustrate, to instruct, to envision alternatives, to comfort, to dramatize, to help us live with the contradictions that are an unavoidable feature of existence, to grasp temporality, to feel” (Polletta 2006:11).

Stories gain substance through their use of cultural images and understandings (Bruner 2004; McAdams 1993; Polletta 2006; Wilkins 2012). They

are “a means by which cultural meanings are accessed, reproduced, and challenged” (Wilkins 2012:3). And the stories that are strongest are ones that draw on other cultural stories that will resonate with an audience (Polletta 2006). Sociologists have defined culture in a variety of ways. In this dissertation I rely on a view of culture similar to Ann Swidler who draws on the work of Ulf Hannerz and Clifford Geertz to argue that culture is “social processes of sharing modes of behavior and outlook within a community” (Hannerz as cited in Swidler 2001:12) that relies on “symbolic vehicles (rituals, stories, sayings) in creating and sustaining those modes of behavior and outlook” (Swidler 2001:12). Previously, Swidler has argued that culture can be thought of as a tool kit that provides individuals with a set of ideas and understandings that they can use at any given time to make sense of their experiences (Swidler 1986). However, Swidler argues that while individuals use culture as a tool kit, the metaphor of a repertoire may better describe this process (2001). In this view, culture is like a “set of skills, which one can learn more or less thoroughly” and that “cultural symbols, rules or rituals only sometimes “work” for people (2001:25). Individuals may use some parts of their repertoire more than others, they may use certain repertoires at different times and with different people, and they may use the same repertoire to solve different problems.

In my dissertation, I examine how my respondents draw on particular repertoires through the stories that they tell. The respondents in my study are in a unique position, as many of them at some point experienced the adultification that some young adults growing up in poverty encounter. However, the majority of my

respondents grew up in lower-middle to upper-middle class families or communities and were either currently studying or had studied at four-year colleges or universities that emphasized middle-class ideals. Growing up in these institutions, my respondents not only learned about the cultural norms of middle class families, but also compared their experiences to their middle-class peers. While much of the work focused on exploring the “subjective experiences” of children and young adults of parents with mood disorders have used qualitative interviewing as a chance to document the “real experiences” and “real lives” of children of a parent with a mood disorder (Mordoch and Hall 2008; Mordoch 2010; Trondsen 2011), I use my qualitative interviews as a chance to explore how my respondents use middle-class stories about parents, childhoods, relationships, the transition to adulthood, and mental illness to make sense of the challenges of growing up with a parent with a mood disorder. At the same time, I explore how my respondents use the stories they generate from these cultural ideas to give meaning to or justify their life decisions. By treating my data in this way, I am not saying that my respondents’ experiences are not real, but instead look at when and how they use culture to interpret their experiences and what they lose and gain in this process.

Chapter Organization

In the chapters that follow, I explore the stories that my respondents told me about growing up with a parent with a mood disorder. In chapter two, I address the methodological issues associated with recruiting and interviewing an invisible population. In addition, I also explore my own relationship to the research as a child

of a parent with a mood disorder. In chapter three, I show how my respondents made sense of the impact of their parent's illness through comparison to middle-class ideals of parenthood and childhood, and their own observations of their peers' relationships with their parents. These comparisons emphasized one particular idea of parenthood and the importance of a protected and innocent childhood. In chapter four, I extend the cultural stories used in chapter three to explore how my respondents, who felt their experiences were invisible or misunderstood, relied on a specific narrative to make sense of their experiences and the transition to adulthood. In chapter five, I examine how my respondents used their parent's illness to explain their relationship choices, including the benefits and limitations they encountered by talking about their experience in this particular way. In chapter six, I introduce case studies of four cross-gender sibling pairs to explore the role that gender plays in how respondents understand and discuss their experiences. Finally, in chapter seven, I discuss the implications of this study for how we understand children of parents with a mental illness and the importance of examining the role that culture plays in shaping how individuals interpret and talk about their families and the transition to adulthood.

CHAPTER TWO

METHODS

The young-adult children of parents with mood disorders are not an easily identifiable group. They don't share a common space or common identity, and some may not even identify themselves as children of parents with mood disorders. Those who do acknowledge their parent's illness may only do so to close friends or family, and in general, it is not information most young adults will share with a stranger. Even though support groups do exist for family members who are affected by mood disorders, most of the attendees are parents who have children who have been diagnosed. In my early fieldwork, I attended three different support groups for those affected by mental illness in the area, but I only twice encountered young adults who were there because of their parents. Given the invisibility of this population, my primary goal for this project was to use my interviews as a way to explore the ways in which young adult children of parents with mood disorders talked about their experiences and how the stories they tell are shaped by broader cultural ideas about parenthood, childhood and the transition to adulthood.

Recruitment

I recruited my initial interview respondents through my own social networks, including acquaintances whom had disclosed their parent's illness to me. I also presented some of my initial research in a colleague's class and had several students approach me with an interest in participating. During this time, I placed my first two advertisements on two city Craigslist volunteer sections. Through

these advertisements, I recruited several respondents who had come across my ad in their search for volunteer opportunities. I slowly recruited more respondents through Craigslist with increasingly specific advertisements.

During one spring semester, I attended five sociology classes to announce my project and ask for participants. Respondents said they enjoyed being able to hear about my project and that seeing me in person helped make it easier for them to decide to participate. As this process began to slow, I learned of a research listserv for one of the local universities. This listserv reached students, faculty, and staff who had expressed interest in participating in primarily health-based research studies. Over a quarter of my respondents were recruited through this method. Respondents from this listserv represented a broader age range and also had more varied educational achievements.

My recruitment for the second half of my project shifted after a conversation I had with a local pastor whose congregation had been active in mental health education and advocacy. He suggested that the individuals he knew would be much more willing to participate in my study if they knew that they would be talking to someone who was also a child of a parent with a mood disorder. After this conversation, I modified my recruitment materials to include a brief discussion of who I was and my motivation for my project: “I am a doctoral student at the University of Colorado and my mother was diagnosed with bipolar disorder when I was three years old. I am pursuing this research because of my own experiences and conversations with other children who feel like their stories and experiences were

often overlooked.” This strategy proved to be extremely effective. Well over a quarter of my respondents said they would not have even considered participating in this study without this information. I discuss this in more detail below.

Participants

I conducted semi-structured interviews with 50 young adults between the ages of 19-34 who had a parent with a mood disorder (see Table 1). 43 of my 50 respondents identified as white, six identified as multiracial with one white parent, and one identified as a South Asian immigrant.

Table 1: Participant Characteristics		
Gender		
Women		39
Men		11
Race		
White		43
Asian		1
Multi-Racial		6
Age Category		
18-24		22
25-29		18
30-34		10

All of the respondents I recruited for this project self-reported that they had a mother or father who had been officially diagnosed with either major depressive disorder or bipolar disorder (I or II) by a medical professional³ (see Table 2).

³ I had several respondents who helped to recruit their siblings into the study. I discuss this below and in chapter 6. In a few cases, the siblings were not clear on when or if an actual diagnosis had been made.

Table 2: Parental Diagnosis

Parental Diagnosis*	
Severe Depression	27
Bipolar Disorder	30
Diagnosed Parent	
Mother	28
Father	18
Both	4
Respondents' reported age of awareness of diagnosis	
Under 10	9
10-12	12
13-15	13
16-18	6
18+	4
"Have always known"	4
Unsure of diagnosis	2

*Numbers are not mutually exclusive as some respondents had parents with multiple diagnoses and some respondents had two parents who were diagnosed

I chose to focus on mood disorders for several reasons. Mood disorders often lead to non-normative behaviors and feelings, and (as discussed in the introduction) are often the focus of studies exploring the impact of mental illness on children. In order to be diagnosed with major depressive disorder, individuals must have experienced at least one depressive episode but no manic, hypomanic, or mixed episodes (discussed below). A major depressive episode is diagnosed as having depressed mood or loss of interest or pleasure and at least four of the other symptoms listed below during the same two-week period. In addition, this behavior should be seen as a change from previous behavior:

- a. “depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad or empty) or observation made by others (e.g., appears tearful)
- b. markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
- c. significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
- d. insomnia or hypersomnia nearly every day
- e. psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
- f. fatigue or loss of energy nearly every day
- g. feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
- h. diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
- i. recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide” (American Psychiatric Association 2000b). ⁴

In addition, these symptoms must “cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. The symptoms are not due to the direct physiological effects of a substance or general medical condition and the symptoms are not better accounted for by bereavement...the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation” (American Psychiatric Association 2000)

⁴ The DSM-IV was released in 1994. There was a text update in 2000, but the next Diagnostic and Statistical Manual is currently being updated and will be released as the DSM-5 in 2013.

Bipolar I disorder is diagnosed with the presence of at least one manic episode but can also include episodes of hypomania and major depression. A manic episode is defined as “a distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary). During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable and have been present to a significant degree:

- a. inflated self-esteem or grandiosity
- b. decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
- c. more talkative than usual or pressure to keep talking
- d. flight of ideas or subjective experience that thoughts are racing
- e. distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
- f. increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
- g. excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments) (American Psychiatric Association 2000).

In addition, the symptoms must not meet criteria for a mixed episode. The mood disturbance is “sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features” (American Psychiatric Association 2000). Similar to the depressive episode, the symptoms must not be caused by drug abuse, reactions to medication or other medical treatment or another medical condition. Individuals who are diagnosed with Bipolar II may meet similar criteria as those discussed above, however rather than manic episodes, they may experience episodes of hypomania.

In contrast to manic episodes in Bipolar I, a hypomanic episode “is not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalization, and there are no psychotic features” (American Psychiatric Association 2000).

I included both depression and bipolar disorder for several reasons. First, both depression and bipolar disorder can lead to disruptions in expected parenting styles because of unexpected changes in moods and behaviors. Parents with bipolar disorder or major depression are also more likely to demonstrate increased irritability, anger or agitation (Fawcett, Golden, and Rosenfield 2007). All of these effects can have real consequences for the psychosocial functioning of a household. Secondly, depression has been studied more frequently than bipolar disorder, but the term “depression” has been conceptualized and measured in a variety of ways and many studies that do measure depression do not make distinctions between respondents who do and do not experience mania as well (Bruce 1999).

Consequently, some children whose parents may be bipolar might actually have only ever received a diagnosis of depression. In addition, bipolar II, which is similar to bipolar I except that the manic episode is marked by the presence of hypomania (generally less intense) instead of a mania, is often diagnosed as major depression (Fawcett, Golden, and Rosenfield 2007). Consequently, there was potential overlap between these two diagnoses that would be lost by limiting the sample to either depression or bipolar alone. My respondent’s stories validated this decision as some had parents who had been diagnosed with one diagnosis earlier on

in their lives only to have the diagnosis change as they got older. Finally, I included both diagnoses in an attempt to ensure an adequate gender distribution between mothers and fathers who had been diagnosed. Major depressive disorder is more commonly diagnosed in women than in men (Kessler et al. 2003). However, both men and women experience similar rates of bipolar disorder, although women are more likely than men to be hospitalized (Hendrick et al. 2000). Consequently, in order to be able to examine the role that the gender of the parent plays in children's narratives it was important to have access to both populations.

The severity of a mood disorder can vary quite widely; however, my pilot data pointed to common narratives across these variations, which my data also support. Given my pilot data, I decided against sampling based on severity as the only objective measure I could use would be hospitalization and knew that criteria would limit the population I was interested in. The majority of my respondents did not have parents who were institutionalized; despite this, they still talked about the impact their parent's mental illness had on their lives. Throughout this process, I was less interested in knowing definitively whether parents matched the clinical diagnosis of depression or bipolar disorder. Instead, I was more interested in how children who were aware of a parent's diagnosis used it to make sense of their experience. My initial sampling criteria specified that children must have been aware of their parent's illness by the age of 16 because I was originally interested in the impact of mental illness in a household. However, as it became clear that many of my respondents were focusing their narratives on how their parent's illness

influenced their lives today regardless of when they found out, I removed this restriction. Nevertheless, the majority of my respondents were aware of their parent's illness by the age of 16 (see Table 2) and most said that they began to notice symptoms or behavior that they later understood to be connected to their parent's illness in their early childhood.

My respondents' ages ranged from 19-34. The average age of my respondents was 25.7. Because I was interested in how young adult children throughout the transition to adulthood make sense of their parents' illness, I divided the sampling strategy for my respondents into three groups following the work of Rumbaut and Komaie (2007). These groups are: young adults in early transition (18-24), young adults in middle transition (25-29), and young adults in late transition (30-34). I collected data from 22 respondents between the ages of 18-24, 18 respondents between the ages of 25-29, and 10 respondents between the ages of 30-34. While these ranges were useful in pulling a balanced sample, the ages of my respondents did not always match the expected experiences of my respondents, as I had some who graduated college early, others who started college late, some who married early and other who never planned to marry. These norms did not neatly break down by the transition periods discussed by Rumbaut and Komaie (2007).

I had hoped to achieve a gender balance between men and women respondents. However, I had difficulty recruiting men. Researchers have demonstrated the difficulty of recruiting men into qualitative interview studies, especially about health (Brown 2001; Oliffe and Mróz 2005). Schwalbe and

Wolkomir describe the qualitative interview as a potentially threatening endeavor for men because “the interviewer controls the interaction, asks questions that put these elements of manly self-portrayal into doubt, and does not simply affirm a man’s masculinity displays” (2001:91). While Schwalbe and Wolkomir’s arguments may be connected to some of the challenges I faced, my data also suggests that women may be more likely to identify themselves as being a child of a parent with a mood disorder and are more likely to use their parent’s illness to understand life decisions. After years of researching men’s health, Oliffe and Mroz (2005) argue that recruiting men for interviews related to health is best done in person or through referrals from friends, colleagues, or partners. I was able to recruit several men using this strategy. I also heard stories from sisters who described brothers who were either unwilling to “deal” with their parent’s diagnosis or who simply did not want to share their emotions. I discuss the implications of this in more detail in chapter six. My final sample consisted of 39 women and 11 men.

My respondents were the children of 18 diagnosed fathers and 28 diagnosed mothers. Four respondents had parents who were both diagnosed with a mental illness--usually one parent with depression and one with bipolar. These respondents tended to focus on the illness of one parent and talked about their experiences in ways that were similar to the other respondents in the study. My respondents shared their stories from early childhood up to the present day in our interview and thus described sometimes changing family structures. 27 of my 50 respondents had parents who were currently still married to each other. In three of

these cases, parents got divorced and subsequently remarried each other. Three of my respondents grew up in strictly single-mother households in which their mother had been diagnosed. Of these, one respondent still had contact with her father. Another respondent had no contact with her biological father, but grew up with her diagnosed mother and stepfather whom her mother married when she was four. Fourteen of my respondents came from divorced families. In four of these instances the divorce occurred in my respondents' late teenage years, so participants spent the majority of their childhood in two-parent households. In the remaining households, parents had gotten divorced by the time the respondent reached the age of 10. In four of these households, the mother was already diagnosed, and at the time of divorce the respondents' fathers gained custody - although all children continued to have contact with their mother through most of their childhoods. In the other four, children remained with their diagnosed mother after their parents' divorce with three of the four children continuing some contact with their father. Finally, in one household, the children were split between parents - both of whom were diagnosed. The remaining five respondents grew up in married households but had experienced the death of one of their parents. Despite the diversity of family forms in my sample, there was significant overlap in the ways in which my respondents discussed the impact of their parent's illness. I examine these dynamics in depth in chapter three.

The sample was generally well educated. All respondents in my sample had completed high school or received a GED and all had at least some college

experience (see Table 3). Over half of the respondents in the sample were currently in some type of degree-seeking program at the time of their interview. Their selection was primarily connected to my recruitment methods, which included two major universities and a more general sampling in a college-town with one of the highest ratios of advanced degrees.

Table 3: Education Demographics	
In College	17
Some College	5
Associates	2
BA/BS	10
Currently in Advanced Degree Program	9
Achieved Advanced Degree	7

By focusing on this population, I was hoping to move beyond the conceptualization of children of parents with mood-disorder as being “at-risk” by specifically being able to tap into respondents who had successfully graduated high school and were working on completing college-level coursework. I was also able to explore specifically how white, middle-class cultural expectations are used to understand the experience of growing up with a parent with a mood disorder through recruiting that focused on respondents who were either solidly middle class or who had been exposed to middle class ideals and peers within the education system.

Over half of my sample was in some form of romantic relationship at the time of our interview and most were either living with their partner or with roommates (see Table 4). The majority of my sample identified as heterosexual. Four of my 50

respondents were still currently living with their parents. Eight of my respondents already had biological children, one was expecting and one would soon be living with her fiancé's son.

Table 4: Relationship Status and Living Situation	
Single	18
Dating/Partnered	15
Engaged	2
Married	12
Separated/Divorced	3
Married/With Family	14
Alone (or alone with Children)	13
Roommates	12
With Partner	6
With Parent(s)	4
With sibling	1

Some of my respondents had been diagnosed with some type of mental illness. Several had received their own diagnosis of depression or bipolar disorder, but the most common diagnosis was anxiety disorder. While some respondents did discuss the impact of their own diagnosis, it was not the central explanatory strategy they used when discussing the themes I explore below. In addition, I did not specifically ask all respondents if they had been diagnosed with a mental illness as it was not the goal of this study, and I did not request IRB approval to explicitly collect this information. However, the respondents who had been diagnosed themselves talked about these themes in similar ways to those who had disclosed they had never been diagnosed. Consequently, I do not link specific diagnoses with the respondents that I introduce in the following chapters.

Sibling Recruitment

I initially did not plan to specifically recruit siblings for my project. However, in my first interview, my respondent spent a significant amount of time talking about the differences between how she and her siblings talked about and responded to her father's mood disorder. This pattern continued over the next five interviews, so I contacted my first respondent to see if she would be willing to share my contact information with her sister. A little over a month after my interview with my first respondent, I interviewed her sister. After this first pair, I began asking my respondents to share my contact information with their siblings who were within the 18-34 age range to see if they would be interested in participating. In total, I recruited nine sibling-pairs. The recruitment was informal, so I do not know for certain if respondents actually shared my information with their siblings and/or their siblings opted not to participate. In only one case did a respondent tell me that her sister was not interested in participating. She explained that her older sister felt that sitting down to talk to a "stranger" about their mother's mood disorder would be a betrayal of her mother's confidence. I recruited four cross-gender sibling pairs, one pair of brothers, and four pairs of sisters. In each of the cross-gender pairs, the sister was the one who initially volunteered for the interview and then recruited in her brother in to the project. I describe these interviews in depth in chapter six.

Shared Experiences and Sharing Stories

My interest in mood disorders began at the age of nine. My mom had been diagnosed with bipolar disorder when I was three years old, and as I grew older I was intrigued by both the biology of mental illness and how people responded to it. My mom was very open with me about her illness, and I can recall interviewing her psychiatrists for school projects and being able to clearly articulate what her symptoms and their effects might be. As a child and an adolescent, my mom's illness could be classified as "severe": she was hospitalized multiple times and suffered from intense manic episodes that sometimes resulted in hallucinations and delusions that were difficult to understand and respond to as a young child. Despite her illness, my mom was a wonderful mother and when my parents divorced, I wanted to continue living with her. As difficult as it was for my dad, he knew how much I loved my mom and was concerned about the consequences of severing our relationship. Consequently, I spent most of my adolescence living with my mom and the effects of her mood disorder.

My mom did not hide her illness from those around us, but it was also not something that we publicly broadcasted. In spite of that, many of my teachers and school staff were aware of her diagnosis and were able to be supportive and involved when she experienced an extreme episode. I was also fortunate to have wonderful godparents and parents of my close friends who stepped in to offer their support and sometimes even their homes when my mom was hospitalized. My dad lived 800 miles away but did what he could to help as well.

As I started college and began taking sociology classes, I began to think about others who were like me. Up until then, I had never met a peer who I knew had a parent with a mood disorder. I wanted to know if my experience was similar or different. I attributed much of my success to the support system that I had, particularly in school, so I framed my honors thesis research around an investigation of the support systems that college-aged children had while growing up. I interviewed 10 college students who had a parent with a diagnosed mental illness. In those 10 interviews, it became clear that my experience was distinct in key ways. In particular, most of the people I interviewed did not share information about their parent's illness as easily as I did. Accordingly, my focus turned from the supportive role that schools could play to the role of family dynamics and communication. The information I gained in my thesis research provided a useful foundation for thinking about this current project, but as I developed the project, I was less interested in simply telling the story of what it was like to grow up with a parent with a mood disorder. Instead, I was fascinated by the way my respondents used their experiences growing up with a parent with a mood disorder to make sense of and explain their current lives. Below, I further discuss the benefits and limitations of studying a group whose experiences were so similar to my own.

I identified myself as a child of a parent with a mood disorder during recruitment or before the interview began. My decision to disclose was a conscious one. Feminist research has a rich history of reflexivity (DeVault 1996; Hertz 1997) and some ethnographers have argued for the utility of studying topics from the

inside. Ellingson (1998) details her experience as a cancer survivor studying cancer survivors in a clinical setting. She describes how having the ability to empathize with her respondents allowed her to be a better researcher, as she was able to give her respondents room to talk and to feel. In turn respondents seemed to trust her and give her more credibility because of her own experiences. Chavez (2008) documents the advantages of being an insider in the field, including being able to understand respondents in a more complete way, being able to gain easier access to respondents, and gathering information and building rapport more easily. However, she also highlights that being an insider can create complications including:

Requires large amounts of impression management to maintain rapport and identity; observer and/or participant role may be culturally inappropriate; difficulty with recognizing patterns due to familiarity with community; bias in selecting participants; breaking or maintaining relationships with participants when leaving the field; community interaction style compromises interview process or observation; and overload with exchange or reciprocity requests from participants (Chavez 2008:479).

Many of the issues that Chavez discusses are important considerations when spending extensive time in the field. However, because I only interviewed respondents once, I did not encounter most of these problems, especially since young adults in my population generally do not interact with each other and would not consider themselves a community.

My decision to disclose my identity was further supported by my previous pilot work. In my previous work, I disclosed my positionality at the beginning of my interviews to 6 of the 10 respondents I interviewed. The difference between these interviews was striking. The six respondents who knew about my mom early on

often spoke for longer, revealed a broader range of emotions, and gave richer and thicker descriptions. This process was confirmed with my current research as a large portion of my respondents said they felt more comfortable and could be more “honest” because they knew they were talking to someone who “understood.” In the post-interview debriefing at least seven respondents told me that they would not have agreed to participate except for the fact that they knew I was a child of a parent with a mood disorder. Norum (2004) summarizes what can be gained from this approach:

If we have experienced what we are studying, some of what we are finding will echo with our own thoughts and experiences (Hertz, 1997). This does not mean we indubitably “contaminate” (Krieger, 1991) our research. Rather, it may mean we bring a new dimension to our research, a level of understanding that may not be there otherwise (Adler and Adler, 1997; Charmaz and Mitchell, 1997; DeVault, 1997; Hertz, 1997; Krieger, 1991; Pierce, 1995) (Norum 2000:334).

My own disclosure was a useful tool both for recruitment and for establishing rapport. However, because my respondents identified me as someone who would “understand,” it is possible that they crafted their stories in ways that highlighted the difficulties and frustrations they faced that they might not have shared with an outsider for fear of stigma or misunderstanding. At the same time, it is possible that they assumed a shared understanding between us and so failed to more explicitly discuss specific events and their interpretations of these events. Consequently, what I am able to capture in my data is an exploration of how my respondents created their stories within the context of our interview, and how some of the cultural ideals that they relied on are not only representative of their social location

but also an attribute of the assumptions they may have made about my own experiences, age, and class background. Below I address my analysis style and the impact my own identity played in analysis.

Analyzing Stories

I viewed my data collection and analysis through the concept of active interviewing (Holstein and Gubrium 1995). The active interview treats the interview process as a collaborative meaning-making process:

The interviewer's background knowledge can sometimes be an invaluable resource for assisting respondents to explore and describe their circumstances, actions, and feelings. Indeed citing shared experience is often a useful way of providing concrete referents on which inquiries and answers can focus (Holstein and Gubrium 1995:45).

Through active interviews, researchers can explore how respondents understand and make sense of topics they might not otherwise discuss in casual conversation (Holstein and Gubrium 1995).

When I began interviewing, I had a particular idea of the narratives young adult children of parents with mood disorders might tell. My own experience, pilot research⁵, and observational time in support groups for family members with mental illness pointed to the contradictory feelings and emotions surrounding growing up with and providing support to a parent with a mood disorder. Based on this information, I created a detailed interview guide (see Appendix A). However, after my first interview it became clear that what I was interested in was how respondents told their stories. Consequently, instead of allowing the guide to shape

⁵ The pilot fieldwork is not included in the analysis for this dissertation.

the interview, I relied on the strength of the active interview (Holstein and Gubrium 1995). I began each interview by asking respondents to tell me when and how they remembered learning about their parent's diagnosis and allowed the interview to progress from there. While I expected my respondents to spend a majority of their interviews talking about their childhood and their memories of growing up, after my initial interviews it became clear that my participants were much more interested in talking about how they saw their parent's illness influencing their current life choices and perceptions. I allowed my respondents to talk uninterrupted as much as possible, but at times I did interject with questions or probes based on the ideas in the interview guide.

Holstein and Gubrium (1995) refer to respondents' "stock knowledge" and that at any given time they may share or use only certain parts of their stock knowledge within an interview. This stock knowledge is similar to Swidler's cultural repertoires (2001). Through my interviews, I was able to meet respondents at a given time point in their lives and explore how they used different sets of "stock knowledge" with their "cultural repertoire" to make sense of what it meant to them to have a parent with a mood disorder.

Similar to the strategy used by Wilkins (2012), I analyzed my interviews with respondents as a case of storytelling that draws on specific cultural beliefs and expectations rather than a representation of the lived experiences of children with mood disorders. Within two days of completing my interviews, I wrote a 1-2 page summary of the interview describing the respondent's demeanor, the content of the

interview, and my own impressions during the interview. As I completed each interview, I also created data collection memos that detailed topics and ideas that arose in the interviews and how they related to each subsequent interview. I transcribed 34 of my interviews, including the first 25. During the transcription process, I created transcription memos focused on the themes that emerged from listening to the data. A professional transcriptionist transcribed four of the 50 interviews and semi-professional transcriptionist transcribed 12 of the 50 interviews. In the cases where another individual transcribed the interview, I re-listened to the interviews and added these themes to my observations. After the interviews were transcribed, I loaded the interviews into HyperResearch 3.0. Based upon my field notes and my notes from the transcription process, I generated an initial set of emerging codes (Corbin and Strauss 2008). As I finished data collection and began to analyze my interviews as a whole, I developed a set of more focused codes that I refined from the initial set of emerging codes and recoded the data again (Charmaz 2001). My analysis, however, did not stop with coding. While the codes laid the groundwork for my initial thinking, much of the analysis arose through the memos I wrote. In addition to the data collection and transcription memos discussed above, I relied on constant comparison (Charmaz 2006; Corbin and Strauss 2008; Glaser and Strauss 1967) and wrote memos concerning the themes that emerged during my analysis comparing how and when respondents discussed particular topics, both within and across interviews, and how these ideas related to broader cultural ideals.

Throughout the analysis process I was conscious of the role my own experiences would play in shaping how I interpreted the data. Many have raised the potential bias associated with analyzing data from an insider position (Van Heugten 2004; Hewitt-Taylor 2002; Kanuha 2000). However, all researchers approach their data with certain ideas and narratives that influence the way they interpret their data (McCorkel and Myers 2003). In many ways, my analysis of my respondents' stories was also a critical analysis of my own story that I told. While there were some similarities, I was also deeply focused on the differences. The two biggest differences arose in my decision to analyze how my respondents discussed their romantic relationships and their siblings. In my own narrative, I never drew connections to my experience with my mom and my relationship choices and consequently focused on my analysis on these stories. As an only child, I was fascinated by the ways in which my respondents discussed their relationships with their siblings and their perceptions of their sibling's responses to their parents' illness. Another possible issue that has been raised about insider research is that the researcher may be "too familiar" and consequently will miss the chance "for the mundane and ordinary to inform the study" (Labaree 2002:108). However, my experience was actually much more extreme than most of my respondent's. The vast majority did not have parents who were hospitalized as frequently as my mom and very few reported the same types of psychotic behavior. Consequently, I was fascinated to hear how they talked about what I perceived to be as more "mundane" experiences than what I had encountered but nevertheless interpreted the impact in

similar ways. Finally, my analytic approach was focused more on understanding my respondents' stories than documenting their experiences, so during the interviews and analysis I was focused more on how they were saying things rather than what they were saying.

Chapter Three

“I wanted a parent who...” Cultural Comparisons and Middle-Class Parenthood

Sitting in an outdoor café, Rebecca⁶ told me that she thinks her mother was probably diagnosed even before she was born, but she doesn't remember really learning about her mother's depression until she was a teenager and her parents separated. Now 27 and a mother, Rebecca began her story focusing on the unpredictability of her mother and her behavior:

[It was] definitely back and forth, never knowing when she was going to be okay with me versus not okay with me, really vacillating between having all this warmth and affection and holding me close to stay away, “I don't want anything to do with you, go watch T.V.” When I was a teenager, that's when it became really clear-cut. She would sometimes lock her door for like a month just to keep me out of her room while she was gone, and when she got home she would just go straight into her room and lock her door behind her and not really talk to me. Or she'd sit in front of the T.V. and not really talk to me. It was that, or she would be in this great mood, and she would wake up, put on music, be dancing around the house and wanting to dance with me and take me out to lunch, that kind of thing. I just never knew.

Rebecca lived with her mom after her parent's separation and says she constantly struggled with defining her role in the family:

I think I probably was aware of it when my parents separated, that I'm a child, I need to be having a childhood. But I was a child; I was confused, I didn't understand fully. So I would believe in one moment that I'm a child, I need my mom, and she needs to take care of me. And in another moment, it's like, this is my fault, I need to take care of her. I went back and forth.

⁶ All names have been changed.

She tells me that as a young adult, she sees her mom's illness influencing almost every facet of her life--from her sense of self, to her approach to relationships, to her plans for the future.

Some of my respondents told stories that were similar to Rebecca's, while others described parental behavior that they felt had a less intense impact in their lives. My respondents' parent's symptoms and the severity of their illnesses varied from those who had to be hospitalized multiple times to those who were consistently medicated but high functioning. The family dynamics and amount of social support my respondents received from friends and family also ranged from those who never talked about their parent's illness to those who went to family counseling and shared their experiences with their communities. Despite these differences, most of the young adults in my study described the relationship with a mentally ill parent as something that was complicated, emotional, and often frustrating, especially as they grew older. However, instead of using my respondents' stories to simply detail these feelings and concerns, in this chapter I use the experiences of my respondents and the stories they tell to explore how cultural expectations about parenthood and childhood in primarily white, middle-class families provide a frame through which respondents interpret their own experiences. My respondents used a variety of strategies in their narratives to respond to their parent's illness and faced challenges because of the specific assumptions about parenthood and childhood that structured their social worlds. I conclude this chapter by exploring how respondents

used the emotions and understanding that arose because of their parents' illness to explain their own feelings towards and decisions about childbearing.

What Makes a Good Parent?

Despite the vast diversity of families throughout history, Americans cling to specific ideas about what families should look like and the roles that children and parents play in those families (Stephanie Coontz 1992, 1996; Rosenfeld 2007). Expectations about parenting have shifted throughout history in response to economic and cultural changes (Coltrane and Adams 2008; Coontz 1992; Rosenfeld 2007). Researchers have also documented the racial, class, and ethnic differences in parenting and family forms that existed throughout history and today (e.g. Coontz, Parson, and Raley 1999). However, Pyke argues that the ideal of the "Normal American Family" is the pervasive storyline through which most people presently understand family. In this model, "American family ideals stress democratic rather than authoritarian relations, individual autonomy, psychological well-being, and emotional expressiveness" (Pyke 2000: 241). This contemporary notion of parenting relies on middle class norms and resources. Annette Lareau refers to this process as concerted cultivation in which parents "actively foster and assess child's talents, opinions, and skills," children's lives are organized around "multiple child leisure activities orchestrated by adults," parents provide directives as well as reasoning and there are "extended negotiations between parents and child," parents are willing to intervene within institutions on the child's behalf and children begin to feel an "emerging sense of entitlement" (2003:31). Lareau contrasts the model of

concerted cultivation, prevalent in contemporary middle class families with that of the accomplishment of natural growth, prevalent in most working-class and poor families. Families who utilize the accomplishment of natural growth model are more likely to “hang out” and play, often with relatives, are given clear directives from parents with limited negotiation, and are granted more autonomy to manage their own affairs in institutions outside of the home” (Lareau 2003: 32). Both of these models have benefits and drawbacks for families and their children. However, the ability to navigate social institutions and relationships with adults of those raised in the concerted cultivation model showed real advantages in Lareau’s follow-up work, especially in relation to the college application process (Lareau and Weininger 2008).

These narratives of parenthood are present throughout US culture. The media, “experts,” parents, and children themselves all play a role in creating and sustaining these expectations of parenthood. In her study of adult children of Korean and Vietnamese immigrants, Pyke (2000) found that her respondents wished their parents were “less strict and gave them more freedom; were more liberal, more open-minded, more Americanized and less traditional; were emotionally closer, more communicative, more expressive, and more affectionate” (246). Pyke’s respondents used these ideas about what parents “should” be like to understand their own childhood and by comparing their parents to this image labeled their own parents as “unloving, deficient, and not normal” (2000:251). Despite the vastly different historical and cultural models of families and ideas

about what is good for children (see Coontz 1992), these idealized notions of parenthood carry significant weight as a yardstick against which children measure their own experiences.

The young adults in my sample formed their narratives of growing up with a mentally ill parent by comparing their experiences to cultural ideals of a middle class parenthood focused on involvement, communication, and financial and emotional support. Of course the nature of mood disorders means that parents are sometimes unable to be involved, aware, or supportive and may also exhibit behavior that appears irrational or unexpected. The experiences of these behaviors can be difficult in and of themselves; for my respondents it was not just the behaviors, but also the fact that their parents were not like their friends' parents that compounded the difficulty. In many of the stories I heard, respondents relied on comparisons between their peers' parents who appeared to meet these relationship expectations and their parents, who they described as being unable to meet the demands of concerted cultivation. Comparing their own mother or father to their friends' experiences often led to feelings of jealousy:

Oh my god. It makes me want to cry. Like it makes my stomach hurt. I'm just so jealous. I am so jealous when I think about my close friends and the relationships they have with their mothers (Samantha).

I definitely still feel some jealousy, like with you know close friends and their relationships with their mom. Like on an emotional level that I don't have. Like, my boyfriend recently moved here this semester from (state) and you know he's older than I am, but he and his mom are really close and she calls all the time and like just checks on him all the time, like is coming up to visit next week for mother's day. She's just a very constant presence in his life even though they have the distance. I don't really feel that with my mom. Like...I don't know it's not like, like if something happens, she's not the first

one that I call. And I am kind of jealous of some people that have that relationship. I'm not angry with her because you know I understand that this has been a really long fight for her, and I think she's at a really good place, but it's still like that emotional connectivity that lacks, and I wish that was different. You know, I definitely had to be more sensitive with the way that we talked to her, or the things that I bring up with her (Sarah).

Over half of the respondent said they never could connect with their parents in the same way they believed their friends did. For these children, the relationships with their parents felt forced, superficial, or difficult to maintain. George, a 19-year-old college student, said he never felt close with his father and was often on-edge waiting to see how his dad would react to things. George's relationship with his father existed in stark contrast to the relationships he saw other boys having with their fathers through his time in Boy Scouts: "It's definitely weird because I see people go to their dads and just tell them things that we really didn't talk about. For me, I never had that and it's tough to try and force it. Like I'm trying my best, but, it's definitely, it feels strained at times."

Some of the children discussed the distance and frustration they experienced by not having a parent whom they could be close to and rely on, while other respondents talked about relationships that were too emotionally demanding and draining. Alexandra drew a distinction between what she described as a very tenuous relationship with her own mother and the relationship she saw between her roommate and her mom:

So I think like immediately of my roommate and her mom. And they're like; they're close but not as emotional. Like I am really emotional with my mom. But then they don't have to deal with the guilt trip. So...I don't, I mean, it feels like my mom's relationship and I's is a lot heavier and harder.

In these instances children described feeling responsible for their parent's emotions that arose because of their parent's mood disorders. Children were critical of both their fathers and their mothers and the role they saw their illnesses playing in their ability to parent. However, in their discussions they held mothers and fathers to different standards and used different normative ideas about what good moms and good dads should be like to understand their experiences. The social structure of a family demands different types of gender performances from men and women. Thus, my respondents' understandings of their parent's behavior and the response to mental illness in the household was structured by these specific gender expectations.

Before moving on to discuss the gendered expectations in my participants' stories, I want to acknowledge the possible impact that divorce has for children's understandings of their parents and families and their responsibilities in the household (see Coltrane and Adams 2008 for further discussion). Indeed, there are many cultural stories that exist surrounding divorce and growing up in single-parent households that emphasize the increased responsibility and non-normative relationships with parents that children may experience in cases of divorce. However, the participants in my study who grew up in two parent households often talked about their experiences growing up with a parent with a mood disorder in similar ways to those who had experienced divorce and or grew up in a single-parent household. In their stories what mattered was their parent's illness not the presence of absence of divorce.

What Makes a Good Dad?

Children's perceptions of fatherhood focused on stereotypical ideas of masculinity. These constructions generally emphasized the image of fathers as providers and protectors. In his study of fathers, Townsend (2002) found that fathers discussed four central components to being a good father including emotional closeness, provision, protection, and endowing children with opportunities and character. And while all of these attributes mattered many men saw breadwinning as the biggest way in which they expressed their love (Townsend 2002). The importance of being a "breadwinner" to understandings of fatherhood increased with industrialization when "men came to be seen as fulfilling their civic duty not by teaching and interacting with their children, but by being good providers" (Coltrane and Adams 2008:140). According to some researchers the emphasis on breadwinning has been replaced by a new cultural ideal focused on involved fatherhood, which Coltrane and Adams (2008) argue began in the 1970s and continued to rise in popularity. This new story of fatherhood today focuses on fathers who are more involved and engaged in the family than before (Freeman 2002; Marsiglio et al. 2000; Pleck and Pleck 1997). However, "the extent of this alleged cultural revolution is called into question by empirical evidence which fails to detect the anticipated widespread realignment of parenting duties; in other words, the conduct of fathers does not match the cultural prescription (Dermott 2008:17). Even though new cultural ideals emphasize this model of involved fatherhood, researchers continue to demonstrate the centrality of being a

breadwinner to conceptualization of fatherhood (Hatten, Vinter, and Williams 2002).

When comparing their fathers with mood disorders to a definition of fatherhood focused on breadwinning, a few respondents described their fathers as failing at fatherhood because of their inability to help provide for their children.

Jill's story of her father was one example:

Umm just totally, totally different. Um, you know all my friends' fathers are responsible and there and take care, you know take care of them and help them out with college and you know help them financially or whatever else they needed. And my father was really never there for anything that I needed.

While some children echoed Jill's frustration and disappointment, other children often focused on the fact that their father financially supported them regardless of his illness—an act that satisfied their initial understanding of what made a good dad. Even though Callie had a tenuous and frustrating relationship with her father, she told me, “Well, he's always gotten up in the morning and went to work and taken good care of my brother and my mom and I. Like you know, we've always been taken care of well, in that sense. I guess he's always been a good dad in that sense.”

Even though some fathers could succeed in performing masculinity simply by providing for the family, the children's perceptions of their fathers as men were nonetheless rooted in more complex gender expectations. Several daughters wished their fathers were more willing to play the “protective” dad role and to step in to “defend their honor.” Jenny told me, “I wanted my dad to care that much about who

I was dating and how they treated me.” For some daughters, fathers needed to be strong, tough and more authoritative than they were. Older sisters pointed to their father’s inability discipline their brothers. They worried that their brothers did not have an effective male role model to teach them how to behave or keep them in line. Charlotte contrasted her brother with her boyfriend and argued that her brother “stepped out of line” because her father was too depressed to be a disciplinarian: “For example, a large part of the difference between my boyfriend, who never did drugs because he was afraid of his dad, and then my brother you know it’s kind of like, oh well my dad is not the kick your ass kind of a guy.” One sister even attributed her brother’s decision to join the military to his lack of having a strong male role model:

Certainly for my brother I just think my father didn’t turn out to be the sort of dad he wanted to be. I think my brother is now in the army, I would never have pictured him going into the army, but I think that sort of in his formative years he lost all of the structure that was in our house when he was younger, and he suddenly felt that he needed an extremely structured life, and that’s why I think he went into the army. I think he wanted all these rules and security that wasn’t there before (Kathy).

Children were critical of fathers who they believed did not meet the ideals of hegemonic masculinity (Connell 1995). Many of the children reinforced the idea that fathers should be emotionally stoic and able to act rationally—showing too much emotion or the act of crying were seen as unacceptable from fathers. Charlotte, a sociology major, explained that after she took a course that explored these expectations she was able to see how her father’s other attributes were actually beneficial, but she still struggled to explain to her boyfriend and friends that her

father's divergence from a hegemonically masculine performance could have positive consequences for her family.

While many of the women in the study emphasized their father's inability to fulfill hegemonically masculine traits, a few children, both men and women, also criticized fathers for not being emotionally available and supportive. Like George, above, who discussed being frustrated by not being able to connect to his dad in the same way he saw his other friends in Boy Scouts doing, Callie also identified difficulties connecting to her father:

Like very distant. Like non-connected. Like I feel like...like when my dad - he occasionally makes an effort to play golf with me just one on one and it's awkward and weird and I don't like it. And like a lot of my friends are like oh, well, you know, like I can tell my dad anything. Or have these close relationships with their dads and I am like I would never tell my dad any of that.

Many fathers are uninvolved in their children's lives or unable to emotionally connect with their children (Eggebeen 2002; Furstenberg 1988), but instead of looking at this as a broader phenomenon, the respondents attributed this behavior to their father's mental illness. However, as I discuss below, the inability to fulfill a parental role was not as straightforward for mothers. Some children, like Jenny and Callie, were frustrated by their father's unpredictable emotions and felt that they did not act or behave like other dads should, but they never suggested that their father was "not" really a dad. A father may have been a "bad" dad or an uninvolved dad, but this did not negate his role as a father and because many of the fathers were still able to provide financially, they satisfied the narrow definition of

fatherhood and masculinity. In addition, children were more likely to accept and move past a father's lack of involvement or emotional support because they believed they could turn to their moms.⁷ Conversely, as I discuss in the next section, participants criticized mothers who were unable to provide emotional support and stability much more harshly, and several of my respondents actually told me that their mom was in fact, "not a mom." Indeed, researchers have repeatedly demonstrated lower cultural standards and expectations for fathers compared to mothers (Hays 1996; Milkie, Simon, and Powell 1997; Walzer 1998).

What Makes a Good Mom?

Fathers were certainly criticized for either being too emotional or not emotional enough, but the criticism was framed as much less problematic and damaging than it was when children talked about their relationships with their mothers. In the mid-90s, Sharon Hays (1996) introduced the concept of intensive motherhood. The assumptions of intensive motherhood demand that childcare should be "child-centered, expert-guided, emotionally absorbing, labor-intensive and financially expensive" (Hays 1996:122). Mothers should consequently be willing and able to sacrifice their time and energy to ensure their children's success. My respondents held tightly to this definition of motherhood and criticized mothers who did not invest emotionally enough in their children or did not take a highly

⁷ The vast majority of my respondents who had a father who was diagnosed lived in two-parent households or spent the majority of their time in two-parent households prior to their parents' divorce. None of the respondents in my sample lived with single fathers who had been diagnosed with a mood disorder.

attentive interest in their children's lives. Erica, a 21-year-old college student, said she had to grow up too fast because she couldn't rely on her mom:

Their (her friends) moms are always willing to take care of them, they call them twice a day, like, 'How are you? You want to come over for dinner?' Whereas me and my mom... I feel... I guess like, I became independent a lot earlier than anyone else that I know.

Similarly, Sophia and Michaela both talked about how they could not rely on their moms to support them through difficult times in their lives:

I just went through a break-up, and I wish I could have called my mom and had her talk me through it. But I just can't. I mean, I could, but what would come out of her mouth would just stress me out even more. So yea, it's something I'm learning to deal with (Sophia).

Yeah I guess for the most part, most of my friends have relationships with their moms that I envied, because they just seem a lot healthier, a lot more light-hearted, a lot more back and forth, a lot more of being supported by their moms and helped through things rather than the other way around. (Michaela).

In my respondents' narratives, mothers were supposed to be the ones who were there to comfort their children through break-ups, to motivate them to achieve in school, and to help them navigate tumultuous teenage years. Those who no longer had relationships with their mothers often felt that they missed out on the love and support mothers should give. Emily, who had cut most of the ties she had with her mother, said that there were many times she missed having a mom in her life, "I think it's difficult because on Mother's Day, Christmas, Thanksgiving, breakups, questions I have about makeup, doing hair, cleaning my house, I don't have that person." Like Emily, respondents imagined that other mothers were extremely

involved and emotionally supportive. In comparison to these types of relationships, their own mothers seemed unavailable and unsupportive.

Children were also much more likely to have a broader list of expectations for motherhood than they did for fatherhood. They were quick to point out the ways in which they saw their mothers fail in terms of appropriate domestic skills and tasks. Miranda told me a story about how she found a video she didn't even remember making as a child that illustrated this frustration:

When I felt that I needed her you know, I saw a video once of my neighbors when we were little kids and we used to play with video cameras and she showed me this video when I was 20, 21. I didn't even know, because I've always been really camera shy, so I'd never be in front of the camera, but she actually had a tape. I was probably like 8, or 9, and it was just this ranting on of like that my mom was just this mean lady and she was never nice, and she always yelled. Every morning when I woke up, she was gone, because she had to be at work and she never made us breakfast. I remember saying, "she never made us breakfast, she never packed our lunch." It was like this kid just pretty much just getting all the things that I had almost forgot about when I watched the video. I was like, "oh my god." I thought...I knew I had felt that way, but I was like, wow I did feel that way even that young.

Children's' expectations of maternal domesticity and sacrifice persisted for many of the mothers in my sample through young adulthood. Erica still found it hard that her mother wasn't able to do the same kinds of things her boyfriend's mother did:

She invites us over for dinner every Sunday; she does our laundry if we can't do it or if we're too busy. You know? And my boyfriend will be like, 'Oh, I'll take some laundry over and do it at my parent's house' and his mom will end up doing it for us. She's very motherly like that. She sends home food with him so that she makes sure that we're eating okay. Whereas my mom, she doesn't do that. You go over there for an occasional dinner maybe once a month, if that.

Respondents used these stories of perceived maternal failures to contextualize and make sense of their own decisions. I explore this process in more depth in chapter four.

What was most striking was the ways in which mothers were held to a higher standard than fathers in respondents' narratives regardless of which parent was diagnosed with mental illness. Of the children who had a father who had been diagnosed, most came from two-parent households. Ten of these 14 households had parents who were still together. Some respondents did discuss the threat of divorce that loomed in their household, but at the time of our interviews, only four respondents with a diagnosed father had parents who were divorced. In almost all of these instances, respondents discussed the immense burden of care their mothers took on. Kim described her mom as being the "the parent, parent," and Debra explained, "I think my mom has to be one of the strongest people I know, to have dealt with everything that she has, quite honestly." In many of these household mothers not only shouldered some if not all of the financial burden, they also provided most of the day-to-day and emotional care. Sisters, Kathy and Felicity, both described their mom as the all-around parent:

My mom really did everything around the house and did the disciplining and took care of us when we were sick or when we had problems. He loved us, I mean, I know he loved us, but he was more a body in the house than an active participant in what was going on. (Kathy)

I feel like my mom was really one the one who raised us. Even though my dad wasn't working and he was around a lot, I feel like she was the one who really did the nurturing, and he never did that. (Felicity)

Daughters and sons expressed gratitude for the roles their mothers played, but respondents' narratives also painted a story of mothers who were held to high standards that were sometimes contradictory, which I explore below.

Some respondents criticized their mothers for not sharing enough information with their children about their father's diagnosis and being unwilling or unable to talk about what was happening in the family. Mary Ann struggled with the feeling that her mom was not emotionally available, "if I felt like I could talk to my mom and she'd listen, I definitely would have done so, but she didn't really listen that well." At the same time, others criticized their mothers for talking too much about what was happening with their fathers. These respondents felt pressured to be the support system for their mothers. Jenny described this responsibility beginning early in her teen years:

When she (her mom) could no longer talk to him about things, I got to be the person that got to hear all of it, and so I turned into her support network. So from about 13, I knew everything that was going, I knew that he had been contemplating suicide, I knew he was depressed, I knew all of it.

Jenny expressed immense frustration at this role and felt that the pressure from her mother forced her to grow up too quickly due to her father's depression. Callie described experiencing a similar situation:

Like I said, they fought a lot. My mom doesn't have many friends, and I became her sounding board, and I became her outlet for being frustrated and upset about her marriage, which is totally inappropriate, but that's how it happened. And she would always say stuff to me about how sick he is and how angry she was and you know, just so mad at him for being this crazy person who had all these problems he couldn't deal with.

Both Jenny and Callie's parents are still married today, but both women told me they wished that their mothers had left their fathers when they were younger. George, who expressed gratitude and compassion for his mother throughout our interview, still blamed his mother for her decision to divorce and then return to his father. He explained, "my mom for the most part has said she stayed with my father so we could have more opportunities, and like I thank her for that, but at the same time I, I think I would have been a little better off just having a single mom."

Children were also much more likely to hold their mothers accountable for making sure fathers received and participated in treatment. Mary Ann regretted that it took so long for her father to officially be diagnosed and felt that her mother could have stepped in sooner, "I was, we really didn't talk about it but I was kind of upset that my mom didn't really push him to get diagnosed any sooner." Similarly to Mary Ann, April appreciated the support her mother gave her father and the fact that he mother did not leave, but she too wished her mother would have gotten involved earlier:

I really credit my mom for staying there, but she probably could have been more insistent about improving the situation. She was so emotionally involved and everything. And I don't know that she really had the power to say 'you need to get treatment, you need to apologize to our daughter, you need to whatever.' But I think a more active approach would be good.

According to these narratives, mothers walked a tenuous line in these situations. Children expected them to be emotionally present and supportive, self-sufficient and strong, and ultimately able to handle whatever was thrown their way. Even when children could recognize the sacrifices and struggles their mothers

encountered, they consistently held them to higher standards than they did their fathers. Kristina, whose parents did get divorced, illustrates this process clearly in her discussion of her parents' divorce. She continually blamed her mother for putting pressure on the children to "side with her" and to recognize the pain and difficulty their father's illness had caused. However, instead of looking at the impact their father's illness had had on their mother, she described how both she and her siblings gave their father the benefit of the doubt and assumed that he did care even if he could not show it:

It always came across as like blaming the divorce on him and just blaming so much on him, not like directly but you could kind of tell the way she talked about it. That's how she felt. And for us, it was just so frustrating because he did care so much whether or not he could always show it. And now it's like totally obvious how much he cares and how concerned he is about us. It was just frustrating because we sort of, we totally saw that in him. We, I mean, yeah it was just frustrating because we didn't feel that way at all and she was just very harsh and kind of taking out her own frustrations. That was the other thing, that she was trying to convince us of this, and that's really not fair to him.

As Kristina's story illustrates, children had high expectations for both mothers and fathers. However, fathers were given more leniency than mothers often because children had a mother in the household who they could turn to. However, these mothers were also held to a higher standard and expected to be able to balance the demands of having a spouse with a mood disorder in a graceful and competent way.

The expectations for mothers, whether mentally ill or not, becomes even more apparent when comparing how children talked about their non-diagnosed fathers. In comparison to the families where a father was diagnosed, there was much more

variation in family forms when the mother was diagnosed. Some children had only ever lived with their mother, either never knowing their father or having limited contact, and a few had lost their father when they were children or adolescents. For the purposes of this analysis, I focused on the 16 families where the parents were either still married or had been divorced when the respondent was old enough to remember. What was striking about these stories was that fathers appeared to be given a pass regardless of their decisions. Fathers who divorced the children's mothers were often described as smart and protectors of the family. In the majority of these instances, the children often ended up living with their fathers, but still maintained contact with their mentally ill mothers. These respondents described fathers who were not as emotionally supportive or available but for all but one respondent, this behavior was excused. Robin, whose parents had an abusive and damaging relationship when she was a child, told me, "I don't hold any of that against my dad. He definitely comes from a very horrible childhood upbringing as well. He is working from a deficit. He doesn't know what good parenting looks like and he's done the best he actually could." Samantha recounts the time her mother was institutionalized and her father took care of her and her sister:

When my mom was in the state facility, we were so young. My dad basically, he worked 7-5. He would come home, he would take us to daycare at like 6:30 in the morning, go to work, come pick us up at 5, take us home, and feed us terrible food like microwave food or boiled steak, I mean it was terrible. Then he would give us a bath and put us to bed.

Even though Samantha described this experience as difficult, she did not blame her dad. In her narrative he had "done the best he could." Her father may not have been

able to provide the emotional support she felt that she needed, but she described him as “being the rock” in terms of finances and providing stability. By fulfilling the breadwinning role and providing some stability, non-diagnosed fathers met the basic understanding of being a good dad.

In the nine households where children’s biological fathers were still married to their diagnosed mothers, non-diagnosed fathers were also held to a lower standard than non-diagnosed mothers. Children expressed anger at their non-diagnosed mothers when they felt they had to step in to take care of themselves or their young siblings because of their father’s illness, but children who had to do the same thing in cases where their mother was diagnosed stated it as more of a fact. Lucy said her dad did help, but “we sort of just kind of took care of ourselves.” My respondents described fathers who tried to help, but maybe didn’t know exactly how to handle the situation, and that was okay. Michael remembers, “I guess my dad’s approach was here I am and I don’t know what the fuck to do. (He) tried to be supportive and tried to be real.” Michael says that he thinks his dad ultimately did a “good job” of raising him. He vaguely remembers his dad talking to him about his mom, but he didn’t have the same kind of expectations that his father keep him informed that children had of their non-diagnosed mothers when it came to sharing information.

Children often chastised non-diagnosed mothers for over-sharing information or relying on their children to serve as sounding boards, but children never interpreted their non-diagnosed fathers in the same way. Some of this is probably

connected to the fact that most non-diagnosed fathers did not express their emotions in this way as many fathers were described as non-emotional or quiet. However, when or if fathers did want to talk about their experiences, children understood it differently. Alexandra's description of a phone call with her father is the most telling:

I remember once, it was really weird, he called me and this is rare, because we don't really have that emotional conversation. He called me and was like, "you're mother is just driving me crazy because," I don't even remember why, it was really weird to hear though. Like he's called me and like talked about it before. But that's rare and that definitely made me feel a little uncomfortable. And then I realized that my dad doesn't have anyone to talk to either. You know, just like my mom feels like she can't burden my dad with her issues, my dad can't burden my mom. [...]. So then he talks to me sometimes, but that's rare.

Diagnosed mothers and fathers were both perceived as having an impact on the family and their children, but the real gender discrepancy becomes visible when looking at the non-diagnosed parents. In these instances fathers were accepted or excused for their behaviors and mothers were blamed. The two quotes below from Jenny and Carly illustrate the stark differences:

Have you ever seen the movie *Amélie*? You know that part where she mentions that she's strung between a neurotic and an iceberg? That was my childhood. My dad was the iceberg, for real. Very logical, rational. I felt much closer to my dad than I did to my mom; however, I never was really told I love you, but I kind of felt like he did. And we would have really good conversations, but I couldn't tell him anything about my stuff either. He didn't know how to deal with it. He didn't know how to do anything, but... I was much closer to my father than my mom (Carly).

Umm. This is odd but I think I resent her more than him. Because he was mentally ill, but she's the one that chose to bring me into all of it, and she's the one that chose to tell me everything and to rely on me, and she wasn't mentally ill. She didn't let me have a childhood, and I blame her almost as

much as I blame him. And I think that at some point I'll have a breaking point with my mother, and I think I might just snap (Jenny).

Regardless of which parent was diagnosed, mothers were ultimately responsible for family problems (McGuffey 2005). By relying on the images of the normal American family, many of my respondents reinforced the ideals of intensive motherhood.

When their mothers failed to meet these demands either because of their own illness or because of the caretaking and emotional demands of their husband's illness, children blamed their mothers and in doing so reinforced traditional gender roles and family expectations (McGuffey 2005).

Childhood

By explaining the ways in which their parents did not fulfill normative parenting expectations, my respondents also clearly highlighted concrete and limited expectations of childhood. While my some of respondents grew up in working class families, the majority grew up in middle class households and/or attended middle-class schools, and almost every single young adult talked about the importance of childhood innocence and problematized the idea of children ever having to seriously take care of a parent. Childhood has not always been a protected time. Prior to industrialization, children were expected to contribute to the family economy or family's status (Cosaro 2005). In the United States, in the late seventeenth and early eighteenth century "we find no notion of childhood innocence, no protected place for children, no separate children's toys or games" (Hays 1996: 26-27). For the Puritans, children were sinful and a primary way to be saved was through their hard work (Hardyment 1983). The idea of the sacred child

and the emphasis on a mother's maternal nature and necessity of her care is a relatively new phenomenon dating from the 19th century (Hays 1996; Zelizer 1985). However, it has been immensely powerful in shaping modern day understandings of childhood and parents. In their discussion of conceptualizations of children of mentally ill parents, Gladstone et al. (2006) find that the importance of a protected childhood is central to how researchers understand having a parent with a mental illness:

Childhood is usually idealized as a time of little responsibility, innocence and being carefree. From this perspective, children of parents with mental illness are considered 'robbed' of or to have 'lost' their childhood. According to Newman (2000), work by children, especially caregiving activities for parents and siblings is often interpreted as part of the same moral universe as child abuse (2006:2546).

In other words, care work is an adult task, and children who have to participate in it are conceptualized as at risk. Many participants shared this interpretation.

About a quarter of the respondents emphasized the role shifts they experienced in childhood and relied on this cultural narrative of childhood innocence to critique their experiences. In most cases, the role shift was gradual as a parent's illness got worse or as children began to get older and accept more responsibility. A smaller number of respondents said they felt like they had been taking care of their parent in some capacity since they could remember. Rachel's parents divorced when she was very young. At the age of 13, Rachel said she decided to move to live with her dad because she felt like he needed her more than her mom:

Yea. Basically, it was always me taking care of daddy in one aspect or another. Financially, emotionally, any emergency situation that comes up, I'm the first one he calls. And recently, for me, especially with the last few things that have gone on, it feels as though he's almost like a 5-year old kid, and he just doesn't understand the consequences of some of his actions and everything. So it does feel like I've been more of a parent than really a daughter.

Despite the diversity in their experiences, almost every respondent discussed feeling a sense of responsibility or obligation toward their parent. When respondents were aware of their parent's illness from a young age, both men and women identified an increased awareness and concern for their parent's emotional stability and lives. Often times this resulted in children feeling they needed to take care of their parent. Lucy told me, "I always felt like I had to take care of my mom as a kid." The care often included being available to talk and share feelings and an intense feeling that they needed to look out for their parent. Rebecca remembered, "My reaction in general was to try to help her, to try to be there for her, take care of her, do whatever I could to keep her from going to that dark place, because she told me as a child that she had been suicidal before. It was inappropriate, but anyways, I was afraid for her life." In a few instances, children identified taking time away from their own passions and pursuits to focus on helping their parents. The help included the emotional support discussed above as well as financial and logistical support. Lilly talked in-depth about how she and her siblings shared the responsibility of caring for their father even though he had remarried after their parents' divorce:

Well my sister went to (college) and then my sister wanted to go. She wanted to, she was done taking care of my dad and was like, "alright I need to start

my life and do my own thing,” and so she moved out to (city) and my brother followed a couple months later cause dad was okay. So he (brother) wanted to move and get his own life too because he’s tired of taking care of my dad and all this shit and he was like, “I’m done with it,” you know. “Don’t have to take care of him anymore.” So you know he gave up two years of his life to help out my dad stay in (state), and he really hated it and my sister gave up a year of college to come home and take care of my dad, so, you know all of us have worked together. It’s hard having kids take care of your parents, but we did, you know.

Sometimes the care was not always direct. Instead, respondents often focused on the increased worry they carried for their parent. Erica identified how the worry she felt for her mom was something she could not escape even today:

I worry about her a lot. I think it causes a certain level of stress on me. I know that when she doesn’t answer her phone, there’s always a heightened sense of anxiety and urgency. And especially if she doesn’t answer her cell phone or her work phone, then my brain automatically goes to what’s going on? Am I going to be okay? Is this going to be okay? What do I do?

Like Erica, many of my respondents explained that obligations and responsibilities they felt towards parents in young adulthood as being difficult to manage and out of line with “normal” expectations in the parent-child relationship at this time in their lives. Even if children expected to one day have to provide care for their parents, they did not see it as something they should have done as children or should be doing as young adults.

Regardless of a parent’s marital status, women were much more likely to feel like they had to accept a maternal role towards their mentally ill parent and often referred to the ways in which they became a “mom” at a young age. Robin remembers being aware of the switch early on: “I talked to her as much as I possibly could. I really have an over-developed sense of responsibility in the situation,

because the tables were turned when I was young and I kind of was the mother of the family and she was much more like the child.” Like Robin, respondents described multiple instances in which they had to “take over” or “take charge” of a situation even when their non-diagnosed parent was in the household. Sometimes this meant accepting instrumental responsibility for the household as was the case with April whose parents were still married, “So there were periods of time where I would sort of take over the house a little bit... like I would drive, I would do the grocery shopping, cook dinner, whatever needed to be done.” Other respondents did not accept as much instrumental responsibility but instead felt the need to provide emotional support to take care of their parent. Carly, whose parents were still married, told me, “Forever. Pretty much. I felt like I had to take care of my mom, to some extent. I mean, obviously she could clothe and feed herself, but I had to be her support. I didn’t really identify as a kid, I guess, ever.” Alexandra, whose parents were also still married, echoed a similar sentiment, “Like I felt like I was the parent to my mom when those situations (she was crying in her room). You know I would make her feel better or like say, no that’s not how it is or how can we fix this.”

The women in my study were much more likely than the men to focus on the need to take on this emotional work and often contrasted their approach with their parents to their brother’s. Alexandra describes the pressure she felt to make her mom feel better:

I always grew up being the one who did that. Like even when I was 10, when this started, I would be the one to go to my mom’s room and make it okay. My dad or myself, but usually me because you know she would come around

faster with me. Umm and he (brother) never had that role so now he doesn't hear it.

Alexandra's brother, Luke, told a similar story about the differences between his sister's interactions with his mom and his own, "I think Alexandra is just better at picking up on that kind of stuff than I am usually. That's definitely much more in her nature than mine and she's definitely more empathic person than I am. Um, and would be a lot more involved in it than I am." Luke discusses this process as though it was simply a matter of personality, but other brothers and sisters followed similar patterns, with sisters almost always being the ones to shoulder this extra burden. Other researchers have demonstrated the same gender inequality of care-work in families in general (Gerstel 2000; Hochschild 1989; Walzer 1998) and among siblings (Connidis 1989; Coward and Dwyer 1990; White and Riedmann 1992). I address this discrepancy in further detail in chapter six.

As respondents told their narratives of growing up with non-normative parents and the ways in which their roles and responsibilities challenged their perceived idea of childhood, they often expressed frustration and resentment. Rachel, who earlier discussed taking on a maternal role towards her father, was the one respondent who said she did not resent taking care of her father and in fact was happy to help him. However, even Rachel discussed the cultural understanding of parent-child roles. Rachel says that she encountered this pressure with her friends who often asked her about her decision to help her dad:

It's kind of weird, because anyone I've ever talked to about it or who knows the situation like my best friend – who's been my best friend through all this stuff with Daddy – they always feel resentful on my behalf. Like, 'you

shouldn't have to do that. That's too much for you. You should be able to have a life.'

Not only did Rachel's friends and other respondents believe it was inappropriate for children to feel responsible for taking care of their parents at an early age, they also focused on a story of the inappropriateness of having to take care of a parent during the transition to adulthood when children were supposed to be independent and focused on their own decisions and lives. I explore this in further detail in the next chapter. Being imbedded in middle-class institutions and surrounded by middle class peers, my respondents used a limited and traditional understanding to make sense of their experiences. This is not to say that living with a parent with mood disorder can not be difficult and destructive in its own right, however what makes this process even more difficult for children is that they cling so tightly to a model of parenthood focused on intense emotional involvement, support, and encouragement, especially from their mothers.

Managing Ambivalence

The roles and responsibilities that many children experienced and the cultural stories they used to frame these experiences often lead to conflicting and intense emotions. Love, hate, resentment, frustration, and pride co-existed in children's narratives of their feelings towards their parents. Kourtney pinpointed this tension by explaining, "I have a very weird relationship with my mom. Because there is as much love as there is...negativity, I guess. And so it's this really strange love/hate relationship." The respondents focused on how these conflicting emotions were difficult to manage because they didn't feel they were "normal" or appropriate

feelings to have for a parent. Many relied on the idea that one had to love a parent because they were a parent in spite of the disappointment or sadness they felt. This story helped respondents justify why they continued to support and care for their parent regardless of their behavior. Derek explained:

It's, it's very strained. I have a hard time trusting him and I don't know, I just have hard time listening to him kind of to feel what he's put me through. But I mean I love him, he's my dad. That's never going to change but it's just like I kind of wish that it could be a little different.

Even though many respondents discussed the importance of loving and caring for one's parents simply because they were a parent, others challenged this narrative by saying that their parent never acted like a parent and thus they could no longer be there for them. Emily, who had cut almost all contact with her mom because of her illness, said she had to finally learn to let go of her mom, "I would think, okay she's my mom. Be nice, it's Mother's Day, and the same thing would happen.... I can't, it affects me too much to continue a relationship with her." While some respondents were able to recognize the need to cut ties with their parent and relied on a narrative of self-preservation and independence to do so, the majority of the respondents struggled to hold both feelings of love and hate at the same time. They could explain individuals who unconditionally loved their parent, and they could even understand those who hated or had cut ties with a parent, but to hold both emotions simultaneously was extremely frustrating. Samantha acknowledged the expectations to want to love and care for her mother while also recognizing the difficulty inherent in that task: "And so, I just, you know there's also that mom is so loving why can't I be loving to her like she deserves it, but god dammit, screw her."

Like there is such this, it's so hard." The ambivalence of being caught between the narratives of familial love and care and one of independence was something that few of my respondents were able to resolve and instead used their feelings of frustration to explain how and why they made certain choices.

The frustration that respondents identified in their relationships with their parents existed in two ways. Some children grew frustrated over their inability to help their parents and felt responsible for not being able to help facilitate a change:

And it was so frustrating. And that sort of translated into my relationship with my mom. Like why couldn't I fix it? Why couldn't I make it better? Or like why wasn't it enough? So, letting go of that is still hard, but I think it's necessary but it's like work all the time. It's work all the time and hard not want to be like, "why aren't we good enough for you to just be happy?" (Lucy)

I felt a lot of anger and just felt sad, because I felt like I needed to support her emotionally and fix things, and I didn't know how to and I didn't want to lose my mom. So it was a combination of sadness, helplessness and anger (Michaela).

Others expressed frustration when their parent couldn't be the parent the children expected or do things the children associated with accepted parenting roles. Sarah remembered, "I would definitely get frustrated because I would just constantly wanted her to be like that amazing mom that I knew and when you know she wasn't it was just like, I don't know it was really hard." Kourtney also explained the frustration she felt because she could never really trust her mom, "she also, there's a lot of resentment towards my mom because she, she never does the right thing." The idea that there was one right way parents could do things or one right way to

parent persisted and culminated in a very focused understanding of what makes a good parent.

The complex and intense emotions that many of the respondents identified in their narratives often became something they wanted to share and express with their parents. While there were a few respondents who actively talked to their parents about their feelings or had cut contact because of their feelings, a majority of children talked about their inability to share their thoughts. The fear that their parents might negatively react or be too deeply affected often stopped the children from sharing these emotions:

Well sometimes I just want to yell at him. I just want the opportunity to just scream at him sometimes to let him know that. Sometimes I know it's mental illness, but I just want to be like "you selfish bastard. Because you only thought of yourself and you couldn't even handle your own life you've ruined my childhood. You weren't there for me to the point that I didn't even care if you were alive," and I just want to scream at him. And I can't. And I can't just yell at him, and I can't just get it out because at the end of the day, he's not emotionally stable enough to handle that. And that sucks. That's the hardest thing for me right now. Is that...I just want to tell him and I can't, because I'm too afraid of what that will do to him. And it always comes back to him (Jenny).

Children focused on the sacrifices they were willing to make for fear of upsetting their parents. Because of their parent's illness, they felt that it was their responsibility to work through their own emotions before "unloading" them onto their parents:

So um, and so that's, so it's hard for me to talk to her today for example because um, my ambivalent feelings are so much more in my awareness and I still want to shield her from that until I am able to process it, you know. So I'm at a place of kind holding these insights or these ideas that I have and, kind of not having much contact with her until I'm able to process that and

come at it from a more compassionate and aware and grounded kind of place (Michael).

Some talked about how they felt their fear was justified and was a conditioned response from their experiences as children. This immense need to protect parents was pervasive and powerful. Alexandra said her concern for her mother's emotions and feelings were strong enough that she would never ever tell her that she had participated in the research study and would never directly admit to her mom the impact her illness has had on her life:

You're not going to make her feel any worse. You're not going to say a thing, you know. You are only going to say the things that made her feel better. And then, even when she's not crying in bed, like just seeing the impact that like my words had on her, totally trains you what to say and what not to say, you know. Like I would never tell her I did this interview. I would never suggest that her sadness and depression ever had any impact on my life, because that would just be so awful for her to hear, you know. And I can't even imagine saying that to her. I would never.

Instead of pursuing these desires, the respondents framed their fears in an understanding of mental illness as disability and did not want to feel responsible for upsetting their parents or making the situation worse. However, this strategy often left many of my respondents unsatisfied.

The ambivalence my respondents felt towards their parents was palpable throughout their interviews. Young adult children of parents with mood disorders exist in a set of structured social relationships that expects particular types of behavior from parents and children. However, my respondents experienced contradictions when they compared their own relationships with their parents with

these cultural expectations of parenthood. Despite my respondents' attempts to make sense of these relationships they are ultimately left with feelings of ambivalence. I conclude this chapter by exploring how respondents used the ambivalence that arose with their parents to explain their own feelings towards and decisions about childbearing.

Childbearing Desires

My respondents' ages ranged from 19-34 and they had differing views about if or when they would have children. Despite these differences, my respondents similarly drew on their previous discussion of their parents and their perceptions of childhood to contextualize their own decisions regarding children. The importance of childhood innocence and living a protected childhood were central to these stories. However, they used this cultural narrative in two different ways. For some of my respondents the idea of an innocent child who offered unconditional love was described as an important change from the unpredictable and frustrating experience of having a parent with a mood disorder. Jenny recognized that a child would still "need" her, but described it as a different kind of need, "And not that I want a child just to like verify that I can be loved, but I want someone to need me, but in a different way than I've been needed by everyone else. I want them to need me in the most pure, innocent form and not because they have these emotional issues." Like Jenny, several of my respondents thought there was an important distinction between the care they felt obligated to provide for their parents and that which they could give to children.

Drawing on this idea of childhood innocence, several of my respondents crafted a story focused on how they would do things differently from their parents. For them, they saw having children of their own as a chance to “get it right.” Derek knew he wanted to do things differently than his father, and his grandfather, who also suffered from depression, but couldn’t quite articulate what that meant:

R: Yeah I want a marriage. I want kids. I want. I want to do it differently than my dad did it.

I: What do you mean?

R: I don’t know it’s just, I feel like in a way he robbed my childhood of just all this shit that went wrong, and I just want to do it differently.

I: Do you have ideas of how you would do it differently?

R: (shakes head)

I: You just know you don’t want to repeat the...?

R: I just don’t want to repeat the cycle, because I know like, I know my grandpa’s grandpa did the same thing and then you know my grandpa did the same thing to my dad and my dad did the same thing and I just don’t want it to continue.

For Derek, like some of my respondents it was easier for them to point out what parent’s shouldn’t do and what they would not repeat than to articulate what they would do. Like Derek, George said that he did not want to be like his father when he grew up. While he recognized that most of the time his dad was able to provide for the family, he emphasized the lack of emotional support and involvement that he saw central to being a good parent:

I: So you mentioned earlier kind of one of the things being you knew that you didn’t want to be like your dad when it comes to being a father, so what do you think? How would you want to be a father?

R: I would definitely have rules because my family they really never had rules, just don’t piss off Dad. So, like I could be gone for two or three days and come back and be like, “oh I’m back,” and like a lot of kids say, “oh I wish I had that,” but at the same time I just didn’t feel like I was loved really. I just felt like I was born, and they feed me, and they keep a roof over my head, but that’s it.

I: Yeah

R: So I want to give some sort of control so they know that they are being cared for. Even if they don't like it at the time, when they look back they can see well my parent actually cared about me. Other than that, being more understanding, more patient. I think that's about it, and just in general showing them that I care about them and go to school functions for them.

The importance of expressing love and emotional support seemed to be the most important thing that children said they would do differently if or when they were parents. Lilly provides a good example of this belief as she explained, "It teaches me what I want if I had kids. Like what not to do (laughing) and what to do and so you know don't be like Mom, be a better fucking parent. Be there for your kids, you know tell them you love them every day because that's really important."

While some of my respondents saw having children as a chance to get things right and protect and care for an innocent child, other respondents used the same cultural narrative of childhood innocence to explain their desires to not have children or their ambivalence towards the idea of having children. Some respondents were afraid of the possibility that they might one-day act like their parent. However, instead of discussing their fears of being diagnosed with a mental illness, respondents' described fears of repeating the same type of parenting approaches as their parents. Sophia couldn't see herself replicating the pattern she had with her parents:

So, I guess my fear is that I'll have a kid, and they'll experience a lot of the same issues that I experienced with both my mom and my father. I just never want that for anyone, ever. It's... I'm sure, you living with someone that's mentally ill, some of these things that have happened, happen over and over again and they seem perfectly normal to me, and I tell them to people, and they're like, "What?! Are you kidding me?" And I'm like, "No, that was like an everyday thing!"

It was much more common for the women to be concerned that they would one day possibly end up like their diagnosed parent than for the men to be afraid they would be like their parent and they expressed this as a real fear and reason to not have children. Carly was not afraid of being diagnosed with depression but did fear repeating the relationships she had with her mom:

Yea, and it's especially worse when you've had a bad relationship with your mom, too, and you're like "I'm just going to go jump off a cliff now." So I worked very hard to... and I'm still very terrified that I do that, that I'd become that critical, passive aggressive person if I had children, and that's why I'm afraid. Very afraid. I probably won't ever have children!

April told me she felt a very similar feeling, "And, I mean I think in a lot of ways I just don't want to be him. I mean, I get scared when we talk about having kids. I don't want to be like that! I don't want my kids to see me get depressed. I don't want them to grow up in that kind of an environment." In these stories the men were much more likely to describe the ways in which they would be different and break the cycle. All but one of the men in the sample either had children already or expressed strong desire to one day be a "family man." They all expressed an immense sense of agency. In contrast, many of the women were more likely to express fear and doubt that they might one-day act like their parent. One possible explanation for this pattern was that this story provided the women in my sample an acceptable narrative to bypass desires of becoming a mother. Despite shifting cultural norms around childbearing desires and timing, the demands of compulsory motherhood remains strong, and motherhood is still a significant marker for women's gender and age identities (Edin and Kefalas 2005). While quantitative

research has demonstrated that women hold more favorable views of childlessness than men (Koropecky-Cox and Pendell 2007), qualitative work amongst young adults continues to illicit women's strong desires to eventually get married and have children (Hamilton and Armstrong 2009). While several of my women respondents alluded to their desires to postpone or avoid childbearing as being connected to their own self-development and careers, they ultimately emphasized their own childhood experiences as the primary concern for having children. Erica's discussion illustrates this tension:

I think it's really interesting that you ask that, because it has a lot to do with my mom. I basically think that I'm too like my mom to have kids. You know what I mean? I would never want my kids to go through what I did. And, you know, what I still am going through. And I know since I'm so like my mom, I guess that I don't trust myself enough [whispers] to be a good mom. As like, strange as that sounds. So yea. That's kind of how it is. I thought about adopting and stuff like that, but I don't know. That's kind of... I'm definitely not going to have my own children just because, another thing is too, I want to be a lot older when I do have kids. Just because I'm not going to be getting my doctorate until I'm 28 or so. Or 30. And so it's like, I don't really want to when I'm starting my career or getting out of school to have kids.

Serena, also acknowledges the societal pressure to have/want to have children, "I think I did. Umm for a long time and I think it was a mix of that's kind of what you're expected to do plus oh I want to see if I can raise a kid you know," but she returns to the difficulties she experienced with her parents to explain her apprehension:

I think I don't want kids. So, yeah, it's strange. But I don't know. I think having, going through kind of like my dad especially you know was so difficult, that I think that his influence and growing up with him on top of the mother really just, I mean I think it will be a long time before I kind of work everything out to be able to make those decisions.

This story was useful for the childless women in my sample because it allowed them to maintain their femininity while expressing their ambivalence towards having children of their own.

Conclusion

Growing up with a parent with a mood disorder can be a complex and confusing experience. I do not want to minimize the difficulties children of mentally ill parents face. However, by analyzing participants' interviews as stories it becomes clear that part of what makes this experience difficult are the cultural assumptions that children used to make sense of them. The expectation that parents, especially mothers, be emotionally attentive, involved, and supportive left many of my respondents feeling as though they had missed out on the childhood they were owed. By framing their comparisons of their parents with their middle-class peers, they problematized the care and support they provided to their parents and understood it as having a negative impact on their lives. These same kinds of expectations shape much of the literature of children of parents with mental illness. The risk/resilience models that rely on a narrow definition of a sacred childhood perpetuate middle-class ideals and leave little room for alternative interpretations. These stories continue to reaffirm the power of the nuclear family while ignoring the role that extended families, social networks, and the education system play in supporting children and families. They also reinforce ideas that children cannot be active agents in their own socialization and do not have the knowledge, skills, or maturity to successfully navigate non-normative experiences.

My respondents' stories also illustrate how traditional gender norms are enacted during times of family trauma (McGuffey 2005). While children told stories of the impact of mothers' and fathers' illnesses, they did so in different ways. Children held mothers, regardless of their diagnosis, accountable for the functioning of their families. When a mother was mentally ill, my respondents described the immense emotional burden and responsibility they faced, but rarely discussed how or if their non-diagnosed fathers stepped in to help. In contrast, when a father was diagnosed, children were more likely to accept his behavior if he could still continue to act a breadwinner and were sometimes even more critical of their non-diagnosed mothers who they described as being unable to support, control, or intervene in ways to successfully help the family. These stories suggest that gender matters for how children understand and talk about growing up with a parent with a mood disorder. Much of the research on children of parents with mood disorders focuses on the impact of having a mentally ill mother as more detrimental; however, by looking at the cultural components of my respondents' stories, it suggests that part of this may be connected to the unfair expectations placed on mothers and the expectation that mothers are ultimately responsible for the emotional well-being of the family regardless of their diagnosis.

Finally, my respondents' stories also point to the power of culture for shaping how we interpret our experiences and use these interpretations to explain decisions. The cultural repertoires or stories that we have access to shift over the life course and how we use these stories may depend on our audience. The majority of my

respondents did not have children of their own, but their stories of childhood and parenthood allowed them to explain their own childbearing desires. In these stories, the majority of the men expressed confidence, agency, and strong desires to one day be fathers (if they were not already). They believed they would be able to be “better” parents. In contrast, many of the women expressed concern or fear of repeating their parents’ behaviors and were unsure about if or when they would become mothers. For many of the women in my sample, these fears allowed them to avoid the pressures of compulsory motherhood and justify their choice to focus on their careers and self-development. However, these stories also reveal the limitations inherent in discussing mothers and fathers in the ways that my respondents did. Despite the shifting norms surrounding fatherhood, the image of fathers that my respondents constructed ultimately seemed attainable and possible for the men in my sample. In contrast, the demands of intensive motherhood and stories of responsibility that centered on mothers set such a high bar that it makes sense why many of the women in my sample, regardless of age, expressed concerns over their ability to be successful moms in the future, especially given their expectations of creating a sacred and safe childhood for their children.

Chapter Four

“I’m years and years ahead of my peers.” Invisibility, Maturity, and the Transition to Adulthood

When Michael first emailed in response to my Craigslist ad looking for participants, he seemed to be a bit skeptical about why I was doing the project and what I hoped to gain. I immediately disclosed my own situation to him and we exchanged several emails back and forth concerning my motivations for the project and my own experiences.⁸ In one email, Michael told me, “My mother suffered from depression since my early childhood, and has been diagnosed with major depression. I’ve recently been thinking about how this has affected me, and I think that telling my story could be helpful. However, it’s a tender emotional matter for me at this point.” In another email, Michael explained that he had spent most of his life thinking about how other issues his mom encountered affected their relationship and his life, but he was interested in trying to think specifically about the role her depression played:

I am hoping both to gain some clarity around this issue for myself by sharing with you about it (as a sympathetic sounding board, I suppose), and to be of some benefit to others (who may struggle with similar issues, and who might be aided at some point by my participation in your research). Finally, I’m excited to gain some perspective on this issue, which I’ve never considered formally. -- I mean, I was a caretaker to my mom a lot of my childhood, and she was not consistently emotionally available, but I attributed it more to her RA, work schedule, and character, than her depression.

⁸ Michael provided his consent for me to use these email exchanges as part of my analysis.

Michael, like some of my other respondents, had never explicitly thought about the role that his mother's depression played in his life or as he later told me, had never tried to put together a coherent narrative about its impact. Other respondents had spent years in therapy and had developed rich narratives detailing the experience and how they saw it impacting their lives. In this chapter, I examine some of the main issues children of parents with mood disorders identify and how these relate to their understandings of themselves and the transition to adulthood. This process builds on the argument made in chapter three that my respondents made sense of their experiences as children of parents with mood disorders by comparing their relationship with their parents to cultural expectations of middle-class parenthood and childhood and their own observations of the relationships their peers had with their parents, both as young children and throughout the transition to adulthood. I begin the chapter by exploring the feelings of invisibility and misunderstanding that my respondents saw as having a significant role in their experiences. I then explore how the demands of a therapeutic culture shape the types of stories my respondents tell about their experience and how they connect this to ideas about childhood and the transition to adulthood.

Invisibility

Like other researchers have documented, one of the most poignant feelings my respondents shared with me was the invisibility of their experience (Gladstone et al 2006, Trondsen 2011, Mordoch 2010). For most of my respondents, this invisibility began while they were children and continued to become worse as they

grew older. Some focused on this as an issue that resided within individual families, while others identified it as a broader systemic issue.

Respondents who were looking for support or information were not sure where to turn, and some were either told that their parent's diagnosis was something they should not share with others or they believed that it was not something they could share. Callie repeatedly told me how difficult her experiences growing up were because her family refused to let anyone know what was going on with her dad, "they worked their very hardest to make sure like nobody really knew." Callie remembered wishing she had someone else whom she could talk to about what was going on in her family and believed that she would have benefited from having support either in her school or community. Instead she had neither. To illustrate the consequences of this invisibility, Callie dramatically told me the story of the time her father was suicidal and she had to call the police to go check on him at home:

I know what is going on. This is huge. You need to take him to psych ward. And they are like we are not doing it. And this goes on for like 2 hours. And you know, like I said, this is a big deal because there are police officers at my house and like "God Forbid anyone know something was going on at our house."

Callie believed that if her family had been more open to sharing her father's illness, he would have gotten help sooner and more effectively, and consequently her family could have avoided some of the more serious consequences of his illness. If he had received help earlier, Callie said she might have had a closer relationship with her father and also a less stressful relationship with her mother, who was often

burdened by her father's illness. Instead, Callie described her father's illness and the lack of communication around it as creating increased stress and responsibility for her as a child and as she transitioned to adulthood.

Unlike Callie's family, most of my respondents' families did not actively tell them not to discuss their parent's diagnosis. Instead, for about a third of my respondents, a parent's mental illness was not discussed at all. Not only did these families never talk about mental illness to outsiders, they also did not discuss it within the family. Isabelle said that the past was something that simply wasn't talked about in her family, "I've never really talked to anyone about this, and as open as we all are now we don't talk about the past. We don't bring any of that up again." In these instances my respondents had limited tools to make sense of what was going on in their household. They discussed feeling confused and frustrated by the lack of information.

In contrast, some respondents did discuss their parent's illness within the family, but were not sure if was something they could talk about to outsiders. Lucy said it feels "kind of like you are outing someone or you are letting the cat out of the bag of this big family secret." It was difficult for Lucy and some of my other respondents to figure out how much they could or should share with others. They felt like this was their parent's story to tell and struggled with how to reconcile that feeling with the belief that their parent's illness had played a role in their life.⁹

⁹ For these respondents, their willingness to participate in an interview was directly linked to my own disclosure of being a child of a parent with a mood disorder. For them the chance to talk to someone who "understood" seemed worth it. Several respondents also mentioned that they thought the only way to shift this cultural belief was to make this experience more visible.

These decisions around disclosure were primarily motivated by fears of stigma. In many instances parents and the family opted to hide this information. However, according to their stories, the decision to do so held real consequences for my respondents. I discuss how the issue of stigma, specifically courtesy stigma, affected my respondents in more depth in the next section.

Moving beyond individual family explanations, several of my respondents told me that the United States health system focused only on the individual who was diagnosed while ignoring the consequences for the rest of the family. Jenny spoke about the way this lack of awareness about how illness can impact the whole family affected her own life:

Because I think, I thought it was fascinating, because no one ever asks. No one ever looks at what the kids go through. I mean it was always all about him and it was never about us and so I liked the fact that you were doing something that had to do with what I was going through because no one ever asks that. They think that the disease is isolated to the patient.

While sociologists and public health scholars recognize and explore the impact of health events and chronic health problems in the family (Chesla 2005; Ell 1996; Hughes and Waite 2002), my respondents said that few people acknowledged that a parent's illness affects the entire family. Going to the doctor was something that was reserved for their parents. As young children, only five of my respondents remembered participating in any kind of therapy or discussion with a professional about how their parent's illness was affecting them. Thus, as children, many of my respondents believed they had no professional outlet to which they could turn, and that they lacked important information.

A few respondents were aware of support groups and information systems that sought to include the family and others who may be affected by another person's mood disorder. However as Lucy, a social worker, pointed out, even groups who sought to provide information and support to family members were generally not focused individuals like her (a young adult with a parent with a mood disorder). The groups instead tended to focus either on children of alcoholics or on parents of children with mental illness:

Also because I think it's really important that people will read this hopefully and see that this deserves attention and you know there's always a couple of studies that then make people flock to that population and hopefully that happens. Because you know there's all, like I just think about it, I compare it a lot to like substance abuse. There's all this, there's support groups for adult children of alcoholics and blah, blah, blah, and I've gone to some of those and I don't feel like that's best to serve me, you know. I feel like I wish there was something other than NAMI (National Alliance on Mental Illness) because that really is for parents or maybe NAMI would do something for kids, but not just kiddos, but adult children of people with mental illness to sort of, "woo, we did it."

Lucy also addressed another issue in her comment, noting that organizations are beginning to expand to include "kiddos" of parents with a mental illness, but that the experiences of adult children, especially young adult children, remains unacknowledged as these children did not receive help and support and consequently as young adults have a different set of needs that continue to go unmet.

The lack of visibility meant that many of my respondents felt isolated, as though they were the only one who was experiencing this significant experience. Like Lucy, Erica pointed out the resources available for children of alcoholics, but

shared that she could never find anything, even on the Internet, that resonated with her experience as the adult child of a parent with a mood disorder:

Other than Al-Anon, I haven't seen anyone else interested in the children... at all. Like what they go through. With the totally different outset that me and my brother had for dealing with what happened and my new career per se of understanding it a little bit better. I was kind of disappointed about that. So when your email popped up that you were looking for children of depressed parents, I was like, 'Okay, that's somebody I want to talk to!' Because nobody ever... you would have to search out on your own a therapist or a psychiatrist to talk about being a child of a depressed parent. You don't necessarily have to have issues to still want to talk about it and understand it. Most people won't do that, and I think it would be very, very helpful to have something out there that has a little bit more information. Even on the Internet they don't really talk about it, which is shocking by the way.

Kate had a hard time finding resources and just couldn't believe that there was not a larger conversation out there about what it meant to be a young adult child of a mentally ill parent, "I sort of looked for resources like groups for people dealing with the same thing, and I found like nothing! Which is really weird cause it is such a huge part of how I define myself and how I view the world." The lack of social services and even online and print media targeted at children of parents with mood disorders and the explicit or assumed belief that a parent's illness was not something one talked about left little room for respondents to understand their own childhood experiences.

Misunderstanding

Many of my respondents focused on how the invisibility of having a parent with a mood disorder left them feeling as though their social networks and society at large would misunderstand their experience. Even though some of my respondents did not feel they needed to "hide" their parent's mood disorders, it was

also not something that most actively shared. Those who did share the information usually spoke to a few friends or family members and that was it. Several of my respondents specifically connected their apprehension about disclosure to the stigma associated with mental illness, but many more talked about a general lack of understanding about mental illness in our culture and limited cultural scripts for how to respond. Charlotte said that her family often made comparisons between how communities responded to cancer and the differences with mental illness:

I think, we compare it in our house a lot to mental illness vs. like cancer. You know if someone finds out you know that your mom has cancer, they bring you flowers and casserole, and they, you know, make cards and take you out to coffee and make sure you are doing okay. And when you tell someone, oh my dad has mental illness, they freak out. You know. And it's a total different support system because it doesn't go away. It's chronic, and it's not like, "oh here, I can't bring you dinner once a week for the rest of your life," you know.

Charlotte had almost resigned herself to the fact that most people would be unable to understand and know how to help. She felt grateful that she had a supportive boyfriend who would listen and do the best he could, but otherwise felt it was something that others would not understand. A local pastor, who I met with to help with recruiting respondents and whose congregation was active in mental health issues, also told me that he referred to it as the "no casserole" illness. He expressed concern about a lack of understanding and communication about what it meant to be part of a family confronting mental illness. Just as Charlotte discussed, the local pastor acknowledged the ways in which the stigma and fear surrounding cancer had decreased and with it the support and fundraising grew. There are now certain cultural expectations about what people might do when they find out that a friend

or community member has been diagnosed with cancer, including taking them food, stopping by to visit, offering to help around the house, etc. However, he explained that the stigma and fear around mental illness combined with the chronicity of the disease made it difficult for others to know how to reach out to support a family, if the family even decided to share the information. Robin described a similar set of feelings, explaining that she felt like the lack of support was connected to stigma, “because if your kid breaks an arm, everyone is there in a heartbeat to offer whatever support you need. But if your kid gets diagnosed, or you get diagnosed with bipolar disorder, everyone freaks out and shuts the doors.” Researchers have attributed these reactions to the assumptions that those who are diagnosed with a mental illness are weak, dangerous, and unpredictable (Crisp et al. 2000). Some of my respondents feared that this assumption would be shifted onto them.

A few respondents also pointed to the possibility of a courtesy stigma around mental illness and the power of the current genetic arguments surrounding mental illness as a large concern. They worried that if they shared their parent’s illness with their peers that their peers might assume that they also had a mental illness. Jill explained this hesitancy, “I really never talked about it and I didn’t want anyone to know that my dad was crazy because then they might have thought that I would be crazy too.” Jill’s use of the term “crazy” further highlights the stigmatizing assumption as it draws on images of someone who is out of control and/or potentially dangerous. Most of my respondents did not focus on these extreme feelings of stigma, but they did feel like most people could not understand what it

meant to be a child of a parent with a mood disorder and did express some concern surrounding the consequences of courtesy stigma.

Respondents explained that they were hesitant to share the information with their friends because they felt that their friends did not have the tools to understand mental illness. Kourtney said she found herself talking most often to people who she had grown up with and who had a basis for understanding her mom's behavior, "And I find myself talking more to people that I grew up with that knew her, because trying to explain my mom to a stranger is a really difficult thing to do, especially one who has never had experience with mental illness. It's like trying to describe outer space to them." In these discussions respondents fought against the powerful image of the mentally ill today. They did not want to reinforce those assumptions, but they did also want a way to explain the complex emotions and dynamics that occurred in their households.

My respondents' hesitancy to share information about their parent for fear of being misunderstood was not only connected to concern about the lack of understanding of mental illness in general, but also to the idea that they believed their peers could not understand what it would be like to have a parent who did not fit the norm. Robin said she felt this the most strongly while attending college:

Especially when you are in an undergrad institution and you are looking around and all your friends have these beautiful - not all of them - but a lot of them have parents who are still married and they come from a much more stable background. For the longest time, when you are an undergrad, or at least at that age, when all you want to do is fit in and be like everyone else, it is really hard to explain that you have strife in your family.

Children described being fearful of trying to explain what was going on in their families because it did not meet this idealized norm of the stable, involved, and supportive American family (Pyke 2000). Even though research points to the many ways in which this idyllic family is a myth (Coontz 1992, 1997), my respondents continued to hold this image of family as a norm because it appeared to be the most prevalent family model in their peer groups.

Children's concerns about the lack of cultural understanding in their social networks did not always stop them from sharing their experiences. In fact, some did not have a choice. Lucy remembered trying to explain what was going on with her mom to some of her high school friends:

They've seen her not do well too, and when I was in high school, I was just ridiculously, not embarrassed, but I just didn't know how to explain that, because none of them have anything like that in their families. So I was like, "sometimes my mom gets a little weird," but like I don't know how to be like, and "it's not exactly her fault," but you know it can make people uncomfortable.

Like Lucy, Sophia described herself as being generally pretty open about the impact of her mom's illness on her life, but after a bad experience in high school where many of her peers found out about her mom and rumors "flew around," she described herself as not wanting to face anyone's judgment:

I'm not ashamed of anything that's happened, or embarrassed. But I just don't talk about it, because I don't want it to define who I am. I mean, I know that it has, in many ways, but I don't want anyone's sympathy or judgment. That was the really hard thing about high school was that things flew around, and it was pretty terrible.

Callie, who was able to share her experiences with her supportive boyfriend, said that she still struggled because even if he was willing to listen, he could not really comprehend what her experiences were like:

I mean I put everything on the table, because I thought, if you really want to date me, you need to know what you are getting in to. So I just told him everything. And he was so wonderful in the fact that he accepted me for all those crazy things. But at the same time, he had not shared any of those experiences. So he really struggled to relate to me, and that made me irritated and pissed off and angry that like how can people...why do some people get to go through life without these experiences? But then I do.

Callie's story is full of pain and frustration, that she just felt like no one could understand what was happening to her or her family. The invisibility of being a child of a parent with a mood disorder combined with stigma and general misunderstanding was frustrating for many of my respondents and they grasped for tools to try to understand and communicate what their experiences were like.

Despite respondents' concerns about sharing information about their parent with a mood disorder, many eventually did. The chronicity of their parent's illness forced them to accept the reality of the illness and at least try to integrate the impact into the story of their lives. Consequently, when they shared this information with friends, they discussed how they had to manage their friends' reactions to this sometimes "-shocking" information. Kim was probably the most vocal of my respondents about this issue, "So it's like almost like uncomfortable when people (gasps) "oh no, oh my god, your dad threatened to kill himself" It's like, I can't match the level of emotion because, I've just kind of come to deal with it and it's not that strange to me." Like Kim, many of my respondents walked a fine line

between trying to explain the sometimes-intense impact that their parent's illness had while also accepting that for many of them this was not something that would ever go away.

The final concern surrounding misunderstanding described by some of my respondents was how to explain their relationship with their parent to their peers. These concerns broke down into two categories. Some respondents said that their friends could not understand why they continued to give their parents the same level of support and help as they transitioned into adulthood, without taking the time to focus on themselves. Rachel's friends were probably the most vocal about this:

It's kind of weird, because anyone I've ever talked to about it or who knows the situation like my best friend – who's been my best friend through all this stuff with Daddy – they always feel resentful on my behalf. Like, 'you shouldn't have to do that. That's too much for you. You should be able to have a life.'

According to these stories, in early adulthood, children should not be the ones caring for their parents. Young adulthood is perceived as the time when children are carving out their own lives (Arnett 1997; Johnson and Benson 2012). If anything, parents should be there to continue to provide support for their children (Allen and Hauser 1996; Eccles et al. 2003). Indeed, much of the current young adult literature continues to focus on the ways in which parents continue to help their children during this time (Fingerman et al. 2012; Nelson et al. 2010). Given these patterns, particularly for middle-class young adults, my respondents struggled to explain to their peers why they were not completely focused on their

own lives and also could not depend on their parents for support in the same way as their peers.

While children were sometimes criticized for remaining involved in their parents' lives instead of focusing on their own development, those who had almost, if not completely, cut ties with their parent tended to face the most criticism from their friends. Robin, who discussed above the challenges of trying to explain her family to her white, middle-class peers who she described as coming from stable families, continued her story by explaining that some of her friends actually challenged her and her decision not to help her mom:

You know, officially, the ones who have a really close relationship with their moms; they just couldn't imagine me closing the door on my mother's face. "Like that was just so cold. How do you know that like she'll get help? Don't you want to take charge of it?" And you know... and these comments... I mean like not all my friends came from homes where the parents were still married, but that did seem to be the pattern.

Robin said that she remembers taking this criticism to heart when she first heard it, but then began to draw a distinction between herself and her friends. "I realized we didn't share any of the same values. And all of them - parents were still married, they had really close relationships with their families, with their siblings." She said that for them, they could not understand her decision because they were used to having mothers who were involved and engaged, "So, yeah, there were comments like...they just didn't get that. They didn't get the not taking care of your mother. She is your mother! Yeah, but really, she hasn't been. She is my biological mother, but she has not taken care of me." Like Robin, Noel had also made the decision to

cut contact with his mother as a self-preservation strategy. He said his friends told him he made the wrong decision:

But many of my friends who know me well and also know my mother well they still see what I'm doing as, eh, probably, they would be people at the end of the day who would fall back on, well but it's still your mom and you just tolerate, you just put up.

According to these stories, children found themselves in a difficult decision. On one hand, they were being told that they should be focusing on their own lives and their own development, but, on the other hand, they are told that there were clear expectations for the support they should be willing to provide to their parents. Children in this situation felt misunderstood, because they did not think their peers could really comprehend what their lives and responsibilities had been like. Some of my respondents, who never shared this information, only anticipated the possibility of feeling misunderstood. Other respondents, who did share this information, actually identified and explained the misunderstandings they had to confront. These expectations and the inability to express them in a way their friends understood led to feelings of guilt, which I discuss further below.

Therapy and the Therapeutic Culture

As discussed above, throughout their childhood and during the transition to adulthood, many respondents described themselves as feeling invisible and misunderstood. Those who felt these pressures most strongly believed that they needed to find a way to make sense of what had happened in their lives. This desire to make sense of their childhood and the consequences of their parent's illness stems in part from the pressures of the therapeutic culture we live in. The basic

expectations of a therapeutic culture emphasize the importance of therapy and self-reflection, and more importantly the crafting of stories (Berns 2011; Furedi 2004; Illouz 2008). One of the most powerful components of this cultural expectation is that it assumes that as children we are shaped and molded by our interactions with our parents. Consequently, adulthood is seen as an attempt to make up for things that were missing in childhood or a chance to repeat the same type of pattern. Therapeutic culture emphasizes that particular choices or behavior patterns can be linked to our experiences as children:

The notion that adults are merely acting out a script set in motion during their childhood has encouraged people to continually look for clues about their lives in the past. Accordingly, the key to understanding the adult self lies somewhere in their childhood or beyond (Furedi 2004: 118)

The expectations of a therapeutic culture create a specific narrative that individuals use to make sense of their lives and also to tell to others to explain their experiences (Illouz 2008). The therapeutic narrative focuses on suffering and our responses to it. Illouz identifies eight reasons that the therapeutic narrative has become so pervasive in our culture. Some of those include its ability to explain contradictory emotions, its ability for an individual to be both a victim and an actor, and its ability to allow individuals to reflect on the past experiences of their lives while still leaving room for redemption (2008: 183-184). The therapeutic narrative is pervasive within our culture and individuals learn the expectations of this narrative through movies, radio shows, self-help books, magazines, etc. Before moving on to explore some of the ways in which my respondents used this narrative to make sense of

their experiences, I discuss the prevalence of the narrative in my respondents' stories.

Twenty-one of my 50 respondents actively discussed being involved in therapy and the ways in which they used therapy to help understand the impact of their parent's illness on their lives. Not all of my respondents described their parent's illness as being the foundational experience through which they understood their lives, yet almost every single respondent told me that because of the invisibility and limited conversations they may have had about their parent's illness in the past, they knew it was important to talk about it—even if the interview with me was the first time that they had.

According to my respondents' stories, the only way they (and other children) could make sense of what happened to them was to talk to someone about it. Even respondents, who had not shared their story before, stressed that they would tell other children who were in the same situation to find someone to talk to. Lucy, who is now a social worker, explained the importance of children sharing their stories:

I think that just being able to talk to someone about what you've experienced and seen as a kid you can't process them. Your brain is not equipped and as you get older it just gets more confusing until you're an adult and then it can either be very confusing or you can have some clarity. But I don't think you can reach that clarity in and of yourself. Or with a book, you know what I mean. You got to get it out.

Like Lucy, Sarah felt that her needs were often ignored because her parent was the one with the problem. It was only through therapy that she learned that her thoughts and feelings were valid and that it was okay to react to her parent's illness:

I just, I think support is so necessary. Like, I see a therapist at (health center), and I think it has been one of the greatest decisions that I've made you know recently. I haven't been there for too long but just like talking to someone, because I think a lot of it, you know I don't really know anyone that has bipolar parents so it's hard for me to like understand similar experiences. But from my perspective, I think there is like this cover that kind of puts you at second place and doesn't like put you as the person that needs to be cared for and really liked talked to and understood. Because a person with a problem is a person with a problem and you're kind of the byproduct of it. So I think that it's really helpful to recognize that you do have emotions and the feelings that have come from this experience are just as important as the experience itself. Just because we are not the ones with the problem right now that it does not discount that we experienced something that you know was pretty intense.

Respondents who were in therapy saw it as essential to coming to terms with their experiences and their parent's illness. Through their stories they created boundaries, or symbolic distinctions between themselves and others (Lamont and Molnar 2002). These boundaries took on a moral tone that privileged the therapeutic experience and expressed concern or worry for their siblings or non-diagnosed parents who were unwilling to go to therapy. Kathy discussed throughout her interview how she differed from her brother and sister, who she believed were unwilling to address the impact their father's illness had on them:

And I think out of my brother and my sister, I did personal therapy in (state) for about six years, and I feel like I maybe have the most personal insight, which has allowed me to have some insight on my family. I feel like I can probably have a little more rationalization about things than the two of them who don't have as much. So I like to share that with people and think the two of them just get a little annoyed with me.

Even though respondents described actively attending therapy as the most useful approach to understanding their experiences, those who were not involved with therapy also told me that children needed someone who they could talk to and

someone with which they could “process” what happened. At least five of the respondents I interviewed told me they either wanted to go to therapy in the future or actively asked for a referral to a “good therapist.” Most of my respondents used therapy and/or the therapeutic narrative to help make sense of their experiences, which they had not had the cultural tools to make sense of previously. In line with the tenets of the narrative, my respondents used the experiences they had in childhood to explain facets of their personality and how this coincided with the transition to adulthood. Below I return to their discussions of childhood loss and its connection to the therapeutic narrative.

Childhood Loss and the Therapeutic Narrative

In chapter three, I briefly explored the expectations my respondents had around childhood. Drawing on white middle-class ideals, my respondents told stories of an ideal childhood that should include limited responsibility, consistent emotional support and attention, and a general sense of feeling carefree. However, because of the uncertainty and unpredictability of their parent’s illness, many of the children felt they were forced to grow up too fast or were expected to do things that children should never have to do. Consequently, the stories they told set the foundation for their therapeutic narrative. By identifying the struggles they faced in childhood, they laid a framework for understanding their current choices. These stories, which children in both single-parent and married households told, tended to focus on helping out in the house beyond typical chores, or providing emotional support by acting as a sounding board for their parent, or actively comforting a sad

or upset parent. The children viewed these actions as outside of the normal expectations of childhood and said that having to step in to these roles made them grow up “too fast.” Carly, who remembers that as a young child, she thought that all moms took long naps and cried frequently, told me that she always felt like an adult because of the support she provided her mother, “Forever. Pretty much. I felt like I had to take care of my mom, to some extent. I mean, obviously she could clothe and feed herself, but I had to be her support. I didn’t really identify as a kid, I guess, ever.” Callie did not feel responsible for providing her father emotional support but remembered that she had to accept a more adult role because her father was sick and her mother was consumed by work and helping her father:

My dad never really did parent me. I feel like I always parented myself, because my house was in such chaos on such a frequent basis. Like by my senior year, I was cooking all the meals. I was doing all the cleaning because my mom was working, my dad was working and they were just such a mess that I was really holding down the fort.

The responsibility of “holding down the fort” or acting like a “second parent” left many of my respondents feeling as though they had been robbed of something they were owed. This feeling of loss appeared so salient to my respondents, because most of their friends and peers had parents who fulfilled, or at least appeared to fulfill, these expectations of providing their children with a sacred childhood. Appearing to have lost this sacred time was frustrating. Jenny said this realization of having to grow up too soon made her angry and frustrated:

J:I don’t know. I just deal with it (pause). I mean it’s just made me grow up a lot faster than I think I should have ever been expected to.

L: How do you feel about that? This idea that you had to grow up a lot faster?

J: Umm. It bothers me. It makes me mad. I get mad at my dad for just not being what a dad was supposed to be. And I get mad at my mom for not allowing me to be the kid that I wanted to be. I don't know.

Like Jenny, many respondents were frustrated, because their peers around them all seemed to be given a carefree childhood. They had parents who were involved and engaged and thus the children did not have to take on extra responsibility. Most of my respondents lived in communities where parents practiced concerted cultivation (Lareau 2003) and felt that the absence of this model of intensive parenting was something to be concerned about. Noel, one of my oldest respondents, actively recognized and refused to participate in this narrative. In doing so he does a nice job of identifying some of the assumptions of the protected childhood story:

I'm not one of these folks that buys into this whole, you know "I was a kid and I should have had a childhood," I just think that's bullshit; I don't buy into that at all. You know my mom (who was the diagnosed parent) was a single, working mother who had three kids and you're damn right that we should have been helping out at home. I mean this whole concept of like; well you know you were a kid you were supposed to be out playing. I played plenty, you know. It started at such a young age. It was very routine. You know by the time I was 10 or 11 years old it was such a routine. I don't remember having resentment.

Instead of drawing on the therapeutic narrative and assumptions of a carefree childhood to understand his experience, Noel argued this was just part of what you do when you live with a single mom. Noel was unapologetic about his life choices and decisions and did not see a point in connecting these to his mother's illness.

However, most of my other respondents did not feel this way and instead used this idea of a lost childhood to explain their own lives today. The therapeutic narrative is

powerful because it allows individuals to be both a victim and an actor (Illouz 2008). In my respondents' stories, they were able to identify the consequences of growing up too fast, but could also reclaim these experiences as markers of maturity and independence as they transitioned to adulthood.

Maturity and Independence in the Transition to Adulthood

As illustrated above, the therapeutic narrative provided an opportunity for my respondents to make sense of experiences in which they felt invisible and misunderstood, and they did so by highlighting the experiences and support they missed out on as children. However, the therapeutic narrative also provided an opportunity for my respondents to explain how they became actors and strived for redemption in spite of sometimes-traumatic childhoods. The most common positive attribute that my respondents identified was a sense of independence and awareness of life that their peers did not have. Lilly appreciated the independence and strength that she acquired at an early age:

I had to do it on my own. And like my brother and sister have been, we've really stuck together, and I think because of our parent's mental health it has made us stronger people for having to deal with it. It's also, you know, it's given us a different perspective on life. We may have felt weak at times, but I think that because we've gone through this, we have a lot of life experience, you know.

Sarah said that she wishes that she were able to have a closer relationship with her mom, but that like Lilly, she gained a lot by having to take care of herself at an earlier age:

I am a very independent person. I've very self-assertive. I have learned a lot of lessons because I have, either been in situations that have happened that I've learned a lot from or I had a lot freedom to you know make my own

mistakes. I don't know... I'm very independent. I think through this I have developed a big self-assurance, because I've had to learn how to fend for myself and how to take care of myself from an early age. It's definitely deepened my maturity level because I have experienced things that I don't think everyone does experience. You know there is definitely the jealousy thing about people being really close to their moms, that's something that I've learned to accept. But I think really the greatest impact is my independence.

Like Sarah and Lilly, Kate also described making her own decisions and accepting responsibility for her actions when she was younger:

I actually started college when I was 17. So... I don't know. So I wasn't really an adult, but I kind of felt like I was. Yeah. Like...I don't know. My parents have never had...like I never had a curfew in high school. I've never been grounded in my entire life. I have always made my own decisions for myself. And certainly I consult my parents about my decisions for myself, but I've always ultimately been the one to make my own decisions. So I've felt pretty grown up for awhile.

The concept of independence was used in two different ways. In the first, respondents contrasted their perceived maturity with that of their peers. This pattern was especially common among those who were still in college and felt that their life experiences put them on a different level than those around them. Erica told me, "I'm not a normal college kid. I feel like I'm a lot older than that sometimes," and Callie, who was planning to graduate a semester early, said, "I am like emotionally mature... emotionally like more mature than most of my friends here." Feeling more mature and older than their peers was simultaneously a badge of honor and also a cause for frustration, as Robin explained:

I am years and years and years ahead of my peers. I mean because of everything I've gone through. I'm just now finally getting to the age where I feel my age. I have felt 10 years older than everybody since this whole thing started. Since I took on that mom role around age eight or nine.

Robin went on to tell me that she was glad to finally feel like the people around her were on the same emotional level as her, but it took a long time and this process was a continuous reminder of the way in which she had to “grow up too soon.” Like Robin, George reiterated the pain and loss he felt from not having a childhood. However, George explained that being forced to grow up early allowed him to question and challenge the choices that he saw his peers making and to draw a moral boundary between himself and his peers:

I feel like a lot of the kids on campus are idiots. I’m sorry, I don’t mean this in an arrogant way, but like, when mommy and daddy are paying for all their education they are going out and partying. And I don’t know anyone other than a couple people who are paying for this themselves. And like the people who are paying for it themselves understand that if you fail a class, you are going to have to take it again, if you want your little piece of paper at the end of those four years, and like, I don’t know. It really bugs me whenever I see kids on campus just doing drugs left and right and are like, “oh I don’t care.” “Drinking doesn’t hurt me,” except for it makes your brain smaller, and “pot doesn’t hurt me,” except it hurts you. Just like all this information where I’m like, “you guys are just so blind to the fact of what you are doing to yourself and your bodies and your future.”

George portrays his experiences growing up and his economic independence as creating distance between himself and his more privileged peers who still had not “learned to grow up.” Jenny, who attended the same university, also felt economically responsible for her life not because of her parents’ financial situation, but because she did not want to have to rely on her father to help her out. She perceived her financial independence as an important step towards distancing herself from her father and his illness. Similar to George, her story focused on her frustration with the privilege she witnessed in her classmates’ lives and their reactions to her feelings of needing to work and be financially independent. Erica

was still able to depend on her parents for financial help, but said that her experiences forced her to grow up more quickly and develop a more coherent life plan that her friends could not understand:

I think that kind of isolates me, too. Because I have a solid plan of what I'm going to do, and I feel very strongly about it. All of my friends, I think it kind of separates me from them when they ask, "What are you going to do when you graduate?" We're seniors, so we're getting to that point. And I have this big plan, down to a timeline of what I want to do. I'm very focused. Down to when I want to get engaged, when I want to get married, that kind of thing. I have it all planned out. Whereas they're like, "Oh, I don't really know." They'll go to grad school in a year. And when they ask me what I'm going to do they're like, "well, okay nerd!" So yeah. It's not terrible. Sometimes I don't share everything, because it's just like, it just separates me [...] I feel like my maturity is more that of a 25-year old than that of a 21-year old. I feel like I've been through so much that... I guess I kind of feel like I don't have time to waste. Like I've already been over all this stupid, you know, relationships, and jobs, and you know what I mean? So, my sister always says that she forgets that I'm so young because, you know, of the way I am and the dedication. Yea, I guess it just separates me. And sometimes when I like, want to talk to, or when my friends want me to comfort them on their, the fighting of their relationship, I'm like, life's too short! You know? Like, that's ridiculous. They don't really; they don't really get that same aspect that I guess I do.

By drawing these boundaries between themselves and their peers, my respondents drew on traditional markers of adulthood including the importance of finding a job and financial independence and successfully making the most of their education. Erica, George, and Jenny critiqued their college-aged friends and challenged their party culture, lack of work ethic, and inability to plan for the future. They may not have experienced the "ideal" childhood but they saw themselves as more prepared for adulthood. They questioned the notion of continued dependence on their parents both because they felt that it was an impossible goal given their parent's illness, but more because it provided them with a badge of honor.

Many children are expected to accept independence and responsibility in the family while they are growing up, however the ways in which they do this vary by race and class (Bettie 2003; Lareau 2003). My respondents' stories point to their desire to experience the full impact of concerted cultivation and see this route as leading to more benefits and a stronger adulthood. However, their discussion suggests some similarities between their experiences and the accomplishment of natural growth that gave them more freedom and responsibility. Even though my respondents problematized the lack of concerted cultivation they experienced, many still had access to increased financial resources and middle-class peers. My respondent's stories actually illustrate some of the benefits they gained by existing between these two models of parenting, in the sense that they learned not only to be advocates for themselves in ways that their working class peers may not have been socialized to do, while also bypassing the extreme feelings of entitlement that they saw hindering their middle class and upper peers' ability to navigate college.

Respondents' evaluations of loss of childhood were not always completely positive, however. Kourtney explained that growing up in her household, she did not learn the norms (which I interpreted to be middle-class) that her peers did. She described her young adulthood as a time where she had to learn for herself how to behave "correctly" in social situations:

Once you realize that you have been socialized by someone who doesn't necessarily understand social norms, you know you almost have to recreate your own identity, you know what I mean? Like it was totally okay in my house to be completely impulsive and to say really inappropriate things all the time. I mean it was, there was all these, even today, I struggle with

having to filter. I mean I am so... I am so self-conscious because of the way my mother raised me

So while some children, like George, described feeling more in control and aware of their emotions, others explained that this loss of childhood and appropriate modeling and encouragement left them confused and unsure of how to act. Serena said she felt more mature and capable than her peers in some ways and explained how this helped her to navigate graduate school, but while she felt more mature academically, she described feeling emotionally immature, “I think that’s been good and bad. It’s helped me in self-discipline and getting me into school. But it’s held me back in my social life, and emotionally I have a hard time connecting and doing things like that so it’s kind of good and bad.” My respondents were pretty evenly split between those who felt more emotionally capable than their peers, with some saying that they learned early how to handle emotions, where others described lacking an outlet or guide to help them understand what to do with very complex emotions. I explore the specific ideas around emotions, relationships, and the transition to adulthood in more depth in chapter five, where respondents explain how their parents’ illnesses influence their approaches to romantic relationships. Below I look at how children discussed and understood another important piece of the transition to adulthood and role that their feelings of invisibility and misunderstanding played in shaping their stories.

Transition to Adulthood: Freedom, Escape, and Guilt

Many of my respondents were able to successfully navigate the path to college and to excel in school. They wore these achievements as a badge of honor.

Indeed, many explained that they had excelled in school because it was a way to escape their family and to take control of something. While most of the transition to adulthood literature points to the continued involvement of parents when children begin college (Fingerman et al. 2012; Nelson et al. 2010), many of the children I interviewed saw college as a chance to “escape” or a chance at freedom. Lucy explained that she decided to go to college “just far enough:”

It was so nice, I felt like it was a vacation to get away from my parents in college. It was no mistake that I went so far away and to a place where it wasn't easy for them to visit and it wasn't easy for me to visit them. If you're a six-hour drive away that's like feasible but not really, you know? So it was very convenient.

Unlike some of their peers who continued to stay in touch with their parents and to be consistently involved in their daily lives, some respondents “took a break” when they first left for college. Roman remembered the feeling of release that he experienced when he first left, “It was great (laughing). It definitely needed to happen. I don't think I talked to my mom or anyone until Thanksgiving break. It was a good solid two or three months.” Isabelle also remembered that leaving for college gave her the chance to confront her mom in ways she had been afraid to do in the past, “I think once I left the house I got better at telling her she needed to back off a little bit, and um and just speaking up for myself.” Being away from parents and the expectations of their family allowed many of my respondents to start to think about themselves. Maggie, whose father suffered from depression, said that she finally started to think about herself when she got to college: “So I think going off to college and being in my own environment made me figure things

out for myself more.” Maggie says that college provided her the opportunity to figure out what made her happy, without worrying about the impact it would have on her family. April’s parents continued to support her financially throughout college, but she described it as a time where, like Maggie, she could carve out space for herself:

It was good. I mean, I really needed the space. I definitely felt emotionally ready for it. I felt like I needed to take care of myself and be on my own. And the space was really good. Even though I was only in (college town), it was enough. And they were... I mean, that was really a period of time where I got to redefine my relationship with my parents.

The need to separate from their parents was an important aspect of transitioning to adulthood and also highlighted the power of the therapeutic narrative. Alexandra explained that for her, leaving to go to graduate school over 800 miles away from her mother was not only a chance to move beyond their difficult relationship, but was also a chance to show that she did not have the same dependency issues as her mom:

Now that I have done it, I am so glad that I did. I think I knew probably that I had to get away from my mom. She was a burden for sure. And I also knew that if I could, maybe because she was so dependent, she’s such a dependent person, completely. And I knew if I could move across the country for me the whole idea was like, if you can move across the country with nobody and move here and not know a soul, then like, that will really make you a great person, you know. And for me, that was a good goal to try and be completely independent and so that probably related a lot to my mom’s dependency issues. And I did it.

While some respondents were able to draw boundaries and focus on themselves while they were in college, others described the difficulty they experienced leaving their parents. It was mostly daughters, who had been more responsible for the

caretaking and emotion work for their diagnosed parent, who explained that they had a difficult time leaving their parents and felt guilty for working to establish their own lives and identities. Sarah, a 23-year-old college student, said she struggled after high school with the idea of leaving her mom at home. “I don’t know, I guess there’s like a form of guilt that I have in leaving, um, because there’s still like that protection thing that I want to give her.” The only way Sarah was able to initially break the pattern was through doing work overseas, which removed the possibility of being able to go home and help her mom. While she was able to do this, she said she still continues to struggle with leaving because she feels a need to protect and care for her mother. Rachel also experienced that same sort of ambivalence with her father. She felt extremely guilty when she couldn’t be with her father, who lives out of state, but also discussed the importance of focusing on her daily life. However, this focus on her “own” life led to even more guilt:

Also I feel like, I get guilt, spots of guilt, because I can’t constantly be there, because sometimes he does get sick, and I can’t go down there. So then I get the guilt, and then, you know you focus on your daily life, but then you feel guilty for focusing on your daily life, and it cycles back.

Several of my respondents, despite finishing college, felt that they still had not been able to complete the separation they desired from their parents. These children held on to the promise of graduate school. Erica, who already described herself as more mature and aware than her peers explained that she was still unable to completely remove herself from what was going on at home and agreed that graduate school was the best decision:

I have said to my boyfriend before that the reason why I want to go to graduate school out of state is to isolate myself from my family drama so that I can focus more on getting my doctorate. I'd probably be a lot more successful in college had I gone to college out of state, just because I think, and my boyfriend agrees, I think it would be a lot easier to separate myself from it and not feel like I have to go fix things.

Like Erica, Sierra was looking forward to graduate school, but was not sure if she would be able to handle the guilt of leaving her mom:

It kind of feels like I'm holding back. Like, I don't know. I feel like this is the time in my life where I am supposed to be out like doing new things and living with my friends, you know experiencing all of that, but I would feel guilty leaving her, so. Yeah it's hard because I want to go to grad school, and I kind of want to leave (the state) to go to grad school, but I don't want to leave her with the house. It's hard.

At the age of 34, Samantha said she struggles with helping her mom. As someone who was in a Ph.D. program at the time of our interview, she described it as being extremely difficult to balance the demands of school, family and her mom. Her mother's illness was more severe than many of my other respondents and Samantha explained that she had delayed many of her life decisions in order to help support her mom:

I take care of her bills. She calls me, and I pay her bills online. I'm the one who calls and deals with her doctors so I am angry that this is what, this is my life. And I'm angry that my mother still makes poor decisions, and I'm angry because I know there's not a damn thing I can do about it. And I could completely cut her off, but I don't know if guilt is worse, if I can deal with the guilt.

At the time of our interview, Samantha was trying to figure out how to help care for her mom while trying to meet the specific deadlines she had for her Ph.D. program. She described the obligation and responsibility she felt for her mom as something

that had “become a big dead weight for me.” Despite the anger and frustration, Samantha said she worried about the guilt more than anything else.

Like Samantha, several respondents focused on the guilt they felt for not being able to have the relationships with their parents they thought they should. These children experienced a conflict in which they simultaneously wanted to develop close and beneficial relationships, while also recognizing the limitations the symptoms of their parents’ illness placed on this possibility. Kourtney identified this difficulty:

You know I think I feel really guilty about my relationship with my mom all the time really. Because I think she wants so much more from me. But, me giving her more means I get sucked into her orbit, which is not something I am really comfortable doing anymore.

Some children felt compelled to cut ties with their parents in order to maintain their own emotional health and lives but almost all highlighted the guilt they felt for having to do this. So while the importance of adult autonomy helped to motivate some respondents to “live their lives,” the importance of family and the obligations that these relationships demand made it difficult for others.

Conclusion

The young adult children of parents with mood disorders who I interviewed overwhelmingly discussed feeling as though their experience was invisible. As children, many respondents were either told they could not or should not share their parents’ illness or feared that if they did others would stigmatize their parents or possibly the children themselves. This fear that their peers only had one way of

understanding mental illness, an image premised on uncontrollable and dangerous behavior, left my respondents feeling as though they could not explain the complexity of their families. Additionally, by operating on the assumption that all of their peers lived in stable, supportive families, my respondents felt as though their friends would not be able to understand the challenges they faced. Just as my participants worried about sharing experiences they saw as outside of the norm, it is possible that many of their peers may also have been experiencing issues related to mental illness, physical illness or other family troubles. However, instead of sharing their concerns, the complications and challenges that many - if not all - families faced remained invisible and instead my respondents relied on a story of “lost childhood” to understand their own experiences.

Approximately half of my respondents turned to therapy to help them make sense of growing up with a parent with mood disorder, and in doing so acquired a specific set of tools and strategies to tell their story. However, even my respondents who had not participated in therapy grasped on to the therapeutic narrative to talk about their lives. The therapeutic narrative provided a useful tool for my respondents because it allowed them to trace current issues and dilemmas to their childhoods. At the same time, the therapeutic narrative provided an opportunity for my respondents to turn the negative experiences they faced in childhood into badges of honor or stories of growth. Despite being “robbed” of a childhood, my respondents were able to learn independence and maturity in ways that they did not see amongst their peers. In fact, these stories actually allowed my respondents to

explain non-normative behavior and avoid sanctions. Respondents could explain their desire to work hard in school and avoid party culture as a testament to their maturity. They could explain the lack of their parents' involvement or support in their lives as an attribute of the independence they acquired early on in their lives that only better prepared them for finding jobs and succeeding in school.

The stories of independence and maturity that many of my respondents told co-existed with stories of frustration and obligation. Even if my respondents had learned to be mature and independent, many still wished that their parents were able to be supportive in the same way they saw their peers' parents behaving. At the same time, the children expressed feeling frustrated by the continued care and concern they offered to their parents during a time in their life when they believed they should be focusing on themselves. The responsibility for their families had come too early in their life course, and given their location amongst white middle-class peers these non-normative responsibilities bred frustration. The real consequences of the invisibility of this experience arise here, as the young adults grasped for support services or resources that might have helped them balance the transition to adulthood along with the responsibilities they felt towards their parents.

Ultimately, the stories that my respondents told about their parents' illness and the transition to adulthood demonstrate the need for researchers to not only consider the role social attributes such as race, class, gender, and sexuality play in young adults' experiences of the transition to adulthood, but how the types of

cultural stories and cultural narratives available to young adults filter the stories they tell.

Chapter Five

“If I could stop dating my pseudo-father”: The Rhetoric of Relationships

Jenny was the first interview I conducted for this study. We met on a snowy day shortly before Christmas. Jenny was open and honest in her answers, but her body language often communicated closed-off and uncomfortable feelings. She struggled to hold back tears throughout our interview and finally began to cry as she recounted a horrible experience with an ex-boyfriend that she quickly connected to her dad’s illness.

Jenny’s dad was diagnosed when she was between the ages of 14 or 15, but she remembers him having his first breakdown when she was 13. Throughout the interview she discusses his lack of parenting and the constant pressure she felt to be independent:

And so I tried making his life as easy as possible and to not be an emotional burden, a financial burden, and so my way of doing that was becoming very independent, getting a job, doing everything on my own and figuring it out on my own. I never wanted to have to go to him. I also, it got to a point where it was easier to just have no expectations. And that gets hard because on the days where he is okay and he is in a decent mood, you kind of get your hopes up and then you blame yourself for when it goes bad and feel disappointed again. And so I wanted to just know that I was okay without him.

Jenny connected her experiences with her father to her relationships by explaining that she tried to fill an emotional void, “I was looking for the love that I didn’t have from him.”

While Jenny was able to explain the various ways in which she learned independence and gained maturity that she believed far outpaced her peers, she

said watching and living with her dad completely destroyed her understanding of masculinity:

I think another way it's impacted me is in dating. Because it's completely [...]. It's destroyed what I thought of masculinity. Because he could never take care of me. Like when you talk about men not crying, my dad was crying to the point where he couldn't get out of bed.[...] And it was somebody that I couldn't rely on. And so to me, I've always looked at men as being weak, emotionally.

Jenny told me that it was not just her overall view of men that had been influenced by her dad's illness. As a high school student, Jenny said she was so used to being treated poorly by her father, who was either emotionally unavailable or highly frustrated and confrontational, that she had accepted and almost expected the same treatment in her romantic relationships, "Um so with that relationship, I think I allowed myself to get treated poorly [...] he actually, the guy never once picked me up at my door. He always called me. Like he never once treated me the way that I deserved to be treated." Throughout our interview, Jenny discussed feeling this need to take care of her father and how she saw herself repeating this process in her relationships. She said that she often found herself attracted to men who were in need of her help and she had a tendency to "take on their burdens and I find guys that have probably more issues than I do." Jenny believed that she was replicating her relationship with her father and there was no way to break this pattern.

Jenny used these concerns to explain her fear and hesitancy about marriage and the possibility of committing to a relationship. She was so afraid of repeating the same mistakes:

It's hard for me to see that happy ending with a guy. It's something I want more than anything, and I want that family and I want kids, but there's like this disconnect between the end result and where I am at now and there's this massive mountain that I can't seem to get over because I have this fear of replicating what my childhood was like. I don't know. Getting into a similar situation, dealing with a guy that I'm dating or marrying, his issues and his family's issues.

Like Jenny, almost all of my respondents connected the impact of their parents' illness to their romantic relationship choices. For some respondents these stories arose organically in response to a broad question asking them about the impact of their parent's illness on their lives. Other respondents shared these stories after I specifically asked them if they thought their parent's illness had any effects on their relationships. However, regardless of how the topic came up, my respondents were the most likely to talk about their parent's illness having a direct impact on their romantic relationships more than any other facet of their lives. Below I explore how my respondents pulled on broader cultural narratives about relationships but connected them explicitly to their parent's mood disorder and thus emphasized the negative impacts on their lives.

Romantic Relationships in the Transition to Adulthood

Researchers are increasingly interested in the nature and context of romantic relationships in young adulthood. As the age of first marriage continues to increase, researchers argue that young adults now have more freedom to navigate their romantic relationships (Arnett 2004; Cohen and Manning 2010; Waters et al. 2011). Large-scale quantitative studies of young adults and their romantic relationships have sought to answer questions relating relationship duration (Giordano et al.

2012), relationship disruption(Halpern-Meekin et al. 2012) and cohabitation (Cohen and W. Manning 2010). Some research has also examined the role that parental divorce has played in young adults' relationship decisions (Cui, Fincham, and Pasley 2008; Cui and Fincham 2010).

Most of the current scholarship on young adults and relationships seeks to explain and/or predict young adults' behavior and attitudes. Some scholars, however, have begun to focus on this information as a set of cultural stories and strategies rather than an indication of young adults' decisions. Even though researchers have pointed out the demographic shift towards independence in young adult relationships (Rosenfeld 2007), many young adults still appear to hold on to a relatively limited view of what young adult relationships should look like. These views are partially dictated by gender. For young men, college and young adulthood is a time to pursue the sexual experiences they so strongly desire (Bogle 2008; Kimmel 2008). While researchers are beginning to show that this approach is not as pervasive as is believed (Giordano, Longmore, and Manning 2006), it is still the primary cultural story of young men in college and their early 20s. In order to manage this expectation, young men, who may not conform to these expectations of sexuality or hegemonic masculinity, rely on other strategies to realign themselves with masculinity. Wilkins documents how Christian and Goth men use non-normative relationship practices and intimacy talk to reclaim their marginalized identities by reinforcing traditional ideals of masculinity (Wilkins 2009).

While young adulthood has been presented as a time for freedom and exploration, many qualitative researchers have demonstrated the continued pressure for young women to be in committed relationships during this time. Hamilton and Armstrong refer to this demand as the relational imperative in which “normal women should always want love, romance, relationships, and marriage” (2009:593). In their research, they found that middle-class women felt pressured to justify their single status and “felt pressure to be in relationships at all times” (600). These women, while acknowledging the demands of the relational imperative, also had access to another story: what Hamilton and Armstrong refer to as the “self-development imperative.” In this paradigm college is a time to develop their own skills and identities. However, the middle-class women in Hamilton and Armstrong’s study often found themselves caught between the demands of both imperatives, and so relied on hookups or casual encounters. However, “While hookups protected privileged women from relationships that could derail their ambitions, the double standard gave men greater control over the terms of hooking up, justified the disrespectful treatment of women, supported sexual stigma, and produced feelings of shame” (2009:606). Extending the conversation about relational expectations, Wilkins shows how middle-class black women at a predominately white university use stories about interracial relationships to perform “women’s commitment to heterosexual relationships in the absence of actual relationships” (2012:189). In other words, even when women are not in

relationships, they find ways to express their desire for and commitment to heterosexual relationships as a way of doing gender.

Returning to the Therapeutic Narrative

The young adults in the studies mentioned above told specific stories that were culturally situated based on their race and class locations to explain their partner choices and ability to commit to relationships in young adulthood. Even though my respondents could access some of the same stories above, most chose to explain their relationships choices and personal decisions by using attributes of the therapeutic narrative. In her study of co-dependents, Irvine notes the pervasiveness of the family therapeutic model in which “adult life consists of re-enacting your childhood, and unresolved conflicts rear their ugly head throughout” (1999:20). Participants in these groups have very different experiences, but each learns to tell their story in a particular way that begins by focusing on a “dysfunctional” childhood that would lead them to participating in “dysfunctional” relationships in adulthood. As discussed in chapter four, my respondents drew on this narrative to explain how their “loss of childhood,” while difficult, in many ways allowed them to be more mature and independent. In other words they were able to present the consequences of their parent’s illness in a positive light. However, when my respondents used the therapeutic narrative to discuss their romantic relationships, they almost always connected their “dysfunctional” childhoods to their “dysfunctional” adult relationships. Below I show how my respondents used the therapeutic narrative to explain relationship choices and approaches that were non-

normative. However, in using this narrative it often meant that respondents were unable to see that they did not have to be in a relationship at all, or that at least half of them simultaneously described strong relationships while still emphasizing their problematic relationship decisions.

Trust, Fear, and Commitment

I first noticed George after announcing my project in a local classroom. He was outspoken, intelligent, and spent the start of class talking to a classmate about his future plans and the pros and cons of leaving the local university for an East Coast school. When he arrived for our interview he was engaging, sarcastic, and open with his answers. As a 19-year-old freshman, George presented himself as more mature and aware than his peers, which was something he discussed during our interview.

George began his story by talking about his mother who had been diagnosed with depression “ever since I could remember.” George said his dad was diagnosed with depression around the same time as his mom, but was also just recently diagnosed with bipolar disorder. George was “pretty sure he’s had it his whole life.” While George said his mother’s illness made him more empathic and aware of her needs, he believed his father’s illness had a greater impact because of its unpredictability. George’s parents divorced when he was in second grade but got back together after his mother lost her job.

As I have discussed in the previous two chapters, George also emphasized the ways in which he had to grow up too fast: “Like, I, I feel like I really never had a

childhood. I've gone to psychology appointments and they've always been like, yeah it's okay for you to not like your father because he kind of took away your childhood." George's narrative of himself, which I discussed in chapter four, distanced him from his "immature" age peers, and he saw having a "stable" relationship as another marker of his maturity. For George, college was not a time of experimentation and exploration, but instead was an opportunity to solidify his adulthood. Thus, in his model, having a stable relationship was another central component of living an "adult" life. Despite this desire, George expressed ambivalence about romantic relationships.

George used the therapeutic narrative that he learned from his psychologist to understand his own ambivalence about relationships. He initially described himself as being somewhat hesitant towards love and marriage because of his father's illness and how his parents' relationship progressed:

I know definitely it's just screwed up my perception of what love is. Not even with solely my father but my mom and father, seeing exactly how like, what is love whenever your parents divorce, get back together only for money's sake and you see your mother flip-off your father every day. Like that just really screwed up my perception of what love would be and why would I want to get married to someone who could possibly be flipping me off every time I turn my back.

In this case, George saw his childhood as damaging and wondered if he would be able to move beyond what he viewed as a distorted understanding of love and marriage. This particular application of the narrative was useful for George because it could explain why he did not necessarily need or want to be in a committed relationship. While George could have easily accessed a narrative of hegemonic

masculinity, he had already created a story that distanced him from the expectations that he associated with his “immature peers.” Not being able to commit did not fit with George’s picture of himself, and so he relied on the therapeutic narrative to explain how his father’s illness had allowed him to become more mature but also made it difficult for him to find a stable relationship.

Like George, some of my other respondents also discussed their feelings of maturity and independence, and while they could identify some of the benefits, as they did in chapter four, they also discussed how the same experiences that forced them to establish maturity and independence hindered them in relationships. Many focused on their inability to trust. Several of my respondents said living with a bipolar parent was like being on a constant roller coaster - they never knew what to expect. Serena explained these feelings and said she thinks they have affected every relationship she has ever had: “Yeah, I think it affects it, because if you don’t know what to expect out of people’s behavior, um and so you know you grow up with a parent who might be one way one minute, the next minute a completely different way and just going through that feeling of never knowing what to expect...” Like George and Serena, Derek explained that he spent 19 years trying to believe in his father and constantly being disappointed:

Well it’s been 19 years of putting trust and putting belief that something’s going to happen, and it never does. And it’s just, the thinking, oh he won’t do it again and he does, and you know there’s no way that this could go in this direction and it does. I don’t know, it’s just I can’t. I have a hard time putting trust in him and all of that.

Derek said his experiences with his father left him feeling like he could not trust

anyone - either in a romantic relationship or even among his friends.

A common theme for many of my young women respondents was what they described as their tendency to “push” people away. Researchers have highlighted the importance of relationships to young women’s identity (Hamilton and Armstrong 2009; Holland and Eisenhart 1991) and despite the growing power of the narrative as a time for self-development (Hamilton and Armstrong 2009), many of the women in my sample talked about their inability to form stable relationships in adolescence and young adulthood as problematic and connected this to their parents. Lilly told me, “Like, um, I find that I’m, I’m pretty independent and I definitely push people away in that aspect (in relationships).” Like Lilly, four of the female respondents under the age of 24 talked about their tendency to push guys away, especially when they were younger. Erica remembered, “I liked to push people away before him (her current boyfriend), because it’s like I don’t want to depend on anyone if they’re going to fail me. Kind of like Mom.” Sydney describes herself as “picky” and not wanting to commit to a relationship in our interview, but instead of recognizing this as a common feeling for many young women, she connects this approach to her father’s illness:

I’ve never had a boyfriend; I just got my first kiss. So I think I tend to push guys away, and I’ll always like put them in the friend zone is what my sister says I do. I’m like really picky. I think I just have really high standards and I, yeah I don’t really let guys get close to me. Like emotionally very easily. Like it takes a lot. Like the one guy who actually I’ll talk to about things, I’ve known since I was ten. So like that’s how long it will take for guys to like really get to know me. I don’t know maybe some of that is because of what happened with my dad; that I don’t want to let guys too close to me.

The comment is slight, but she also nods to learning some of this narrative from her

older sister, Jenny, who identified a much bigger impact from her father's illness.

Michaela, like Erica above, is currently in a committed relationship. She remembers seeing the connection between her approach to relationships and her mother's illness as she got older:

I know that it's affected me, but it's one of those things that I have to realize slowly over the years. I guess like when I was a teenager, my first real relationship that I had, I noticed myself pushing away a lot. Like I ended up being with this guy for four years and I was just you know trying to sabotage the relationship the whole time, and you know I was just really scared of being abandoned and really scared of just not being good enough.

Like Michaela some of my respondents described fears of being abandoned and used this to explain why they were not in relationships. In addition, some of my respondents took this idea further and explained that they felt inadequate in relationships because of their inability to connect emotionally. Michael summarized his concerns and worries based around ideas of attachment. He explained that because of his mom, he was never truly able to learn how to communicate his own emotions and how to support someone who needed to communicate theirs:

So what is communication and how is security achieved in a relationship? How can you be in a relationship and be, how can I be in a relationship and be myself and allow the other person to be themselves and also both of us feel safe in that and feel like we're getting what we need and what we want and do what we want together? So, so it's a pretty big deal. It's a pretty big fuckin' deal.

Like Michael, what was striking in my respondents' stories was that the dependence and maturity that they described feeling in terms of negotiating school, the workplace, and adversity did not transfer into relationships. They saw their lack of relationships as something that needed to be explained and used the

consequences of their parent's illness to do it.

Filling a Missing Piece

I met Lilly in her new apartment on a spring afternoon. Lilly had just moved to town from the Pacific Northwest and was currently in the process of looking for a job. She told me from the beginning that she was very likely to cry throughout the interview. Lilly was open, honest, and eager to tell her story.

Both of Lilly's parents had been diagnosed with a mental illness. Her mother had suffered from depression since she was young. Lilly said that she thinks her father first started showing depressive symptoms after her parents separated when she was in fifth grade, but he didn't show signs of bipolar disorder until Lilly was about 16 or 17. Lilly said that she struggled with her mom's illness when she was a child and described her mom as critical and unsupportive. During this time, Lilly turned to her dad. "She was just really mean and nasty to me. Cause she was so miserable herself. So I had a really hard time with like stuff like that. It was like my mom would beat me down verbally and my dad would be the one picking me back up and encouraging me." However as Lilly got older, her dad's depression worsened and eventually she and her siblings were the ones who had to take care of him.

Lilly discussed the impact that both of her parents' illnesses have had on her life. In general, she has struggled with her independence and responsibilities for her father, but spent much of the interview on the ways in which her mom's illness had shaped her view of relationships. In the section above, Lilly mentioned her tendency

to be independent and to push people away; however she also drew on another cultural story to explain her experiences. She initially talked about her experiences with her parents in a way that is similar to George. She felt as though she missed out on “really having a mother” as a young child. The mother she was looking for was one who embodied the attributes of intensive motherhood as discussed in chapter three. Lilly did not feel supported or encouraged by her mother. She expected someone who would always be there for her and would devote her life to her daughter. She used this idea of a missing piece to explain that she went searching for the love she did not get from her mother. Lilly used her mother’s illness to explain her tendency to be “promiscuous”:

I mean that’s something, not getting that love from my mother I think really hurt me a lot, and I think partially that’s affected my sexual relationships. I don’t know in some weird way, you know, like I just seek love wherever I can find it, and I think that’s why I’ve been so promiscuous, and I have a hard time being, when I’m with someone I have a hard time not cheating on them too.

Lilly felt as though her mother had “damaged” her so completely that no one could provide her with enough love to fill the hole. Her need for love was compounded by a broader cultural and generational phenomenon in which “trying to have a connection with someone who is a guy is really hard because they just want to sleep with you.” Even though Lilly so desperately wanted to fill the missing piece left by her mother, she described these relationships as culturally unable to fulfill her needs. This idea, combined with the story that Lilly’s mother had damaged her self-esteem and self-image, left Lilly telling the story that she chose short, unfulfilling relationships because she subconsciously thought that was all that she deserved.

Instead of challenging the cultural imperative that women focus on emotions and deny themselves sexual pleasure and exploration, Lilly relied on the therapeutic narrative to problematize her sexual relationships with multiple partners and her failure to remain monogamous in her early 20s. As a recent graduate, Lilly was one of the few respondents to connect her self-described promiscuity to a need to feel “loved” in whatever way she could find. However, over a third of my respondents described their past and current romantic relationships as a way to find things that they thought were missing in their relationships with their parents.

The “missing piece” story that my respondents told generally started off with their discussions of what they lacked in their childhoods. For some it was love, for others it was support, and for others it was encouragement. The quest for these traits fit the general cultural ideals attributed to healthy relationships. However, according to my respondents, their intense desire for these attributes that went unsatisfied when they were children meant that they sometimes made the wrong choices in relationships in order to try to get them. They felt that their desire to “be loved” had lead them into unhealthy and codependent relationships. Jenny explained that she started her quest for relationships looking for the love she did not receive from her dad: “I think really, my dad being depressed was the base. It was where it started but it, I was looking for the love that I didn’t have from him.” She then explained how this desire lead her into relationships that she described as unhealthy and where she was not treated “right,” “with that relationship, I think I allowed myself to get treated poorly [...] he actually, the guy never once picked me

up at my door. He always called me. Like he never once treated me the way that I deserved to be treated.” Jenny says she stayed in that relationship for too long because of her desire to be “loved” and because she ultimately didn’t really know how men were “supposed” to treat her. Like Jenny, Maria said she also found herself staying in relationships that she described as unhealthy because she did not want to be lonely in the same way she was as a child: “Umm, you know um it’s made me stay in relationships, you know I feel like my fear of being alone it’s made me stay in relationships for longer than I should have you know because I know it’s not right and I know it’s not good, but it’s like I just don’t want to be alone.” Many of the stories that focused on an intense need to fill a missing piece were laced with regret and the idea that women had stayed in unhealthy relationships for too long.

Some of my respondents focused on their tendency to stay in “unhealthy” relationships while others said they “settled” by picking a partner who in retrospect wasn’t right for them, but whom they desired because they finally felt they were getting the love and attention they missed out on as children. Rebecca, who is still married to her husband, said she choose him for the “wrong reason” at the beginning of their relationship:

I married my husband because I needed someone to take care of me, honestly. He’s older than me by nine years, and he’s extremely intelligent. More experienced, he’s got his degrees and his career and all that. [He was] more mature in some ways, and so I looked up to him, and I was just ready to be loved.

While Rebecca does not completely regret her decision, she focused on the ways in which she and her husband have struggled in their relationship because Rebecca

wasn't truly "ready" for marriage. Because of her experiences with her mother, Rebecca felt she lacked the self-esteem and knowledge of herself that she needed to be successful in her marriage when it first began.

Not all of my respondents framed their desire to fill a missing piece as problematic. Maggie remembers feeling like her dad could never be there to support her when she was upset or having a hard time, and so she always searches for someone who can provide her with that support:

In serious relationships, I've always gone for the kind of person who takes me as I am, and who respects me more. Like, I can be sad sometimes, but it's okay. They're always there to always want to be with me at all times, regardless of my mood. I think that maybe it stems from my dad, because whenever I'm sad, he doesn't want to be around me.

Unlike most of the respondents above, Maggie described this quest as a positive. In other words, her childhood had taught her what she thought was unhealthy in a relationship so she was able to find boyfriends who were the opposite. However, most of my respondents were much more likely to frame their desire to fill something they missed out in childhood as leading to problematic decisions. Before moving on to the most powerful relationship story that my respondents told, I want to return to George. In the section above, George discussed his fear of commitment and the ways in which it connected to his parents' illnesses. However, like the respondents in this section, George also relied on the missing piece story to make sense of some of his experiences.

George described feeling like the only place he could find love and attention outside of his family was through romantic relationships. Even though George said

he was not sure if he would ever find a stable relationship, he said he tried very hard to find one to help fill the void he felt was left in his life:

And yeah like I know that I say, like it's tough for me to believe in it, but I've had seven girlfriends. Yeah, it's like, even though I don't know If believe in it (love), I'm looking so desperately for it. I'm looking for someone, because it's like not really having a family for so long. I know personally, I just went in those relationships to find someone to talk to, someone to be with, someone to actually care about where I was at two in the morning.

George did not draw on a narrative of romantic love to explain why he had entered into his relationships. He also did not use a common college narrative, which equates men's relationships with sexual pleasure and fun (Kimmel 2008). While George said he did feel like he "used" his girlfriends, he drew a distinction between the manner in which he used his girlfriends and how his peers might use women for sex or view them as objects. His story was based on filling an emotional void and a need to be cared for that he identified as stemming directly from his father's and mother's mental illnesses.

The therapeutic narrative was a useful tool for George to make sense of his relationships, allowing him to connect his parents' illnesses to his current dilemmas. However, in our interview, George eventually began to use this narrative to explain another decision in his life that was not related to his relationship choices. George had just started dating a new woman and he said that he no longer felt the same way about relationships. Now he said he feels like, "I don't have to stay with it (a relationship). It doesn't feel like I don't have an intense urge of I can't lose her, I can't screw this up." George identified his new feelings and approach to relationships as being directly connected to his new religion. Three months before

our interview, George was baptized and is a member of the Church of Latter Day Saints. He said this shift in his life has helped fill the missing piece he felt because of his parents' illnesses, "Most people lose a religion in college, I found mine. But yeah, I am now a Mormon, but yeah, it's a lot of fun. I feel like the family that I've always been looking for the church gave me." He continued by reiterating this point, "Yeah that feeling of a family, that feeling of someone that like, just made me feel whole. But yeah religion fixed that. Yay!" While George was a little sarcastic in his description, he was able to use the basic premise of the therapeutic narrative to explain why religion was now an important piece in his life. For George, this decision makes sense specifically because the therapeutic narrative allowed him to focus on the feeling of "family" that he was missing and how Mormonism can "fix" it. Most of my other respondents did not mention finding fulfillment in something other than a relationship that could replace the feelings of a lost family and lost childhood they experienced; instead they continued to worry about the consequences of these feelings.

Replicating Relationships

I met Robin in a coffee shop on a stormy day during the summer to discuss her mother's illness. As one of my older respondents, Robin exuded confidence and was extremely straightforward about her mother's illness and the impact it had on her. Robin's mother's diagnosis was one of the more severe amongst my respondents. She could not remember exactly when she knew that her mother was bipolar, but she described it as something that, "just completely took over our lives"

and said she knew something was wrong between the ages of five and six when her mom was first hospitalized. She described her parent's relationship as abusive on both sides and remembers being happy when they divorced at the age of nine. Robin and her brother lived with her mother for the next two years during which time her mother "was degrading seriously in her ability to take care of us. So I stepped up and took care of us (her and her brother)." At the age of 11, her mother had another episode and her father was given temporary custody that persisted throughout her adolescence. At 12, Robin's mother decided to move out of state. Robin remembers feeling very happy, but she did continue to try to stay in contact with her mom and says she took on a lot of responsibility at an early age:

I talked to her as much as I possibly could. I really have an over-developed sense of responsibility in the situation, because the tables were turned when I was young, and I kind of was the mother of the family and she was much more like the child. I was taking care of my brother, but I feel like I was taking care of her, too. I had major issues with guilt and letting go. And my Memaw and Dad and my stepmother were trying to help me with that, at that time. I hadn't really began...I was only 12, 13, 14. All through high school I had a lot of guilt about her being far away, and I knew she was sick and I knew she was living with my grandmother, her mother, who really isn't the kind of woman who wants to take care of another grown woman.

Even though Robin kept in touch with her mom, she limited the contact as a self-preservation strategy; when Robin was 21, the family lost all contact with her mother. Because Robin had to grow up so quickly she tells the same story some of my respondents do above, which is that she is "fiercely independent." However, the most powerful impact Rachel describes is her tendency to try and replicate the relationship she had with her mother in her romantic partners:

All I can say, up to this point, is I have definitely gone for the wrong type of guy, and in the end, it seems like a lot of them would share my mother's weaknesses. I realized this by the time I was 27, and I haven't been dating the last couple of years because I've really been trying to work on some of these internal areas of confusion. And just like, you say you want this, but clearly you pursued a guy who was very manipulative, and I swear to god borderline something. And I look back and I go, "what was I thinking?" It is that natural tendency to fall into this maternal role again. Like just like I took care of my brother back then, I'll take care of you, you little confused little man.

Robin used her tendency to pick "unacceptable" men who needed to be taken care of to explain why she had chosen not to be in a relationship. In our interview, she perceived herself to be outside of the norm, "I guess I'm the rare 30 year old woman who is not too terribly focused on marriage and babies right now." She explained that she wanted to focus on her career and developing professionally, and while she could have left her explanation at that, she ultimately connected her decision back to her "challenging" childhood.

Like Robin, older women respondents justified why they were not in relationships or had taken "so long" to find a relationship as being connected to their parent's illness. Rachel, who spent a large amount of her time and energy as a caregiver for her dad, said she tended to replicate this same approach with other men in her life. She believed that because she provided TOO much care they were never able to see her as a viable romantic partner: "I don't really develop actual relationships, or I put myself in the best-friend position, caretaker position where they see me more as a mom or a sister. And there's not really anything sexual. And I just kind of let myself be used by them. So it's never a good thing." Like Rachel, Felicity said that when she was younger she would often find herself dating men

with addiction problems or other issues, “I always just thought, oh I could help them get better, I guess it was that nurturing side of me that I just wanted to take someone under my wing and help them get better.” Felicity explained that it took a long time before she realized what she was doing and began to search out partners who did not resemble her father. Jenny also relied on this story when explaining the disconnect between her desire for a family and her life right now:

It’s something I want more than anything and I want that family and I want kids, but there’s like this disconnect between the end result and where I am at now and there’s this massive mountain that I can’t seem to get over because I have this fear of replicating what my childhood was like, I don’t know, getting into a similar situation, dealing with a guy that I’m dating or marrying, his issues and his family issues.

Instead of framing her ambivalence as a common feeling for a 21-year-old woman who was just finishing college, she instead discussed it as a problem that was connected to her father’s illness.

The women I spoke to were much more likely to talk about concerns connected to replicating the dynamics they had with their mentally ill parent in their relationships, but both men and women told stories about fears of dating someone who was “like” their parent. Roman says he thinks that his first serious girlfriend may have been bipolar and says it was only “after the fact” that he connected dating her to his dad’s illness: “Um, I never really realized until after the fact that I’d been attracted to that at all. And I think it’s because I had some slots where she fit into because I had to deal with that behavior, and so I could make that work.” Emily also explains that she was attracted to men who possessed similar characteristics to her mom: “I end up being attracted to unstable, well charming,

but under the surface either narcissistic or unstable.” And even Blake and Ray, the two men who described their mothers’ illnesses as having the least impact on their lives of all my respondents, both said they thought seriously about the women they were dating and whether or not they could express similar behaviors to their mothers. Blake explained, “I think if anything, I’m a little bit more cautious, just because I don’t know.” Many of my respondents held on to idea that people often seek out partners who have attributes that are like their parents, especially their opposite gender parent. Mark explicitly identified this theme: “I think consciously or subconsciously [...] well kind of like the Freudian, the Oedipal complex where you love your mother, well there are certain aspects of my mother that I feel as though I do seek out in romantic partners.” However, while Mark discussed this as a positive thing, “I am, uh, very attracted to women who are um, very resilient and um very strong-willed and open about their opinions and like straight shooters.” Most of my respondents were much more likely to focus on their attraction to individuals who possessed negative attributes that were similar to their parents and/or were fearful of being attracted to someone who suffered from mental illness. While it appears that most of my respondents relied on this general cultural story of replicating relationships, several of the young women actually recounted instances where their non-diagnosed mothers warned them about the possibility that they would be attracted to someone like their father. Kristina describes herself as being overly cautious in relationships because of the warning she received from her mom:

Because, and this has more to do with my mom and my dad, because my mom was like warning me and my sister “oh you guys are going to end up

subconsciously dating someone who is just like your dad, and they're going to be like bipolar" and just sort of drilling this into our heads that we need to be careful, and so now I think it's almost like I think I'm too careful of that.

The idea that children are subconsciously attracted to individuals who reflect the attributes of their parents is a common cultural narrative that is popular in movies, TV shows, and talk shows and is available for making sense of any young adult's relationship. However, when it is connected to the fear and pathology surrounding mental illness it creates a very limited narrative that makes it difficult for young adult children to recognize that much of what they experience in relationships is common for all young adults in this rapidly changing life course. By using the therapeutic narrative to understand their relationship choices many of my respondents focused on the negative consequences their parent's illness had created for them.

The Missing Story: Finding Stable, Committed Relationships

My respondents used the therapeutic narrative and cultural ideas about relationships to explain decisions they conceptualized as non-normative and to avoid negative assumptions imposed by others and themselves. For many of the young women, who were not in relationships at the time of the interview, the stories provided a way to explain and understand what they viewed as "promiscuous" behavior both in their past and current lives. For some, these stories helped alleviate the pressure of making the "wrong" choices in relationships. Older women, who experienced higher relationship demands and expectations, used these stories to provide a justification as to why they weren't in relationships. For those who

were in relationships, the story could explain their hesitancy to make a serious commitment, or was used to justify behavior they may have found problematic. Most of these stories tended to take the negative impact of their parent's illness as the starting point for their relationship concerns, but these stories missed the fact that over half of my respondents actually were in serious relationships that they did not describe as dysfunctional. Fifteen of my 50 respondents were either dating or partnered at the time of our interview, two were engaged, and 12 were married. Even respondents who were involved in relationships that they described as supportive and fulfilling were initially more likely to discuss the negative impact their parent's illness had on their relationships in the past. Kim remembered feeling afraid that she would relive the experience she encountered with her dad:

I've been afraid. I don't know if it's true or not, it's sort of cliché that you are going to relive your experience that you grew up in or whatever and yeah. I don't know if that's something that actually happens or not, but I was always kind of worried. I would start to see things that way and then get a little freaked out.

In the beginning of her relationship with her husband, Kim said she used this story to understand what was going on with her husband: "there were times for sure when I held my dad's situation against him and maybe reacted a lot more harshly to things that he was doing." Moving beyond the therapeutic narrative was difficult for Kim and some of my other respondents as they continued to use it to talk about and understand their partners. April told me, "I think I'm super sensitive... anytime my partner does something that I think could be like my dad, it upsets me." Michaela said that she still struggles with feeling the need to push her current partner and

father of her child away to repeat the patterns she learned in childhood. “I would do things unconsciously to push him away. You know I guess I still do that now but I’ve been lucky to be with somebody who recognizes it and isn’t affected by those things and calls me out.” And yet all three of the women above and most of the individuals who were in these relationships also talked about the trust, support, and understanding that their partners now provided for them. Sarah said, “My boyfriend is my best friend.” April described her husband as “very supportive.” Marshall explained that he could “really count on [his] wife,” and Carly said “I don’t think I would be here today” without her husband. Unfortunately, by framing their stories about relationships within the therapeutic narrative, many of my respondents could not fully share the strength and support they were able to achieve in relationships, whether in spite of or because of their parent’s illness.

Conclusion

In chapter four, I argued that the majority of my respondents relied on the therapeutic narrative to make sense of their experiences as children of parents with mood disorders. This narrative gave them a way to manage the invisibility and misunderstanding that many of them feared. For most, it also allowed them to discuss the “benefits” of their experience through the increased maturity and independence they gained. The therapeutic narrative also allowed them to see their romantic relationship decisions as stemming directly from their experiences as children. By discussing their relationships in this way, my respondents could explain what they perceived as poor and/or non-normative relationship decisions as

a consequence of their parent's illness. This narrative allowed them to explain why they had entered relationships too soon, why some of the relationships they picked were either "unhealthy" or "unsatisfying", and why they chose not to be in relationships at all. The flexibility of this narrative to explain all types of "problematic" relationships was useful because it offered an individualized story that could be applied to the particular relationship dilemma my respondents were facing at a given time.

My respondents' use of these stories was interesting given shifting relationship expectations in the transition to adulthood. Despite current research that shows shifting marriage norms (Waters et al. 2011), the rise of hook-up culture (Bogle 2008; Hamilton and Armstrong 2009), and new ways for young adults to think about and discuss their relationships (Wilkins 2009; 2012), my respondents still held tightly to a limited understanding of what relationships could and should look like during the transition to adulthood. My participants viewed any relationship that fell outside of this norm as problematic and explained it as a consequence of their parent's illness.

While the stories that my respondents told provided an explanation for the relationship issues they encountered, they ultimately limited their ability to talk about relationships in any other way. Even my respondents who described being in committed, stable, and satisfying relationships mentioned these in passing and continued to return their focus to the negative relationships they had in the past. The tendency to return to the idea that our childhood experiences shape our

relationship choices makes sense because it is so widely available and understandable within a therapeutic culture. However, the reliance on this story focuses attention on individual lives and choices and makes it difficult to examine the role cultural assumptions surrounding age and gender and structural barriers like work-family policies play in shaping how we understand and talk about relationships.

Chapter Six

Complicating the Stories: The Case of Cross-Gender Sibling Pairs

Miranda began our interview by telling me that she couldn't quite place when her mom was officially diagnosed, but she remembered her illness always being there. She said she thinks her mom started taking medication the same year that she was born, and by the age of 14, Miranda said that she and her siblings knew what was going on. Miranda remembered, "my mom would, pretty much for about two weeks she went into a big depression and she was going to work but she would come home and go straight to her room for like two weeks we just had no [mom]." Miranda's parents divorced when she and her siblings were very young and the children stayed with their mother. Miranda described her mom as not being around to take care of her, her older brother, and her twin sister:

Because she wasn't around so like she'd come home at 9 o'clock at night and I'd be out playing hide and seek with some friends, where most kids were at home and they weren't allowed to be outside, you know and she didn't care, so I was able to get away with a lot.

Miranda remembered being embarrassed that her mother was not like other moms. She described her mother's illness as having a direct impact on her life, one that has influenced her difficulty in finding her path and her desire to always be needed. When I interviewed Noel, her older brother, he told me he was not sure his mother had even had an official diagnosis. "I'm not sure if there has been an official diagnosis. I would be interested to see what Miranda said about that, not that we'd be in disagreement about that..." Miranda and Noel's mom had also been diagnosed with AIDS. While Miranda explained that her mom's depression made it harder for

her and possibly for doctors to recognize the symptoms of AIDS, and thus delayed her diagnosis, Noel believed that an official diagnosis of bipolar disorder came only after she had been diagnosed with AIDS. Noel said he didn't use the label of "bipolar" to understand his mom and even now is not sure he would explain her behavior as an effect of her mood disorder. He went further to say that he is not sure he ever would have classified himself as a child of a parent with a mood disorder:

I am still totally on the fence of whether I would describe myself as a child of a mentally ill person. I mean, I really don't know if I would use that classification. I don't know if I would use it from the age 1-18 and in my adult life. I'm not even sure where my mom became mentally ill, so a lot of that idea about classification and because I have certain understandings now do they apply or even make sense [in the past]?

Even though both siblings talked about their mom's unpredictable behavior and the responsibilities they took on at an earlier age, they did so in very different ways.

The premise of my dissertation has been to treat the data that my respondents shared with me as stories. Rather than simply looking at their experiences as the representation of what "really" happened, I have examined them as a cultural process. In other words, my respondents drew on particular cultural stories to interpret their experiences but also used specific stories to share their experiences with me. Nowhere was this clearer than in the nine interviews that I completed with sibling pairs. In this chapter, I use data from the four cross-gender sibling pairs and the stories my other respondents shared about their cross-gender siblings to begin to look at how gender may shape the stories my respondents tell

about growing up with a parent with a mood disorder and how and when they use gender to make sense of their experiences.

Research on Siblings

The vast majority of literature that explores the relationships between siblings focuses on relationships in childhood and late adulthood (Weaver, Coleman, and Ganong 2003). However, researchers are increasingly interested in the roles that siblings play in the transition to adulthood (see Conger and Little 2010 for review). Researchers have identified a variety of roles that siblings may play during this transition, including confidantes, teachers, role models, and friends (Cicirelli 1980, 1985). Weaver et al. (2003) draw on the works of Bank and Kahn (1975, 1976) to describe a specific set of roles that siblings play in each others lives including, identity formation, mutual regulation, defense and protection, interpreting the behavior of their siblings and others, providing direct services and teaching new skills.

Siblings may play important roles for each other, but research has also demonstrated that children do not always face the same experiences while growing up, specifically in their relationships with parents (McHale et al. 2000; Richmond, Stocker, and Rienks 2005; Tucker, Mchale, and Crouter 2003). Some research has looked explicitly at the impact of sibling configuration or “features as the size of the sibling group (i.e., the number of children in the family), ordinal position (i.e., the child's position in the age hierarchy of siblings in family), child spacing (i.e., the time internals separating the births of siblings), and sex composition (i.e., the

relative numbers of boys and girls in the sibling group)” (Steelman et al. 2002:244). In their review, Steelman et al. (2002) argue that within this research there is increasing interest in the role that gender plays for siblings.

Even though there are conflicting studies and arguments, in a recent review of the literature Raley and Bianchi (2006) argue that gender matters and “the literature suggests that gender of children has implications for the ways in which parents treat, spend time with, invest in, and ultimately receive care from their children in later life” (Raley and Bianchi 2006:417). In the household, girls are consistently responsible for more housework in comparison to boys (Raley and Bianchi 2006 for review). The importance of gender continues as children approach young adulthood, particularly in terms of providing emotional support: “young women provide their siblings with companionship and emotional support as friends and confidantes and are sources of aid and services as they are needed” (Weaver et al. 2003). As women get older, “women as sisters remain distinctive in the familial exchange network in several ways. Even controlling for such factors as age and family income, sisters as providers of care give more help overall, give a wider range of help, and are more willing than brothers to do practical tasks (Eriksen and Gerstel 2002: 852).

In the brief review above, researchers have demonstrated the gender inequities in care work and more specifically care work between brothers and sisters. Arlie Hochschild introduced the concept of “emotion work” as the way in which individuals manage their own emotions based on cultural expectations, but

also explained that “emotion work can be done by the self upon the self, by the self upon others, and by others upon oneself” (Hochschild 1979:562). Peggy Thoits built upon this concept by exploring how we manage other people’s emotions in interaction (1996), and Rebecca Erickson uses the term to refer to “activities that are concerned with the enhancement of others’ emotional well-being and with the provision of emotional support” (Erickson 2005:338) and argues that researchers must pay closer attention to this process in families.

In the analysis that follows, I explore the role that gender plays in shaping the ways in which siblings understand their parent’s illness and the ways that they respond to a parent’s illness with specific attention to expectations around the enactment of emotion work. In doing this, I show how the same patterns that the researchers above have found operate not only through perceptions of who should provide care, but are also connected to the ways in which siblings choose to understand their parent’s illness and whether or not they identify it as a problem in the first place.

Divergent Stories

I recruited the majority of my respondents through advertisements and announcements looking for children of parents with mood disorders. Consequently, everyone who I recruited directly identified with this label and came into the interviews prepared to talk about the impact it had on their life. However, when I had the four sisters in this chapter recruit their brothers into my study; I was shocked by the ways in which the brothers’ stories varied from their sisters. Above,

I detailed the response I received from Noel, who unlike his sister, was not sure if his mother was ever diagnosed and was not sure if he would have ever considered himself the child of a parent with a mood disorder. I experienced a disjuncture between the interpretations of Rachel and her brother Marshall. The stories that Rachel (28) and her older brother Marshall (31) told me also pointed to vastly different understandings of their parents' mood disorders. At the beginning of our interview, Rachel painted a vivid picture of finding her father with a shotgun threatening suicide around the age of ten. However, when I interviewed Marshall, he initially thought I was calling to interview him about his mother, who had recently attempted suicide and was surprised that I was calling to ask about his father¹⁰. He discussed his mother's illness as relatively new and described the suicide attempt as a call for attention. He told me that he wasn't sure his mom had been officially diagnosed, while his sister Rachel remembers their mother sitting both siblings down to talk about her own diagnosis:

With my mom, like I said, she's very hippy and self-aware, and she does a lot of self-help books. So she didn't talk about it too much until both my brother and I hit puberty. And then we had the family meeting, everybody get together and we're going to discuss sexuality, etc., and that led to a discussion of her past and some incidences in her life that were traumatic. That led to a discussion about her being depressed and medicated for it, and all that stuff.

At no point in time did Marshall lead me to believe that his mother's diagnosis was something that he learned about in childhood, in fact he told me, "I don't think at

¹⁰ Rachel and Marshall's mother's suicide attempt occurred after I had interviewed Rachel, so I am unable to comment on how she interpreted and discussed this experience.

any point in time if they were diagnosed with depression we knew about it,” he continued by explaining, “my mom’s depression, I guess you could say has all been recent[...] so it’s not necessarily a childhood thing for me, it’s more of an adult experience.” Marshall pointed to some similarities between himself as his mother, saying that they had a “chicken-little” attitude in which he sometimes resorted to negative thinking and worry, but ultimately says he did not see her depression as playing a huge role in his life.

Rachel spent almost our entire interviewing detailing the ways in which her father’s illness had affected her educational decisions, her romantic relationships, and her ability to move on with her own life using stories similar to those I have detailed in the previous chapters. In contrast, Marshall seemed to gloss over his father’s illness. He begins by connecting this to his parents’ divorce and the fact that he lived with his mom and only occasionally saw his father. He remembers his dad’s alcoholism and his physical health issues, but could not articulate the impact of his depression:

My dad’s deal I wasn’t really exposed to. Like I said, I was exposed to the alcohol portion to it. But then he had serious injuries as a result of some of the serious drinking and that’s maybe where you get into with Rachel because he had all sorts of health issues.

While Rachel certainly did mention her father’s health issues and alcoholism, she emphasized his depression as being the primary cause for concern and the immense ways in which it influenced her life.

Like Rachel, Alexandra spent the majority of our interview discussing the complex and challenging relationship she had with her mother. Alexandra recalls her mom's intense mood swings and the steps she consistently took to make her mom feel better. She says her mom had gone on and off her medication for years and so her depression continues. When Alexandra was home for the holidays before our interview, she said her mom's mood swings were back: "I think she cried twice a day, every day I was home." Alexandra said that when her mom would get emotional she was often the one to step in, "Like I felt like I was the parent to my mom in those situations. You know I would make her feel better or like say, 'no that's not how it is or how can we fix this.'" Alexandra explained that because of her mom she has a difficulty connecting in her romantic relationships, but that the experience helped her to grow up and prepared her for graduate school.

Unlike Marshall and Noel, Alexandra's older brother, Luke, was able to recall learning about his mom's diagnosis, "I would guess I was probably um like 11 or 12 something in that range and basically like uh, like she just told us what had been going on, um like we were just sitting down and she just basically just explained it to us and what it meant and what that was." He said that at the time he didn't think he really had the context to understand his mom's diagnosis, so while he could appreciate it was something important he didn't really know what it meant. He said his relationship with his mom had "always been a very positive, good relationship," and that he is not even sure if she still takes medication because it is something that's "kind of like dropped down into the background." Throughout our

interview, Luke talked about his mom's mood disorder but did very little to connect it to his life or his decisions in the same way that his sister, Alexandra, did. The only area that he saw a direct parallel was in his romantic relationships, which I discuss in more detail below.

Rachel, Miranda, and Alexandra all told stories about the large impact their parent's illness had on their lives and used their illness to explain certain life decisions or aspects of who they are. In contrast their brothers, Marshall, Noel, and Luke either did not acknowledge the illness in the same way or did not use it to contextualize or make sense of their experiences to the same degree as their sisters. Sisters outside of the paired sibling data told similar stories about their brothers, lamenting that they either did not want to talk about their parent's illness or that they could not or would not see the connection between their parent's illness and their lives.

The Therapeutic Narrative and Gender

In the stories above, the discrepancies between how brothers and sisters choose to talk about their parent's illness becomes clear. In chapters four and five, I explored how the majority of my respondents relied on the therapeutic narrative to make sense of their experiences. The use of this narrative did not mean that all of my respondents told the same story, but it did create similarities in how they interpreted and discussed the role of their parent's illness in their lives. This same dynamic emerged as I compared my last sibling pair, Charlotte and her younger brother Derek, to the three other pairs. Both Charlotte and Derek discussed the

dramatic impact they saw their father's diagnosis having on their lives, and while they explained these impact in different ways, they both did so by relying on the therapeutic narrative. Charlotte based her discussion on the 12-step model that she learned in Al-Anon, and Derek said he learned to think through much of the impact through the time he spent in therapy. In contrast, the other three brothers, Marshall, Noel, and Luke did not engage with and or believe in the therapeutic narrative. Noel actively explained that he was not going to think about his mom's illness in that way, "I don't want to turn this into some pity party where we are like at the level of people who are getting abused" and that he was "not one of these folks that buys into the whole, you know 'I was a kid and I should have had a childhood.'" Rachel traces her brother avoidance and unwillingness to confront the consequences of their father's illness to their childhood:

I'm on the phone with him, just bawling and really upset and just terrified. And Marshall... his reaction to Dad is that it's out of his control. So he kind of just wants to ignore it. Like with the whole suicide incident when I was 10, I told Marshall about it when he got home because he was away at a friend's house that weekend. And when he got home, I was like, "Marshall, I found Daddy with a gun. He was trying to commit suicide, blah blah blah." And Marshall just wanted to ignore it so it would go away and was like, "Well, he's fine now. Go away." And so that's always been his reaction to anything that happened with Dad. So, just sweep it under the rug and it will go away!

Rachel described her brother as being unable and unwilling to "deal" with their father's mental illness. She attributed some of this to his connection with their mother, but also argued that Marshall did not have the emotional capacity to deal with her father. She contrasted this with their mother's depression, which she

described as “under control, and he could deal with that” because it was less emotionally intense.

Many of the sisters expressed frustration that both older and younger brothers had not dealt with the impact of a parent’s illness. Robin explained this in the following way:

My brother and I, at the moment, do not have a relationship at all. It is very complex and not what this interview is about. But one important note is that he did not keep in touch with her [their mom]. He did not keep in touch with my grandmother. He did not deal with the repercussions of any of it, and I think whether he is willing to work through it or admit to it at all, now; maybe he will be one day. I think that all of this and him not having dealt with any of it is a big, big, reason why we don't have a relationship right now. He holds a lot of anger and resentment towards me, and I think it is misplaced. I think it is how he feels towards my mother.

Robin argued that her brother does not understand or remember what happened with their mother and has instead created a new and “inauthentic” story about their childhood. This inauthenticity had actually driven a wedge between them. The idea of brothers being able to ignore what happened to their family while they were growing up and consequently have very different perceptions of what occurred arose in many of the stories their sisters told about the family. Callie explained that she was the one to confront what happened with her family:

I would be the one who would like go out when my parents were fighting and go stop fighting and yelling at each other. Or like that day or Christmas, I would like go and put my parents in different rooms and just be like trying to diffuse the situation. My brother would like stay in his room and play on his PlayStation and ignore it. And I just don’t have this ability to ignore. Whereas I think he, on a very deep level, he knows what is going on and it's wrong. He knows it is bad, but he is ok ignoring it.

The sisters, who believed that they had at least done some work trying to understand their experiences, worried about their brothers, and hoped that they would one day be able to “process” what had happened to them. Even though Robin was not currently speaking to her brother, she worried that in her “heart of hearts, I am pretty sure this is a big issue that is yet to be dealt with in his life” and feared consequences of this as her brother got older. The stories that the brothers told about their experiences as well as the stories the sisters tell about the differences between their brother’s responses and their own both provide an opportunity for respondents to “do gender.” West and Zimmerman (1987) argue that gender is not an inherent attribute of individuals but is instead a performance carried out in interaction. In the stories that they tell, brothers do gender by demonstrating their autonomy, rationality, and power (Connell 1995). The stories that the older and younger sisters tell about their brothers reinforce the idea of the inexpressive male (Sattel 1976). However, at the same time the stories that the sisters tell privilege the therapeutic narrative and reaffirm their own femininity through their ability to handle and respond to complex emotions (DeVault 1991; Hochschild 1989). However, based on the stories they tell and previous research there is more to these stories than an opportunity for men and women to do gender. I cannot determine if the differences in the stories the siblings tell are because of different experiences, different interpretative frames, or different coping mechanisms, but the way in which they tell these stories points to a pattern where women are almost always held responsible for the emotion work, both as children are growing up and as they

transition to adulthood. I explore the way my respondents discuss care work and emotion work below and the gender implications their stories carry.

Care Work, Emotion Work and the Transition to Adulthood

A sister's frustration with her brother's inability to discuss the impact of their parent's illness was not only a way to do gender and enact the therapeutic narrative, it suggests there might be real consequences for gender inequality between siblings. However, the way in which respondents told these stories masked much of this inequality by discussing these decisions as though they were connected only to personality.

Before exploring these stories, I do want to note that not all brothers were completely disengaged from providing care for their parent and especially in cases where parents divorced, sisters often told stories of brothers who stepped in to help in some way. In fact, even though Noel did not identify as a child of a parent with a mood disorder, he still played a huge role in helping take care of Miranda and her twin sister:

I don't like to use the man of the house sort of thing. First off I was a boy, but at a young age, I can remember being nine years old, 4th grade, and coming home and having a very set routine. This was in the 80s, I was what they called a latch key kid, my sisters weren't home after school, they were in daycare and I would come home do the dishes, take out the trash, clean out the cat box, and feed the cats. I would do all of what I think would be considered sort of the domestic chores. Not my chores, not like, keeping your room clean and that sort of thing but more general household things and that was expected of me. That was a daily thing. It was known that I would do that every day after school, and my sisters reminded me too in the morning when we would get up, I guess that I was also sort of in charge of breakfast. I think my mom would like leave cereal and stuff out but I would go down and put the milk in the cereal and clean the dishes a put the stuff down the disposal and that sort of stuff too. I did that basically from 9-18, even when I

was in high school, even when they were old enough to actually start doing it the way I had done it.

Noel does not attribute this responsibility to his mother's illness though. When his parents divorced he stepped in to help:

You know my mom was single, working mother who had three kids and you're damn right that we should have been helping out at home. I mean this whole concept of like; well you know you were a kid you were supposed to be out playing. I played plenty, you know. It started at such a young age. It was very routine. You know by the time I was 10 or 11 years old it was such a routine. I don't remember having resentment.

As discussed previously, Noel does not frame his responsibility of robbing him of his childhood innocence and mentions that this "culturally" relative story does not help him explain his experiences. Unlike his sister, Noel refuses to use the therapeutic narrative. Even though Noel and some of the other brothers are described as being willing to step in and help with practical and or financial concerns, many of the sisters, like Miranda, felt that they could not and would not engage in their own or their parents' emotions. Miranda explained her frustration:

He's mean to my mom, you know. But also has helped her, he pulled out a 10,000 dollar loan to pay off a lot of her debts that she still can't get herself out of, you know so he has a lot of animosity and um she was never available so Noel had to kind of take care of us twins, sort of, that was the idea. I mean he was busy, not caring, I mean he was pretty mean but like, he still had the pressure to do that.

Even though Noel was able to help, he did not do so in way that acknowledged either his mother's or his sisters' emotions. Sarah also identified a similar pattern with her brother. She told me she thinks he was asked to take on the father role but was never able to handle their mother's emotions, which she contrasted to her and her sister:

I think that my brother kind of developed, um, uh, um what should I say, I think he kind of took on the father role and I think that was kind of his place, um, not, not from my understanding but he's never really been an emotional person, sensitive person. Like outwardly. I am sure he is.

Even though Sarah's brother was there to help support their mom, Sarah identifies her mother's illness as having a larger impact on her and her sister because of the emotional support and energy they offered for their mom.

In households where parents remained together, sisters described brothers who were less engaged in offering practical care in comparison to the brothers above, but continued the same pattern of being unwilling to engage in any kind of emotion work. In these stories sisters discussed their brother's unwillingness to "put up with" whatever behavior their parent might have been exhibiting. While the sisters were able to accept and work with what they got from their parents, they described their brothers as unable to do the same. Lucy attributed some of her brother's frustration to a lack of understanding, "And for my brother it's like different, he gets frustrated and confused and he's not real, I wouldn't say he's not sympathetic, but he's not very, he doesn't understand it very well. I mean I don't understand it very well, but I guess he has a little less patience." For some sisters it was not a case of "putting up with," but instead a role expectation that they never saw extended to their brothers. Alexandra remembers that she was, "really emotionally supportive of my mom and like would be the one to say that's not true if she was crying in her room like I would be the one to go in. That was always my role." Alexandra says these differences between her and her brother started around

the age of 10 and have always stayed that way. Lucy and Alexandra as well as other sisters do not describe the differences between themselves and their brothers as a gendered issue and instead rely on personality to explain these differences. By focusing on personality rather than gender as an explanation, the sisters are able to acknowledge the frustration they feel with their brothers but do not address the gender inequity that became so clearly evident in their stories. Despite the sisters' frustrations, they continued to be the ones to do the emotion work for their parents as they transitioned to adulthood. Given the nature of mood disorders, the burden of the emotion work was often quite high.

In chapter four, I explored the challenges my respondents faced in carving out their own lives without worrying about their parents. In general this was something that the women in my sample struggled with more than the men, especially because they connected this feeling to guilt. Alexandra said her mom constantly makes her feel guilty for moving away while her brother stayed closer to home, and yet Alexandra is still the one who does the emotional caretaking both for her mom and something for the relationship between her brother and her mom:

He never had that role, so now he doesn't hear it. Like if, my brother doesn't call for a while, my mom will tell me to get my brother she'll be like "well, Luke, doesn't call" and then I'll call my brother and be like you need to call Mom. So he's just, I mean and this is just my perception, I'm sure he feels differently but I don't see him getting dragged in it as much at all.

Kate similarly said her brother has simply made an active decision not to be involved with their mom or any family decisions. Kate saw her brother as a career and family man, but also one who is unwilling to "put up with" his mother, "he is

pretty hands-off at this point. He is like you are going to do what you are going to do and I'm not going to have anything to do with that decision. With any of her decisions.” Kate’s brother’s refusal to help or to be engaged with their mother ultimately pushed the responsibility on to her. Similarly, Marshall acknowledged that he was concerned about their father but he was unwilling to go and help during a critical time in his life:

I was just getting in high school. It was very tough for me. It was a tough call for me to make, you know because part of you wants to be with your dad and hopes he gets better, but the other part of you doesn’t want to adjust yourself and switch up your whole life you know right at that critical moment.

Instead, Rachel decided to move in with her father to offer him the care and support she believed he needed because Marshall “doesn’t deal well with emotions, and especially not with Daddy.” Rachel has continued to care for her father, and even though she wants to rely on her brother for support and encouragement, she described it as being difficult because of his approach to the situation even though she does admit he’s gotten better:

Marshall only talks about Daddy when he’s forced to, at least medical and mental-state wise. And so I’m on the phone with him, just bawling and really upset and just terrified, and Marshall, his reaction to Dad is that it’s out of his control. So he kind of just wants to ignore it.

He keeps tabs on the situation. He’s gotten better at that. He kept calling me while I was down there and saying, ‘Are you doing okay? How’s Dad doing? What’s going on?’ But at the same time, when it was all over and done, instead of trying to come up with any sort of future plans, it was just like, okay, it’s done.

Even though researchers have demonstrated the burden of care that women face in marriage, these stories point to the increased burden that women face during the

transition to adulthood. In these stories, sisters described brothers who were able to step away and focus on their own lives and families, while many of the sisters continued to feel obligated and responsible for at least helping to manage their parents' and sometimes even their brother's emotions.

The Same Gender Role-Model Story

The idea that gender played a role in shaping care work expectations and outcomes went almost completely unrecognized by my respondents. Instead, they discussed it as though it only connected to their siblings' personalities - despite the consistent burden for sisters discussed above. However, gender was not invisible to my respondents, as they used it to discuss the impact of their parent's illness on their siblings through their discussions of the importance of same-gender role models.

Brothers and sisters told stories about how the gender of a diagnosed parent played a role for the same-gender child. Charlotte and Derek both discussed the effects of their father's illness on their lives. However, Charlotte used gender to explain her brother's addiction problems and reaction to their father's illness:

For example a large part of the difference between my boyfriend who never did drugs because he was afraid of his dad and then my brother you know it's kind of like, oh well my dad is not the kick your ass kind of a guy.

Charlotte described her dad as not being able to be adequately masculine enough for her brother because of his illness. While she thought there were benefits to his emotional expressiveness, she ultimately believed that if her dad had been able to be "tougher" and "more assertive" her brother would have struggled less in his

adolescence. Like Charlotte, other sisters told stories about how having a mentally ill father had a huge impact on their brothers. They emphasized the lack of a male role model and how difficult it was for their brothers to grow up without a father who was sufficiently masculine. They attributed their brother's "wildness" or lack of discipline to the absence of a male role model (father) to keep them in line. For example, Kathy believed that her brother joined the army because of the lack of structure in his life caused by her father's mental illness:

Certainly for my brother I just think my father didn't turn out to be the sort of dad he wanted to be. I think my brother is now in the army, I would never have pictured him going into the army, but I think that sort of in his formative years he lost all of the structure that was in our house when he was younger and he suddenly felt that he needed an extremely structured life and that's why I think he went into the army. I think he wanted all these rules and security that wasn't there before.

Kathy's sister, Felicity, also thought their father's inability to be structured and disciplined shaped their brother's desire to be extremely disciplined and organized today.

In the stories above, sisters expressed concern over their father's inability to discipline and provide structure for their brothers. However, some sisters explained differences between themselves and their brothers when a father was diagnosed by telling stories about how their fathers "inappropriately" responded to their brothers. In these cases, sisters described instances where they believed their brothers were just "being boys," but in these moments their fathers were more likely to severely discipline them, as Kristina does here:

You know when they were younger, or when he was younger I feel like the bipolar sort of probably affected my brother the most just because he was sort

of a troubled child. He was a boy, he caused a lot of trouble and you know the times where my dad was, um, not in the greatest mood and my brother was causing troubles, he would probably lash out at him the most. So that wasn't as much of an issue for me or my sister.

In Kristina's story and the ones above, sisters used gender as a frame to understand what was happening in the household. In these stories the sisters pulled on ideas of gender essentialism that assumed that fathers should be assertive and willing to discipline, and that boys, because of their wildness, need a role model who expressed these behaviors in order to grow up to be strong and stable men. However, these stories also point to instances where daughters, like Kristina and her sister, learned to manage their emotions in response to their parent's illness in ways that brothers did or could not.

Like the sisters above, brothers said that they thought their sisters struggled with their mother's illness or faced a bigger challenge simply because it was their mother. Luke, who was able to pass almost all of the care work and emotion work on to his sister, did not identify this responsibility as affecting his sister and instead explained that it was because she lacked a strong female role model: "Yeah, I think it affected Alexandra more than it did me [...] I think it's also just, it was different for Alexandra because it was her female role model." However, in Alexandra's story she actually describes her mom as being a good role model in some ways, "She's a feminist, so that made me a feminist and that's a huge part of my life. Umm, always made me feel capable and strong like built my self-confidence for sure. Yeah. I mean I never doubted myself for a second living in that house. I always felt really

intelligent.” What Alexandra struggled with was not a lack of a strong role model, but the intense amount of emotion work she consistently felt responsible for providing to her mother. I was unable to interview Blake’s sister because she was currently out of the country, but Blake also thought his mom’s illness has had a larger impact on his sister. “If I had to pick if it has affected my sister or myself more, I’d pick my sister. I don’t know if it’s the nature of her illness, or if it’s just the nature of the mother/daughter clashing.” Blake’s narrative matched some of the stories of the other brothers that I interviewed, who described their parent’s illness as having a limited impact on their lives. While I cannot make the claim that Blake’s sister has a similar story to tell, his discussion of his sister does point to that being a very real possibility.

Conclusion

In chapters three, four, and five, I explored how my respondents relied on particular cultural stories to make sense of their experiences growing up with a parent with a mood disorder. However, the data in this chapter illustrate that what is happening within families and for children of parents with mood disorders is much more complicated than previous data may have suggested. The sibling data shows how children in the same household experience and or remember situations differently. Not only do memories differ, but the cultural narratives through which siblings choose to understand their experiences can vary quite dramatically. The fact that some of the brothers did not even identify as being a child of a parent with a mood disorders suggests there could be a variety of different interpretations of

this experience that researchers and service providers are missing. By only focusing on individuals who identify as children of parents with mood disorders and even more on those who are willing to talk about their parent's illness, this experience remains hidden. While the emphasis in this chapter focused on gender, my other sibling data suggests that for same-gender siblings, birth order, time of parental diagnosis, and involvement in therapy also play a role in how children talk about and understand what it means to be a child of a parent with a mood disorder.

In the stories above, it is clear that sisters have a particular idea of how their brothers should react and respond to their parent's illness. These expectations draw on the therapeutic narrative and emphasize the importance of emotional expression and talking about the situation. They also provide an opportunity for both brothers and sisters to do gender (West and Zimmerman 1987). When brothers "do gender" by refusing to talk about or even acknowledge their parent's mood disorder, sisters grow concerned and this has the potential to increase the burden on the sisters as they feel responsible for managing their brother's emotions. In addition to feeling responsible for managing their brother's emotions, the stories that most of the sisters tell also suggest the burden of the emotion work for their parents falls to them. So while other researcher has demonstrated the inequality in care work between brothers and sisters (Eriksen and Gerstel 2002), what seems to matter most for the sisters in my study was the overwhelming responsibility they felt for managing their parents' emotions. Interestingly, the sisters do not discuss this directly as a gender issue and instead focus on their brother's personality.

Ultimately, this strategy leaves them with limited options to challenge the gender inequality that begins in the household and persists as they transition to adulthood. While their brothers are able to “move on” with their lives, many of the sisters describe feelings of guilt and responsibility that are more difficult to escape and that they ultimately see as hindering their lives in some way.

CHAPTER SEVEN

CONCLUSIONS

As I started to write this conclusion, I could not stop thinking about what an interesting relationship the United States seems to have with issues relating to mental illness. I had just returned from a comedy exploring the life of a man diagnosed with bipolar disorder, living in a household with a father with what by all accounts was obsessive-compulsive disorder, who falls in love with a woman with severe depression. The movie, *Silver Linings Playbook*, touches on the stigma and misconceptions of a small town when the substitute history teacher is diagnosed with bipolar disorder after discovering his wife was having an affair, but ultimately the movie elicits compassion and hope for those affected by mental illness (Russell 2012). The next day, while catching up on weekly TV, I counted at least two different commercials advertising pharmaceutical studies and/or medication for those with severe depression or bipolar disorder. And yet, directly after watching one of these commercials, *The Daily Show* aired a segment exploring the comments from National Rifle Association chief, Wayne LaPierre, in the wake of the Newtown shooting in which he said, "We have no national database of these lunatics... We have a completely cracked mentally ill system that's got these monsters walking the streets," (O'Neil 2013). While these remarks seem extreme, the sentiment illustrates one prevailing view of individuals with a mental illness as people who are unstable, threatening and potentially even lethal. It seems that United States wants to reexamine our mental health care system and the lives of those with

mental illness but severely lacks the tools to do so.

Reflecting on these observations, it is no surprise that the children of parents with mood disorders described feeling invisible and misunderstood. They did not see their experiences reflected in popular culture or conversations with their friends. At the same time, they feared confronting cultural beliefs that might label their parents - or even worse, themselves - as “lunatics” and “monsters.” Yet they are not alone, as research suggests there are many children out there who do have parents with a mood disorder (National Research Council (US). Committee on Depression, Parenting Practices 2009). In fact, in the week prior to drafting my conclusion, I discovered three of my acquaintances also had diagnosed parents after we began a conversation about my dissertation. Research that explores the experiences of children of parents with mood disorders is growing, but most of this research focuses primarily on documenting the “real experiences” children have. By looking at the stories that young adult children of parents with mood disorders tell, I take a different approach to examine how children understand their experiences through certain cultural repertoires (Swidler 2001), which shape how individuals understand and talk about their experiences. At times these repertoires, or stories, provide useful frames for making sense of growing up with a parent with a mood disorder. However, these stories also constrain children’s ability to understand their experiences in new and different ways. Finally, the cultural stories that my respondents tell help make visible some of the taken-for-granted assumptions we have about families, gender, and the transition to adulthood.

Fragile Families?

The majority of research on children and families facing mental illness emphasizes the negative consequences that arise (Mowbray et al. 2002; National Research Council (US). Committee on Depression, Parenting Practices 2009; Smith 2004). While some have critiqued the emphasis on the risk-resilience models that pervade the literature (see Gladstone et al. 2006), the general view is that children of parents with mood disorders face many challenges. Indeed, many of the stories that my participants shared echoed similar findings of studies that documented the complex relationships that children have with their parents and the emotions these relationships generate (Beardslee and Podorefsky 1988; Haug Fjone et al. 2009; Luthar, Cicchetti, and Becker 2000; Mordoch and Hall 2008), the potential for increased practical and emotional responsibility (Aldridge 2006; Mechling 2011; Smith 2004), feelings of invisibility (Garley et al. 1997; Mordoch 2010; Trondsen 2011), and stigma (Angermeyer, Schulze, and Dietrich 2003; Corrigan and Miller 2004; Haug Fjone et al. 2009; Hinshaw 2005; Phelan, Bromet, and Link 1998). However, by examining my participants' interviews as cultural repertoires (Swidler 2001), it suggests that part of what makes the process so challenging is the specific idealized images of childhood and parenthood they use to interpret their experiences and shape their expectations.

In their stories, my respondents relied on middle-class ideals of parenthood and childhood to make sense of their experiences. Children expected their parents to practice concerted cultivation and thus to be highly involved, communicative, and

to always offer financial and emotional support (Lareau 2003). These ideas not only stemmed from a general cultural expectation of what parents should do, but more importantly from comparisons my participants made between their parents and their perceptions of their peers' parents. Children expected this behavior from both fathers and mothers, but they almost always held mothers to a higher standard, which emphasized the expectations of intensive motherhood (Hays 1996). My participants' expectations of involved parenthood reified the story of a protected and innocent childhood. In this view, children should be allowed to have a carefree childhood in which they could focus on their own lives and development. Caring for a parent, whether by providing practical support or emotional support, threatened this dynamic. By using these stories to explain their experiences and emotions children gained the ability to try to make sense of what was going on in their households. However, at the same time, these stories tended to frame their parent's behavior in an even more negative light. There is no doubt that some of my respondents were put into difficult positions, but even some of them recalled that they did not think anything was wrong with their childhood until they got older and reflected back on it through the lens of the Normal American Family (Pyke 2000).

There are other available narratives that respondents could have used to understand their families. Noel provided one such example as he discussed his experience through the lens of growing up with a single mother (see page 103), and while Charlotte (see page 90) emphasized the differences between growing up with a parent who has a mental illness and one who has cancer, she could have also

compared her experience to families where a parent is facing a chronic physical illness. Unfortunately, neither these narratives nor other narratives that emphasize the diversity of family experience appeared to be available to my respondents who held tightly to images of the Normal American Family they perceived to be happening all around them. The continued stigma surrounding mental illness silenced some of my respondents who were explicitly told by their families or decided on their own that their parent's illness was not something they should share with others. Finally, as several respondents suggested, they never saw any institutional awareness from schools or the health system that acknowledged their family situation and consequently continued to see it as something that was non-normative and should remain hidden.

The Importance of a Gender Lens

I did not approach my analysis of these stories looking for gender differences. However, my ability to recruit men, the content of my interviews with men, and how respondents discussed their fathers suggest that gender does matter. The men in my sample who had participated in therapy were much more likely to focus on the large impact of their parent's illness on their lives. Men who had not participated in therapy, and especially those who were recruited into the study by their sisters, told stories that minimized their parent's illness and the impact on their lives. While I do not have enough data to argue that men interpret the experiences of growing up with a parent with a mood disorder in fundamentally different ways than women, it does appear that women are more likely to engage in

the therapeutic narrative to discuss their parent's illness regardless of whether or not they have attended therapy and thus may be more likely to articulate the impact within an interview setting.

The gender differences in how brothers and sisters talked about and understood their parent's illness suggest some possible gendered consequences. Sisters' stories highlighted their frustration with brothers who were either unwilling or unable to talk about their parent's illness, which often left sisters feeling responsible for the emotion work for their diagnosed parent and sometimes their brothers. While other research has demonstrated the inequality in care work between brothers and sisters (Eriksen and Gerstel 2002), what seems to matter most for the sisters in my study was the overwhelming responsibility they felt for managing their parents' emotions. The sisters' stories point to the ways in which their brothers' ability to disengage from their parents ultimately left them facing the consequences, which included investing time, energy, and emotions towards supporting their parent. In some instances, daughters described feeling as though they had to put their life on hold or modify their decisions regarding educational, job, and/or relationships choices based on the concerns for their parent. The perception that brothers could opt out of emotion work mirrored a similar gender pattern that was present in my respondents' stories of their fathers in childhood.

The gendered nature of emotion work was a continuation of the same phenomenon my respondents acknowledged when talking about their childhoods. Despite the shifting expectations surrounding fatherhood (Freeman 2002; Marsiglio

et al. 2000; Pleck and Pleck 1997), respondents in my sample held their fathers to a much lower standard than they did their mothers. In these stories, mothers were held accountable for the emotional stability and functioning of the family regardless of their diagnosis. Similar to McGuffey's (2005) findings in families where sons experienced childhood sexual abuse, parental mental illness and its consequences reaffirmed expectations of traditional gender norms for parents and children. These norms weighed heavily on mothers and daughters who were expected to provide emotional support and be intensively involved in maintaining the family.

The stories also suggest that gender affects how children understand and talk about their parents. Much of the research on children of parents with mood disorders describes the impact of having a mentally ill mother as more detrimental (see Goodman 2007 for review); however, looking at the cultural components of my respondents' stories suggests that part of this may be connected to the unfair expectations placed on mothers and the expectation that mothers are ultimately responsible for the emotional well-being of the family regardless of their diagnosis. The participants in my story continued to reaffirm this belief through often-ambivalent stories about their desire to be mothers. The demands of intensive motherhood and stories of responsibility that centered on mothers set such a high bar that it makes sense why many of the women in my sample, regardless of age, expressed concerns over their ability to be successful moms in the future, especially given their expectations of creating a sacred and safe childhood for their children.

Transitions in Turmoil?

Sociologists and psychologists have made enormous contributions towards understanding the transition to adulthood. According to Shanahan et al. (2005) the field of psychology has emphasized individuals' use of cognitive, emotional and behavioral markers of adulthood such as being able to accept responsibility for one's actions or make decisions independently (e.g. Arnett 2000) while sociologists and demographers acknowledge the continued importance of key family transitions as individuals who had "experienced the family transitions—independent household, getting married or cohabitating and becoming a parent—were twice as likely to report feeling like an adult" (Shanahan et al. 2005: 249). Researchers have also begun to examine the role that local context and normative expectations play in young adults' conceptualization of the transition to adulthood (Waters et al. 2011). The respondents' stories illustrate the importance of demographic transitions, psychological shifts, and local context in shaping young adults' perceptions of the transition to adulthood, but they also suggest the importance of paying attention to how perceptions of childhood experiences shape interpretations of adult decisions. The young adults in my study who grew up in middle-class families and/or communities experienced what they perceived as non-normative parents and childhoods. They relied on these perceptions to craft stories to explain their decisions as they transitioned to adulthood.

As my respondents transitioned to adulthood they confronted contradictory feelings and expectations. Some feared the consequences of courtesy stigma (Goffman 1963) and so remained silent about their experiences, which caused them

to return to a narrow idea of what family looks like. Others were less worried about stigma and instead emphasized their peers' inability to understand what it would mean to grow up with a parent with a mood disorder, which also left them lacking an understanding of the issues and complexities that most families face. Without a frame to understand their experiences, many of my respondents drew on the therapeutic narrative. Some encountered and learned this narrative from their time in therapy, while others pulled the language and discourse from popular culture. The therapeutic narrative provided a way for respondents think of their childhood as problematic and frame it as having an impact on their transition to adulthood. They contrasted their experiences with their peers and stressed the ways in which they were more mature and often times better prepared to meet adulthood. By telling a story of redemption, my respondents hoped to move past the consequences of their "lost childhood." However, the stories that they told, which distinguished them from their peers ultimately created another set of challenges as they confronted specific assumptions about the roles of children and parents in the transition to adulthood.

Researchers argue that parents may now be "parenting" longer than in the past (e.g. Nelson et al. 2010). Much of this literature has demonstrated that a positive relationship with parents can lead to beneficial outcomes for young adults (Barry et al. 2007; Kenny and Sirin 2006; Leondari and Kiosseoglou 2002).

However, these assumptions of involved parenting did not always resonate with my respondents, who struggled to manage envy and frustration that their friends and

peers had parents who were able to help them financially, domestically, or emotionally, while many of them felt that they were already responsible for providing the same things for their parents. Having to take care of a parent, no matter how simple the care, was not something they expected to have to confront in their 20s and 30s, just like it was not something they expected to do in their childhood. Rather than considering the many ways in which some children do provide care for their parents, the participants held tightly to the belief that they were alone.

In addition, by relying on the individualized therapeutic narrative, respondents were unable to describe their relationship decisions and challenges as a broader reflection of the transition to adulthood in the modern era and instead relied on their parent's illness as the primary explanatory process. While this strategy allowed them to explain what they perceived to be non-normative relationships, it ultimately reinforced narrow definitions of relationship pathways and left social structural barriers and gender inequality unchallenged. Just as it is important to explore the role that culture plays in shaping how we understand families, it, also matters for studying the transition to adulthood. As we explore the transition to adulthood we can not only look at the demographic and relational characteristics of the population, but must also consider what types of cultural stories they have access to and are drawing on to make sense of their experiences. The stories young adults use to understand their childhoods carry real implications for how they imagine and understand their futures, which I discuss in more detail

below.

Limitations and Implications

Examining the narratives of young adult children of parents with mood disorders through in-depth interviews provided the opportunity to explore when and how young adults used specific cultural ideals and expectations to make sense of their childhoods and the transition to adulthood. However, gathering and analyzing the data in this way has several limitations. The commonalities between my respondents' stories are highly connected to my recruitment strategy. In other words, I was only able to tap into the stories from individuals who identified as a child of a parent with a mood disorder and who saw some benefit and/or felt comfortable talking about their experience. The sibling interviews that I was able to gather suggest that there are children who may think and talk about this experience in very different ways. In fact, there are those who researchers or practitioners would identify as children of parents with mood disorders who may not identify themselves in that way. Future research must consider ways to access this population and whether other research methods may be more helpful in exploring their experiences.

In many ways, my interviews presented an opportunity that mirrored the therapeutic experience and consequently may have shaped as well as limited the ways in which my respondents told their stories. While my own identity as a child of a parent with a mood disorder facilitated recruitment and assuaged many of my respondents' fears of sharing their stories, it also influenced the type of story I was

able to collect. How my respondents shared their experiences with me could be very different than how they understood the experience internally or how they would describe it to an outsider or peer.

Finally, my respondents as a whole could be described as a successful population as the vast majority were currently in college or had already earned at least a bachelor's degree. Their perspectives of the influence of their parent's mood disorder on their lives may be very different from those who faced other challenges or were not embedded in white, middle-class institutions. Future research should examine how children of parents with mood disorders from other class and racial backgrounds understand and explain their experiences and if/how they rely on similar cultural tools.

Despite these limitations, my respondents' stories suggest particular implications for sociologists and policy-makers who are interested in families and the transition to adulthood. By examining my interviews as stories, it suggest that it is not just the events children face in childhood that matter, but also the cultural tools they have available to interpret and make sense of them. Race, class, gender, and location within the life course influence what these cultural stories look like and how young adults may ultimately use them. Because my respondents were embedded in primarily white and middle-class institutions, they not only relied on the cultural expectations of the Normal American Family (Pyke 2000) and concerted cultivation (Lareau 2003) to frame their own experiences, they saw a protected and carefree childhood as something they were entitled to - especially because they

believed it was something the majority of their peers could access. Regardless of whether or not their peers' families actually matched these idealized norms, my respondents' belief that they did was powerful. By telling their stories in this way, they reaffirmed the power of the Normal American Family and used this conceptualization as a way to imagine their own relationships and childbearing decisions. It is possible that if my respondents had access to stories that exposed the diversity of family forms and the possibilities in these forms, they may have imagined their own transition to adulthood, feelings about relationships, and perceptions of childbearing differently.

Researchers who study families need to critically examine the role that culture plays in shaping how children understand and talk about their own families. Ideas about what is "normal," "essential," or "harmful" to children and families should not be accepted as a universal truth but as something that shifts over time and depends on the cultural resources at hand. Rather than treating interviews and surveys of the family as a set of "facts," researchers should use a critical lens to situate their data within the particular cultural context in which it was created. The importance of culture for shaping what matters within people's stories of family should be given more thought and reflection both in terms of research design and data analysis. Researchers should also explore how telling particular stories about families may allow individuals to explain certain ideas of behavior during a particular time in their life course, but may also limit their ability to understand future decisions.

Further exploring sibling data provides one avenue to begin to examine how interpretations of the family and the impact these interpretations have on the transition to adulthood are shaped by culture. The data suggests that two siblings growing up in the same house may not only interpret a parent's illness as having significantly different effects on their identity, but some children may not see the experience as a salient feature of their lives. The use of paired-sibling data offers new opportunities for researchers to explore how children within the same family respond to and understand parental mental illness. Sibling data also suggests the importance of gathering stories from multiple perspectives in one family before making claims about the impact of illness, divorce, or other family events.

The importance of stories stretches beyond how researchers think about and analyze their data. The stories that individuals tell about an experience help to make that experience feel real (Bruner 2004; Maynes, Pierce and Laslett 2008). Thus it is important to acknowledge the fears of stigma, invisibility, and misunderstanding in respondents' stories. These children of parents with mood disorders felt as though there was nowhere they could turn for help and struggled to determine if anyone else shared similar feelings or challenges while growing up with a parent with a mood disorder. What many respondents wanted was to know that there were others who were experiencing what they perceived as non-normative family experiences. They believed that if they had had more access to support services, whether it be support groups, books, or online forums where they could turn to find people who could share their stories and advice, that they may

have been better able to understand what was happening in their childhood. While many focused on the benefits of targeting support towards children still in the household, they also argued that they wished they could find more information for young adults who had left the household. Many of the respondents were searching for confirmation that what they felt was “normal.” They wanted to know that it was okay to have conflicting and sometimes contradictory emotions towards their parents, and they hoped that one day there would be a better understanding of mental illness in the United States so they could share their stories without hesitation. Not all children of parents with mood disorders want a space to talk and share experiences, but the vast majority of those who participated in my study wanted to know that they were not alone. The desire to know that there are other families and children who may be experiencing similar circumstances suggests that making young adult children of mood disorders visible and allowing them to connect to others is essential. However, my data also suggest that this information should be done with thoughtful consideration so that it does not simply reify the limiting and narrow version of the Normal American Family. By providing a framework to think about and understand the complex relations within in families, we can provide the opportunity for young adults to imagine their own relationships and future family choices in different ways.

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Appendix

Interview Schedule

Illness, Diagnosis and Treatment

- Which of your parents is diagnosed with a mental illness?
- What type of mental illness was your mom/dad diagnosed with?
- How old were you when your mom/dad was diagnosed?
 - What reaction do you remember the family having?
 - What did you think about it?
- How did you recognize your parent's illness and when did this happen?
 - Did your ability to recognize concerns change as you got older?
- How was your mom/dad's illness treated?
 - Did they go to therapy, start medication or were they hospitalized?
 - How did you feel about this when you were a child?
 - What did you think was happening?

Present Effects of Parent's Illness

- How would you say your parent's mental illness influences you today?

Current Relationships with Parent

- What kind of relationship do you have with your parent now? How often do you see him/her? Communicate with him/her?
 - What about your other parent? (Probe: parents expectations for the child)
 - Siblings? (Probe siblings expectations, siblings roles in the family)
 - In what ways, if any, would you say your relationship with your parent has changed?
 - How would you compare your relationship with your parent to the relationships your peers have with their parents?

- Does your parent's illness influence your daily life? In what ways? (Probe for boundary negotiation)

Transition to Adulthood Markers

- What if any role has your parent's illness had on your education?
- What about your job?
- What kind of impact does your parent's illness have on your relationships?
 - Who have you told about your parent's illness? Why?
 - What was their reaction?
- If you were to compare your current life situation with that of your peers what are the similarities? Differences?

Do you feel like an adult? Why? Why not? When would you say you first felt like an adult?

Can we go back a bit and talk about what it was like to grow up with a mentally ill parent.

Household Dynamics

(Depending on the results of the family tree, I will structure questions a little bit differently)

You wrote in your family tree that you parents were (married, divorced, separated) If they were divorced when did this happen?

How did your other parent handle your mom/dad's illness?

What do you remember about their reactions and responsibilities?

If they have siblings...What about your brothers and sisters?

How did they respond to your mom/dad's illness?

How did these reactions compare to your own?

When your mom/dad was sick did the atmosphere in your home change?

In what ways?

What about individual responsibilities?

Responsibilities of others?

What was your home like when your mom/dad was in the hospital? (If respondent mentions hospitalization)

How did this make you feel?

What about other family members?

Interpersonal Relationships

Did you tell your friends about your mom/dad's illness?

If so, how did you tell them? How did they react? Did this change as you got older?

If not, why didn't you tell them?

What kind of role did your friends play when your mom/dad was sick?

Did you ever talk to your friends' parents about what was going on?

What was their reaction?

What or who provided the most support for you growing up?

How did they/it do this?

What would you have changed?

Future

**Some of these questions may be asking respondents to reflect on previous decisions

What are your goals/plans for the future?

In what ways do you think your parent's illness will affect you in the future?

Probe: Concerns about affects on the following areas:

Relationships: Telling partners, sharing responsibility for parent with partners, balancing time and energy between parent and partner

Children: Whether or not to have children (both genetic and social reasons), what to share with children, what kind of relationship would you want children to have with your parent

Career: Does the illness influence career choices, time able to commit to career, concerns about promotion, work/home balance

Living situation: If or how parent's illness influence where children live (location, distance, type of apartment/house)

Suggestions

What advice would you give to parents and their children who are going through situations similar to your own?

What support would you suggest to them?

Is there any support you wish you had as a child that you didn't?

What resources do you feel you would benefit from now?

Are there things that you need that would help you with your parent and his/her illness?

What about in the future?

Finally, do you know of any other friends who have a parent with a diagnosed mental illness who you think would be interested in participating in this study?