Mental Illness, Caregiving, and Emotion Management

David A. Karp
Valaya Tanarugsachock

Based on 50 in-depth interviews, this article considers how caregivers to a spouse, parent, child, or sibling suffering from depression, manic-depression, or schizophrenia manage their emotions over time. By considering the turning points in the joint career of caregivers and ill family members, our analysis moves beyond studies that link emotions to particular incidents, momentary encounters, or discreet events. Four interpretive junctures in the caregiver-patient relationship are identified. Before diagnosis, respondents experience emotional anomie. Diagnosis provides a medical frame that provokes feelings of hope, compassion, and sympathy. Realization that mental illness may be a permanent condition ushers in the more negative emotions of anger and resentment. Caregivers’ eventual recognition that they cannot control their family member’s illness allows them to decrease involvement without guilt. The article concludes with a call for research that understands that emotions in groups, settings, or organizations are linked to their distinctive histories.

Although sociologists have always understood feelings of obligation, responsibility, and duty to be the moral cornerstones of society, little attention has been given to the ways in which such feelings are evoked, interpreted, managed, and acted on in everyday life. Candace Clark (1990) has observed that although sociologists often use the language of reciprocity and exchange to explain the give-and-take of everyday interaction . . . [they] rarely ask why people feel they owe something to others, what the “ligament” is that connects people, or what the feeling of owing or obligation consists of. (p. 323)

This article examines the intense emotions that surround efforts to honor a commitment to care for a family member with a major mental illness. The analysis is based on 50 lengthy interviews with parents, spouses, siblings, and children of individuals diagnosed with depression, manic-depression, or schizophrenia. Our goal is to explain the kinds of emotions that arise as family members engage in ongoing interpretations of what they owe a spouse, child, parent, brother, or sister in desperate emotional trouble.

AUTHORS’ NOTE: Portions of this article will appear in a forthcoming book by the first author, tentatively titled Committed to Care: Mental Illness, Family Ties, and Moral Responsibility. The book will be published by Oxford University Press. The authors would like to thank Charles Derber, Christina Johnson-Levetin, and William C. Yoels for their support and helpful comments. Please direct all correspondence to David A. Karp, Department of Sociology, Boston College, McGuinn Hall 426, Chestnut Hill, MA 02467.
Although their sickness might dramatically disrupt the logistical routines of everyday family life, physically ill people are ordinarily deeply involved in getting well and returning to their presickness social roles (Parsons, 1954). In contrast, mentally ill people often cannot abide by the usual rules of social settings, may engage in behaviors considered socially repugnant, sometimes deny that they are ill, and frequently treat their caregivers with hostility instead of gratitude. Furthermore, if ordinary social interaction requires that people take each other’s roles, efforts at meaningful communication with the mentally ill are often short-circuited. After all, they have been identified as mentally ill because they inhabit phenomenological worlds that are inaccessible and incomprehensible to healthy people. In this way, mentally ill people threaten both the concrete routines of daily life and, more significantly, the implicit symbolic order on which such routines are premised. Their behaviors are especially disturbing because they upset the most sacred of all social things: the coherence of everyday life.

With its emphasis on the negotiation and interpretation of caregivers’ emotions, our work fits squarely within the emerging field of the sociology of emotions (Collins, 1981; Denzin, 1984, 1990; Franks, 1995; Harré & Parrott, 1996; Hochschild, 1979, 1983; Kemper, 1981, 1990; Schott, 1979). Illness, emotional illness in particular, constitutes a particularly valuable life situation for illuminating the links between cultural ideas, structural arrangements and . . . the way we wish we felt, the way we try to feel, the way we feel, the way we show what we feel, and the way we pay attention to, label, and make sense of what we feel. (Hochschild, 1990, p. 117)

It is the problematic character of the emotions generated by mental illness that makes it a strategically useful case for generally advancing our understanding of emotion work. Because breaches of social order generate very strong negative emotions (Garfinkel, 1967), the case of mental illness allows us to examine how caregivers reconcile love for a family member with such emotions as fear, bewilderment, frustration, resentment, anger, and even hate.

There is, however, another dimension to the mental illness case that helps to push our analysis beyond conventional discussions of emotion work. In their earlier and groundbreaking research, Glaser and Strauss (1965, 1968) demonstrate that illnesses follow clear and predictable social trajectories. In his recent work on depression, Karp (1993, 1994, 1996) has argued that people afflicted with mental illness follow a discernible career path characterized by critical “turning points in identity” (Strauss, 1959). To the extent that there are predictable moments in the unfolding of a family member’s illness, there will be a parallel caregiving career. We will show that caregivers’ perception of their obligations to an ill family member changes over time. As their felt obligations change, there will be a corresponding shift in the predominant emotions that they feel about their caregiving role. The central task in the data sections to follow is to describe changes in caregivers’ perceptions and emotions over time.

By considering the evolution of caregivers’ emotions over time, our research moves beyond studies that link emotions only to particular incidences, momentary encounters, or discreet events. Hochschild (1990) has called for studies that “ask by what principle . . . we manage our feelings over the course of a long string of moments;
how . . . we fit emotion management to a line of action through time” (p. 118). In a similar vein, Gordon (1990) notes that “we need studies of how people and groups debate, negotiate and bargain over a norm’s exact context and situational applicability” (p. 164). This article derives its conceptual energy from examining the mutually transformative relationship between situational interpretations of obligation norms and emergent emotions. Moreover, consideration of how emotions systematically change over the joint caregiver-patient career allows us to examine more precisely how beliefs about the propriety of emotions at any moment in time may be rooted in a prior history of affect.

Our respondents felt a range and simultaneity of emotions throughout the course of their relationship with the mentally ill person in their lives. Indeed, part of the difficulty posed by mental illness is the sheer volume and volatility of the emotions experienced. Every person interviewed felt the emotions of fear, confusion, hope, compassion, sympathy, love, frustration, sadness, grief, anger, resentment, and guilt. Equally clear, however, are the consistent changes in the relative subjective significance and intensity of each of these emotions over time. We might think of the several emotions felt by respondents as constituting a shifting hierarchy of emotional salience. Our intention is to document and account for the dominant emotions at each critical juncture of the common path shared by the caregivers in this study.

In the data sections to follow, we identify four broad moments in the evolution of the caregiving experience with a mentally ill family member. Each of these junctures provides a corresponding cognitive frame that influences the ebb and flow of emotions. Before a firm medical diagnosis, respondents experience what might be called emotional anomie. They are fundamentally confused by the behaviors of a family member and quite simply do not know precisely what to feel. Such anomie reflects the sheer bewilderment of a life that has moved rapidly from coherence and predictability to chaos and disorder. Eventually, a diagnosis of depression, manic-depression, or schizophrenia provides a medical frame that clarifies the situation for caregivers and provokes feelings of hope, compassion, and sympathy. At a certain point, the initial optimism of believing that their loved one’s mental illness can be fixed gives way to a sense of its likely permanency. The frame of permanency, coupled with doubts about the ill person’s inability to control their objectionable behaviors, ushers in more negative feelings of anger, resentment, and even hate. Some of the respondents eventually conclude that none of their efforts can successfully change things. Such a recognition leads them to an acceptance of the other’s condition. Acceptance can liberate caregivers from the earlier burdensome belief that it is their duty to somehow solve the problem.

SAMPLE AND METHOD

The data discussed in this article are part of a larger research agenda to comprehend the experience of caring for family members suffering from one of three major mental illnesses: unipolar depression, manic-depression, or schizophrenia. Since December 1996, Karp has regularly attended the weekly meeting of a self-help group at McLean’s Hospital in Belmont, Massachusetts. Although most of those attending the meeting of the Manic Depressive and Depressive Association
(MDDA) are victims of depression or manic-depression, there is an affiliated Family and Friends group. Because he had attended the group’s meetings several years previously, and more recently, had been a guest speaker there, the members knew him and his work. They were, therefore, receptive to his sitting in on the Family and Friends group as an observer. As required by the group’s own internal rules, all members were made aware each week that Karp was an observer and that “[he] intends to write a book on the experiences of family and friends like themselves.”

Karp’s ethnographic involvement with the Family and Friends group between December 1996 and May 1997 constituted the preface to a second stage of data collection. Those several months of observation clarified domains of conversation that would be important to pursue during in-depth interviews. Thus, along with six pilot interviews conducted for a single chapter on caregivers in an earlier book (Karp, 1996), Karp conducted 44 additional in-depth interviews between May 1997 and July 1998. Sixteen of the interviews were done with MDDA group members who expressed a willingness to be interviewed. Advertisements placed in a local newspaper eventually yielded 17 more participants. Another 11 interviews were solicited via snowball sampling. The current article, then, is based on a total of 50 interviews. Although questions about obligation, duty, and responsibility are at the core of the continuing research project, these matters do not exhaust the range of issues explored in the interviews, which typically last between 2 and 3 hours. With the exception of the six pilot interviews, each of the additional 44 interviewees was asked to sign a consent form describing the goals of the study and guaranteeing confidentiality.

To interpret the findings in this article, we should note that 48 of our respondents are White. Of the remaining two, one is African American, and the other is Filipino. Using their occupations as a proxy for social class position, we can report that 26% (n = 13) are professional workers, 22% (n = 11) are white-collar workers, 16% (n = 8) occupy clerical positions, 8% (n = 4) are blue-collar workers, 12% (n = 6) are students, and 16% (n = 8) were unemployed at the time of the interview. It is also important to note that women are significantly overrepresented in the sample to date (n = 35). Among the 35 women interviewed, 13 were parents of an ill person, 8 were spouses, 5 were children, and 9 were siblings. The corresponding numbers for the 15 men in our sample were 5 parents, 5 spouses, 5 children, and no siblings. The greater willingness of women to volunteer for participation in this study is consistent with their generally greater involvement in caregiving roles of all sorts (e.g., see Finch, 1989; Gordon, Benner, & Noddings, 1996).

All of the interviews were tape-recorded and transcribed. Thirty-seven of the interviews were conducted at Karp’s Boston College office and the rest at the homes or offices of the interviewees. The second author transcribed many of the interviews done through July 1998. She was actively involved at each step in the analysis and writing of this article. Consistent with the logic of producing grounded theory (Glaser & Strauss, 1967), this study did not begin with any explicit hypotheses to be tested. Instead, we began with broad sensitizing questions about the variety of meanings that respondents attach to their roles as caregivers but with special attention paid to the way they spoke about their obligations and responsibilities toward the ill family member in their lives. As each transcribed interview was scrutinized for themes, it shortly became apparent how central and problematic they considered the issue of managing emotions between themselves and their sick spouse, parent, child, or sibling.
None of the available programs for computer-assisted coding and analysis of qualitative data were used in this study. Instead, all interviews were closely read, and any materials related to the emotions accompanying duty, obligation, and responsibility were collated in a single data book on that dimension of the data. The authors then spent several weeks reading the more than 300 pages in the emotions data book. The close reading of the emotions-related data included making voluminous marginal notations in the data book and sometimes writing longer memos on emerging themes. Following the procedure just described, a comprehensive list of codes was established that reflected the themes uncovered in the data. Finally, an index was constructed to identify the pages in the data book where materials related to each constructed code could be found.

The procedure described above allowed the authors to become intimately close to the interview materials on emotions. The result of the reading, memo writing, coding, and indexing process was the recognition that different emotions characterized different phases of the joint career of caregivers and mentally ill family members. In the next section, we explore the character of emotional anomie that precedes any firm understanding of a family member’s exasperating, confusing, inappropriate, or dangerous behaviors.

EXPERIENCING EMOTIONAL ANOMIE

As sociologists have long observed, the decision that someone is suffering from mental illness is certainly as much a cultural and political decision as it is a purely medical one (e.g., Goffman, 1961; Scheff, 1966; Szasz, 1970). Parents of adolescents or young adults often found it particularly confusing to make sense of their children’s extremely troubling behaviors because they were moving through a life stage normally associated with difficult and contrary behaviors. Several parents described long periods of time during which they were uncertain about their children’s behaviors or how to respond to them:

Well the lines are blurred . . . . But you know what mental illness is . . . . At least if you’re psychotic, you know that. That is different from just rebelling and for 4 years [he] was sort of doing [that] . . . . But my horror was just the experience of knowing that your son is decompensating (sic) . . . . You don’t know whether he is on drugs or what is going on with this kid. You don’t know what to do if he is. If he’s on drugs, do you call the police? Do you call the doctor? Maybe he’s not on drugs. Maybe this kid is just, you know, acting [out]. I mean I never saw a real crazy person in my life. You hear of the crazy all the time, but I never saw anybody doing what he was doing, and acting and saying the things he was saying. . . . [It is] massive chaos.

One of the hardest things for me before she was diagnosed was what was I doing wrong as a mother. You know, she had been through a couple of depressions. She had been through a hard divorce. I mean, she has a grandmother who is crazy, but come on, she was a really nice kid until she was 15 and ran away. Why is she so horrible now? How come I don’t know this kid anymore? I mean, why is she hanging out with slimeballs, and why is she not coming home at night, and why is she lying to me all the time. This was not the kid I raised. It was mine [the problem]. I owned it . . . . Back then it was just sort of this amorphous mess. All of a sudden she was someone [I did not know]. She felt out of control to me. I mean, I can tell you that much. But I couldn’t label the behaviors. There was no way that I could have said,
“This belongs to an illness,” because she hadn’t been diagnosed. I had no understanding of that illness. . . . I mean, it took me 2 years to accept the fact that my daughter was mentally ill. I worked that through for 2 years.

Although adolescence might precipitate the greatest measure of confusion about whether to label a set of behaviors as mental illness, deciding whether to call someone mentally ill can pose dilemmas across the life span. Below are the comments of a young woman who tried to convey her guilt for doubting whether her mother was truly mentally ill. Her words also illustrate the extraordinary jumble of emotions that people can feel when the causes of a loved one’s demanding behaviors are opaque:

I am sitting there, and I am second-guessing my mom. You know? And I am going to the doctors, and a lot of the doctors are saying that it is [all] in her head. . . . The burning sensations and the fact that her jaw was bothering her too, and we had to . . . process her food and stuff for her. And so I am sitting there and I have my mom who, you know, has taught me everything I know about morals and ethics, and I am second-guessing her now, someone who I hold in so much respect. And I am second-guessing her. I am feeling bad for second-guessing her when I am really wondering what is going on, and I am doubting her and it hurts to doubt your mom. . . . I was just confused. I was totally confused and . . . I could never deal with everything at once because there were just so many different emotions, just because there was all of the doubt.

The kind of pervasive confusion described thus far is, of course, most likely in those instances when a person’s ability to function unravels slowly and over a long period of time. However, mental illness can strike with unimagined ferocity, ripping through a family’s home like a suddenly emerging tornado that allows no preparation. It hits quickly and leaves utter devastation and confusion as its aftermath. Interviews were replete with stories, like that of the parents who received a call from India informing them that their son, who spent a year abroad, had gone mad. After a harrowing trip back to the United States, during which their floridly psychotic son tried several times to escape from the plane, they finally got him into a psychiatric hospital. His hospital admission, however, did little to assuage their fears or clarify precisely what was wrong:

We were just scared. . . . We had this collection of doctors and social workers all sort of staring at us because we were trying to explain what had happened, but nobody was really interested in what we had to say . . . because we were not the patient. . . . From the nurse’s point of view, we were being blamed . . . “Why did you let this person . . . go run around the streets? He should be hospitalized.” Well, so we tried to explain what we thought had happened and our concerns about what was going on. We knew that his mind was under attack and had been altered, but we did not know why or how or what have you. So there was a lot of resistance, and the social worker was most unsocial. . . . Nobody wanted to talk to us. . . . We really wanted to know what they were going to do, what kind of medicine they were going to give him. . . . And that was a real no-no. I mean . . . we . . . were the bad ones, the wild ones, because we were so questioning. . . . We wanted to know what was going on, and nobody would tell us. And the other thing was, there was Jack in one of those little curtain things . . . and they wouldn’t let us go be with him. . . . Jack was acting out. Well, big deal, he’d been acting out for the last 3 days. I mean, you know, he might calm down if we [could just] go in there. . . . They wouldn’t let us in. . . . It was just mass confusion.
During the early stages of what is eventually diagnosed as a mental illness, novices to the nature of mental disorders can easily doubt their own reading of the situation. They ask themselves, "Are my loved one’s problematic behaviors only temporary? Will the situation resolve itself? Do I really need to involve health professionals in this matter? Is my spouse, child, sibling, or parent truly mentally ill?" As if questions like these were not enough to produce and sustain great uncertainty, emotional anomie is sharply increased when the sick family member, and sometimes mental health professionals, cause caregivers to wonder whether they might, in fact, be the essential cause of the problem:

I figured I just wasn’t a good person because I must be a failure [as a wife] . . . I knew it was him, but I said [to myself], “No, maybe it isn’t him. Maybe it’s me.”

I felt like . . . life was totally out of [my] control. And especially [because] . . . there were so many times when he [the son] would turn things around to make it look like I was the insane person [respondent laughs]. I mean, I’m just trying to help him, and then he would twist it and say, “I think you need a doctor.”

He [the husband] convinced them [the doctors] that I was the one who had the problem, that I was the one who was overreacting and being silly, and that it was me [respondent laughs]. . . . And so the woman [the doctor] then called me into the room and was saying, “Well, maybe you’re overreacting.” And I was like, “Hold it.” And so we left [the emergency room]. I don’t even remember what happened. Maybe they set up an appointment for him to come back. I don’t remember what transpired.

When madness first comes home, the only certainty is that something has gone horribly wrong. As the data thus far reveal, interviewees felt anxiety, fear, and above all, sheer confusion. Such emotional anomie was further heightened by their impulse to deny that the problem was mental illness. One mother recalled her reaction to the initial phases of her daughter’s illness by saying, “Denial is a wonderful thing. [I tried to believe that] she’s just a little off. She’s a little different.” Another parent recalled her first reaction to the mental illness label, "Mental illness. This could be years. This could be friggin’ years! Can you imagine how I felt? . . . I just said, ‘Oh no, oh no, my son doesn’t have a mental illness. My son isn’t psychotic.’”

Somewhere along the line, troublesome family members were officially diagnosed as suffering from depression, manic-depression, or schizophrenia. Diagnosis is a pivotal moment in the lives of caregivers because they then typically embrace a medical version of what is wrong. As one parent put it, after diagnosis she now lived “in the nation of disability, the province of mental illness, and the village of manic-depression.” The metaphor is apt because diagnosis thrusts both the caregiver and the newly minted patient into a medical culture that defines the latter’s troubles as disease. Moreover, because all cultures specify distinctive “feeling rules” (Hochschild, 1979), commitment to a medical version of what ails a family member also provides caregivers with far greater clarity about appropriate emotions. Because the prevailing medical view is that mental illnesses are brain diseases, healthy family members now feel obliged to treat their newly diagnosed parent, spouse, child, or sibling with the same love, understanding, sympathy, and compassion owed to any acutely ill family member.
GETTING A DIAGNOSIS

Although several respondents found it difficult to acknowledge that their family member was suffering from mental illness, most welcomed a definitive diagnosis. After living for weeks, months, or even years in a kind of emotional limbo, it was comforting to have a name for their loved one’s pain. If the problem could be clearly named, there was also hope that doctors could do something about it. However terrified that they might be by the idea of mental illness and the specific diagnoses of depression, manic-depression, or schizophrenia, at least these categories objectified what was wrong and set in motion a course of medical treatment designed to relieve the problem. After suffering from the emotional anomie already described, we can understand why respondents would say, “I loved getting the diagnosis. That was the best day of my life,” and “I’ll tell you [that] one of the best days of my life was when I got a phone call from the hospital telling me what was wrong with [my husband].”

Once it becomes clear that the problem is mental illness, family members often go through a period in which they actively learn about it. This may involve conversations with medical people and, sometimes, extensive reading. This learning process is typically accompanied by heroic efforts to save or cure the sick person. Heroic measures are more easily undertaken at the outset of a catastrophic illness because sympathy margins remain wide, and caregivers often believe that once an emotionally ill person realizes how much he or she is cared about, they will get better. Heroic measures also display strong commitment, something that individuals are expected to show when someone close is in a crisis. At this point in a family member’s illness career, the caregiving role is normally embraced fully, enthusiastically, and optimistically. Family members care because they feel honest love and compassion for an ill family member, but also because they know that they are obligated to help:

I can say that [it is] maybe 60% obligation. On the other hand, the fact that I do something because I’m obliged to do it does not mean that I do it only for that reason. I also love my mom. So, it’s very mixed. It’s something I know I have to do. But that feeling does not [come from] a superior being, which tells me, “Ah! You have to do that.” It’s nothing like that. Simply put, this is my situation, and I have to handle it.

I just did it because that’s what I was supposed to do. . . . That’s the way I felt. I still feel that way. . . . I mean, when you look at it realistically, what the hell are you supposed to do if you have a sick parent in the house . . . and you’re part of the family? I don’t know what other families did, but what are you supposed to do, throw them by the wayside? . . . I mean, I love my parents . . . I did it out of love and caring and [as] a son who was, you know, the oldest.

To genuinely care for another person presupposes efforts to empathize with them, to feel what they feel, to try to see the world from their standpoint, and to take their role. Of course, all role taking is approximate because we can never fully understand what another person is experiencing. From the outset, healthy family members feel the unique contingencies of dealing with a mentally ill person. The problem of accurate role taking is dramatically magnified in the mental illness case if one has never experienced the intense isolation, the hopelessness and despair of
depression, the feelings of grandiosity during a period of hypomania, or the terror accompanying paranoid delusions. It is hard enough for a healthy individual to empathize with a person who suffers from a physical illness that they themselves have never experienced. It is quite another thing to understand a person whose mind is thoroughly inaccessible. However much they read about their family member’s diagnosis or tried to talk with them about their feelings, efforts to role take were incomplete and tremendously frustrating:

What do words mean? Words don’t mean the same thing [to a mentally ill person]. Reality is not the same. You are not dealing in the same dimension. You have to understand...what that person’s illness is and what the words really mean....What frightens me about it is that reality is different....Mentally ill people see things that are not there or that I don’t see, [that] other people don’t see, and I don’t know what they are seeing.

I don’t understand it. I get absolutely frantic. I try to find out from her [the daughter] why she doesn’t want to live. . . . She said to me, “God won’t give me cancer and I don’t deserve to live, so I have to kill myself.” And I’m thinking, “Why do you...want God to give you cancer?” And she said, “Because I don’t deserve to be happy.” And I’m thinking, “Why?” And, of course, I get off the phone [and then] I’m immediately back on the phone to the doctors to find out how do I respond to this. What do I say to her?

One of the things she [the wife] would say to me [is], “You don’t understand what I’m going through. You belittle what I have here.” In this time period, I came to the realization that “you’re right, I don’t understand and I never will....I could never understand what you’re going through, but I can definitely try to empathize and try to take my worst day when I feel bad and try to magnify 10 or 100 times and even that doesn’t do any good.”

Were we to do an actual word count to determine the frequency with which respondents spontaneously described particular emotions, frustration would likely top the list. Caregiver frustration remained high at all points in the evolution of a family member’s illness. As we will show later in this article, frustration sometimes became coupled with such negative emotions as anger and resentment. Shortly after diagnosis, however, the frustration was linked primarily to a caregiver’s inability to role take with a person that they wanted very much to understand and to help. Although they could not fathom what it was like to be mentally ill, they remained optimistic and hopeful that they could get beyond a family member’s initial episodes of illness. They believed, or tried to believe, that a combination of psychotropic drugs, conversational therapy, and their own demonstrations of love, sympathy, and compassion would shortly resolve a solvable problem:

We didn’t have any understanding [of] how the illness works in terms of regaining one’s focus and how much stress one can take. . . . And sometimes it takes so much time [to see improvement]. [You have to] take a day at a time. So, I mean we had . . . rather high expectations about how fast things were going to go and how much he was going to be able to do.

I felt that if I worked hard enough and fast enough I could make her [the daughter] better. Anything [the doctors] suggested, I jumped on with great enthusiasm.
The emphasis of this section has been on the positive emotions of love, empathy, compassion, and hope because these are the emotions most powerfully felt shortly after someone is formally diagnosed with depression, manic-depression, or schizophrenia. We suspect that caregivers will feel these same emotions early in the evolution of any serious illness. These are the emotions that one is supposed to feel when someone is first stricken with serious illness. Although in the case of mental illness, other more negative feelings begin to creep into a caregiver’s consciousness, even during the early stages of a family member’s sickness. These more ominously negative emotions, like worrisome storm clouds on a distant horizon, are linked to the realization that a mentally ill person cannot fulfill the usual requirements of the sick role. The “emotional economy” (Clark, 1997) of sympathy is rooted in a norm of distributive justice that demands reciprocity in sympathy exchanges. We expect patients to respond to care with expressions of gratitude and cooperative behavior. However, instead of making earnest efforts to get well and to feel grateful for the care and concern that they receive, emotionally ill people often treat family caregivers with disdain:

He was reaming me out the other day. I mean, [he was] beating on me so terribly. I went there [his apartment] Saturday, and this kid just wouldn’t let me in. I bought him a bunch of things. He didn’t want them. He threw them out in the street.

He would just lash back at me. You know, it’s none of your business if I take my medication. It’s none of your business how often I am taking it or if I am taking it too much…. I would always be wondering if he was taking it because of the way that he was behaving, if maybe he was taking it all at once instead of… spacing it out throughout the day…. I would question him about that and [was told] it was none of my business. I would ask him at night when he was home, “Did you take your medication?” Again, “It’s none of your business.”

Very depressed people are often very irritable and they say cruel things. My mother is worse with that. I think it’s that mentally ill people… often act inappropriate or cruel or … aren’t really there, aren’t really tuned into what is going on. And they don’t express … gratitude.

Rebuffs of the kind just described can be tolerated as long as they are seen as temporary manifestations of mental illness. Feelings of love, empathy, compassion, and sympathy shape the emotional terrain as long as caregivers believe that proper family and medical treatment will shortly fix the problem. When a husband, wife, son, daughter, mother, or father fails to respond to the respondents’ caregiving and medical care, the participants begin to harbor more negative feelings. The eventual recognition that a family member’s illness may well continue long into the future provokes feelings of intensified sorrow, anger, and resentment. In turn, the emergence of these unwelcome feelings calls forth the need for more deliberate emotion management. In the extreme case, caregivers had to reconcile sometimes hating someone who they also love.

PERCEIVING ILLNESS PERMANENCY

Each Wednesday evening at 7 p.m., about 25 people come together at the MDDA support group for the family and friends of people suffering from depression or
manic-depression. It is interesting to observe that, within the past 6 months, a number of the spouses of ill wives or husbands, believing that their concerns are sufficiently distinctive, have created a group separate from the one now attended largely by parents, a few children, and siblings. Although in both groups, there is a core of regulars who have been attending faithfully every week, there are also a number of people wearing blue rather than red name tags, indicating that they are first timers. They are frequently referred to the group shortly after their first substantial encounter with mental illness, and consequently, they are often suffering greatly from emotional anomie. As the 2 hours of sharing and caring unfolds, one of the typical group dynamics is for caregiving veterans to socialize the rookies. For troubled people to learn that they are not alone in their feelings and experiences is, indeed, one of the great values of support groups of all sorts. However, newcomers also learn something from veterans that visibly upsets them. They literally wince, shake their heads in disbelief, and sometimes audibly gasp when they learn that many of the regulars have been dealing with the ill person in their life for years, sometimes decades. Although the talk of the regulars is peppered with optimistic references to new drugs, new treatments, and the progress made by a loved one, their expressions of hope seem fundamentally contradicted by their own biographies. The folks wearing the blue tags have to entertain the possibility, often for the first time, that there will be no quick solution to the problem. Whether they have been the beneficiaries of a support group’s collective wisdom, nearly all our respondents eventually had to incorporate into their thinking the likely permanency of their child’s, parent’s, sibling’s, or spouse’s illness:

When I was married . . . after all those years of realizing nothing was going to change, [that] I was going to be married to somebody who was mentally 7 or 8 years old, and I was going to have to care for three children instead of two, it was like, “I can’t deal with this anymore,” and we divorced. Now I have a son who I can’t divorce [italics added]. It’s very frustrating that this may be the way it’s going to be. Here I am with that life [again], you know.

I guess one of the things [I have] learned is about taking time. It takes time. These things do not just sort of flip into the next phase just like that. It keeps evolving.

The realization that a family member’s mental illness may never go away is a crucial turning point in the caregiving career because it forces to the surface of consciousness an array of emotions that previously may have been only dimly felt. Now, caregivers must surrender to the difficult reality that the expectations, aspirations, and hopes that they had for the ill person in their life are unlikely to be realized. Parents, in particular, find it hugely painful to let go of their dreams for their children. Because mental illness may not erupt until late adolescence or early adulthood, parents have spent years anticipating each of the usual life markers that ordinarily await bright, happy, intelligent, and creative children: high school graduation, college, marriage, interesting work, and having children. For many, coming to grips with their children’s gross unhappiness and the knowledge that their life opportunities will be greatly foreshortened by mental illness produces a profound sadness, a feeling of pervasive grief at having lost a child:

So, bit by bit, we lowered the expectations . . . As things go on, it’s like somebody takes pieces of her and throws them away. Pieces of her keep disappearing over the
years. More pieces of her disappear. She starts out whole and perfect and beautiful, and over time, pieces fall off. . . . And the older she got . . . I mean, I cannot bear to walk into [names high school]. I cannot bear it. It’s too painful. [Other] people are graduating high school and going to proms. A couple of months ago, my mother . . . came to visit, and we went to Filene’s. My mother wanted to buy her a birthday present and we ended up [looking at] prom gowns, and I had to leave the store and sit in my car and weep. And I wasn’t just weeping about the prom. It was the prom that opened the door for everything.

They would put her, literally, in a padded room next to the desk, and when I would show up to see her . . . it was almost as if she curled up into my lap again—she didn’t literally, but it was almost as if [she did]—and wanted to be touched and held. . . . I mean, her hair had been very long, and she had shaved it except for a patch on top. It was one of those times the nurses were a little wary when I asked for scissors. . . . I can still feel those moments as she curled up against the wall and I knelt next to her and I trimmed [her hair]. For those 10 minutes she was my little girl, and then she was somebody I didn’t know again.

However, the sense of profound loss is certainly not felt only by parents, as these comments illustrate:

If you are involved with anyone who has suffered from depression and you have a close enough relationship to them, I don’t see how you cannot be very emotional about the situation. . . . Seeing it first hand, it was just really hard on me. . . . I just felt like I lost a mom. You know? There is a chunk out of my life that was just no longer there. It was like this big void and I had to somehow fill it myself. You know, and I had to . . . grow up all of a sudden, and I didn’t necessarily feel . . . ready for it. . . . I felt so alone and by myself. . . . I felt like it was almost like role reversal; an 18-year-old kid taking care of someone that . . . is supposed to be taking care of you.

It’s an immense grief. It’s an immense loss. I have friends that have relationships with their dad, where they call them up and ask them for advice, [relationships] where they’re capable of confiding things in their dad. I’ve never had that experience—someone who could provide a role model for relationships. Do you know how many emotionally unavailable men I dated? It had a major impact on my relationship life as an adult. The only people I knew how to interact with . . . was someone who was really not available to me. It’s really sad.

A family member’s enduring mental illness requires that caregivers not only radically revise downward their expectations for the ill person but also that they ratchet down their own life expectations. For example, although remaining devoted to her sick daughter, an elderly woman complained bitterly that “she has totally destroyed our lives. These are the years that, you know, were supposed to be our good years, and she has totally destroyed them.” Another young woman whose interview exuded compassion for her husband still felt angry that her own doctoral studies were being derailed by his inability to work and his need for constant care. One of his hospitalizations forced her to drop a class, and she admitted to being “pissed off” and “feeling a weird anger,” although “it’s not his fault per se.” A husband, although acknowledging that his wife’s hospitalization “was no picnic,” began to resent that “the focus was always on her and her illness, and it wasn’t on me and what I’ve been doing to keep the family afloat and things like that.” Caring for people who are not getting better, who are unable to express gratitude for the help given them, and whose illness constrains one’s own life creates great frustration. Frustration, in turn, breeds anger.
Their increasing isolation is surely one source of a caregiver’s frustration. As their role extends for months or years beyond a family member’s first episode, caregivers inhabit an increasingly constricted world dominated by the chronicity of mental illnesses, the often unreasonable demands placed on them, and the feeling that few people understand their own turmoil. Sometimes, they respond by fundamentally reconstructing their social circles. One woman commented that she “[didn’t] identify with normal people anymore,” that she “cannot go to a cocktail party and talk nonsense, trivial conversation [but] will be with my Alliance [Alliance for the Mentally Ill] friends in a second.” A mother, who no longer attends such groups as the local Parent-Teacher Association explained, “I’ve separated myself from them, and I live in the nation of the wounded. I deal with my lowered expectations by looking for people who also gave up their expectations.” The problem, however, is that caregivers can never fully separate themselves from the expectations and moral judgments of those who know little about the contingencies of caregiving:

Some people I don’t know very well, like a neighbor down the street…. My mother shows up on her doorstep and says, “I have no food.” [The neighbor] will call and leave a message and say, “Go get your mother some food.” Or my mother… doesn’t have any friends or anyone to talk to but this one woman who, every once in a while, I’ll hear from…. I don’t really know how my mother even knows her, but she leaves a message, “I’m just calling to tell you, your mother’s really sick, so could you get her some help. Thank you.” And [then she] hangs up…. People who have no understanding of mental illness really just think that the reason she is so sick is because you are not taking care of her.

My mother-in-law and father-in-law are coming up for Thanksgiving. It’s gonna be very interesting because they think it’s [the daughter’s illness] a fabrication. The way my father-in-law sees it, she needs to get her ass kicked royally. He’s into severe punishment. My mother-in-law isn’t any better.

Research exploring the distribution of empathy suggests that, based on principles of distributive justice, we most thoroughly empathize with those whom we consider hardworking (Hoffman, 1989; Lerner, 1975). In a society bounded by a history of Protestant ethic ideologies and a cultural ethos of individualistic achievement, empathy is especially accorded to those who show a willingness to pull themselves up by their bootstraps. Welfare debates in the United States center on the identification of the “truly disadvantaged” (Wilson, 1987) and the “deserving needy.” Increasingly, both federal and state governments seem disposed to provide welfare only to those who are viewed as willing to help themselves. If, as the Puritans believed, “God helps those who helps themselves,” the secularized version of that dictum applied to mental illness would be “caregivers should help only patients willing to help themselves”:

I got very angry at my father, not so much the first year when he had the breakdown…. When I got really angry was last year when I was moving into this [new law] office. We had been through [it] all [with him] last summer, and I wanted to sit there and go, “Hey, listen, you are being really selfish now, okay? You are having these little episodes. You are not doing what everybody is telling you to do. You are not following what people are recommending.” … He’d take the medicine, but he wouldn’t do anything else. I said, “The medicines are [only] part of it.” And he’d sit there with the “woe is me, woe is me, I am taking these medications,” and I said,
“Listen...nobody is saying it isn’t awful. I am sure these medicines are making you feel terrible.” [But] I was furious. I was so angry. I just wanted to say, “Will you just stop?” . . . The pity was gone.

When interviewees admitted to powerfully negative feelings, they nearly always offered the disclaimer that what disturbed them was not the person but the person’s illness. Because most of those interviewed believed that mental illness was a biochemical brain disease, it made sense to draw the illness-person distinction. However, we suggest that such a dichotomy is also an invaluable tool for doing the emotion work required when a person has distressingly negative feelings toward a loved one. The person-illness distinction was mentioned in virtually every interview, but it was unfailingly invoked whenever the word *hate* entered the conversation. The following comments are particularly instructive because they illustrate both how the person-illness distinction is used and the palpable residue of ambiguity about what a caregiver might legitimately hate:

It’s one of those things that sounds sort of probably corny, but it’s the thing that you hate her [mother’s] illness, but you don’t hate her. And I hate what she has done to us, and the hell that she has put us through. . . . I don’t think that I hate her. You know, I probably . . . there’s probably some degree of hating her. It feels like that, but I think that it’s more hating the illness. . . . I try to tell myself that it’s not her. . . . You know, you’re looking at her and saying, “Well yeah, I hate you,” but it’s not I hate you. It’s I hate what you have done. I hate what you are doing. You know, I hate the illness. . . . Your first reaction is to do that [hate them], but then . . . I guess . . . you have to realize that it’s really not them.

Sometimes I hate her, but mostly I don’t hate her. Mostly I’m angry at what she does. I mean, I’m angry at the behavior. I don’t hate her. I hate the behavior, and I’m angry at the behavior. You know, I hate that she took off and left me, and I’m furious at her that she took off on her 18th birthday and didn’t call me for a week and I thought that she was dead in a ditch. I am so angry at her that she could do that to me. And the therapist keeps saying, “She didn’t do it to you, she just did it. . . . You weren’t a piece of this picture at all. She just did this.” But its going to take me a really long time to forgive her for that. . . . I’m angry at her for doing that, but I don’t hate her because it’s the illness, it’s not her. But there have been moments when I hated her. Every time she does something bad, I call it the illness now, you know . . . They tell me she’s really sick, and they tell me she’s really severe. So, it’s easier to call this illness than to call this asshole adolescent behavior, you know?

I don’t think that I have ever gone to hate. There is plenty of resentment, more for the situation that it puts us in than at her. Probably more at the disease than at her, but [then] she is the disease.

In another paper drawn from these same interviews (Karp & Watts-Roy, 1999), the authors focused on the ongoing interpretive dilemmas faced by caregivers as they try to draw appropriate boundaries between themselves and an emotionally ill family member. Decisions about how to draw boundaries are compounded by a widely held cultural prescription that over involvement with dependent people might properly be considered a disease. The existence of a whole social movement in America dedicated to avoiding enabling and codependence (Kaminer, 1990) is striking evidence of Americans’ confusion about the permissible limits of human closeness. Drawing appropriate caregiving boundaries is difficult throughout the entire course of another person’s mental illness, but it becomes a more insistent task.
once respondents understand the likely permanency of another’s illness. Family members have already felt, by then, the pain of losing their once well child, spouse, parent, or sibling. By the time that they have traversed the emotional journey from anomie to compassion to periodic feelings of hatred, they have also realized that they are in danger of losing themselves. Distancing themselves from people who they love, even as a measure to save themselves, is emotionally wrenching.

ACCEPTANCE

One of the tricky things about formulating an analysis that focuses on change and process is that each respondent is, to some degree, in a different place in their caregiving history. Just as in the MDDA support group, the people interviewed for this study range from those who are caring for someone only recently diagnosed to those whose lives have been surrounded by mental illness for a decade or more. Thus, although everyone faces the same problem of balancing a sense of obligation with the proper level of caregiving involvement, the time spent at the task leads to a different calculus of care. Within the Family and Friends group, for example, the veterans most enthusiastically endorse what might be thought of as the group’s “4Cs mantra”: I did not cause it, I cannot control it, I cannot cure it. All I can do is cope with it. Such a proscription has a Buddhist-like motif, because those who can truly act on it in their daily life have learned that suffering substantially diminishes with its acceptance.

Efforts to fix another person’s illness are typically abandoned when caregivers viscerally understand that, however much they care (emotionally and physically), they cannot control their family member’s illness, and that by caring too much they are losing themselves. First, this is how they spoke about the lack of control:

I’ve got to read you something. I’ve got to read you this. [She reads from a paper she has written] “There is a special place in my country called the garden of acceptance. It’s very difficult to find and no one is able to give directions on how to get there. In fact, each villager reaches the garden by a different route. The only common feature in the journey is the letting go of control. As long as one seeks to hold on to control of their illness or disease they cannot enter into the garden of acceptance. Only when you lay this particular burden down do you find the elusive peace which this garden provides.” And right now, I’ve cried a lot because I’m giving up the last piece of control.

It took me 2 years to accept the fact that my daughter was mentally ill. I worked that through for 2 years. I can’t imagine that I am going to have to work that through again. I mean, I accept the fact that I have no control over her. This is the acceptance. The acceptance is not so much that she is mentally ill. The acceptance is that I have no control over her. I can’t prevent her from being a jerk, or from being out of control, or from making bad decisions. I have no control over her. . . . It took me 2 years to get there. I worked hard to get there. It doesn’t change the fact that she’s going to be hard to deal with. It just means that . . . the struggle that I do is different. The struggle that I do with her right now feels smaller.

Second, this is how they spoke about losing their identities:

If I could not maintain my own self-identity, if my identity was so caught up . . . into this aspect of him [the husband] that it was crippling me, I could no longer do this.
And the two times I’ve bailed out, or temporarily wanted to be separated, was exactly for these issues. I felt like he was sucking all of my spiritual [and] emotional energy right out of me. . . . I left him at Christmas time because I just couldn’t take the negativity any more. It was the hardest, it was the most difficult, the best thing I ever did. [I told him], “I love you, but I can’t live with you anymore. I have absolutely no problem that I love you, but I just can’t be pulled down by this anymore. I have to take care of me.”

I guess I have seen with both my mother and my sister what a devastating effect it [depression] has on the people around them. So I just don’t want that around me very much. I don’t feel like I am strong enough to withstand it. I guess I feel some people would be, [but] I am not. And I don’t want to be destroyed by it. . . . Even now I feel . . . with my mother sometimes [that] her desire is to destroy me. . . . I know [this] isn’t really true, but I feel if she could completely absorb me and take all of my energy and life in her illness, she would. This is sort of what she is after, and I have to protect myself from that.

Although caregivers can cognitively understand that their efforts of control are fruitless and that their identities are being undermined, the decision to back away from the obligation to care remains, nevertheless, emotionally very difficult. This is partly so because respondents have deeply internalized conceptions of what it means to be a moral person. One daughter allowed that she “could walk away from it” but did not want to meet her God without having done “everything that I could have, everything that was reasonable for me to do.” A mother who was “working [her] hardest to break the bond” with her daughter knew that, “if [she] is going to survive, I’ve got to let her go.” A woman, married for more than 30 years, although acknowledging that she no longer loved her husband, also said, “I feel badly for him. He’s a human being. I’ve known him most of my life. You can’t throw people away.” A husband who felt he was able “to keep an arm’s length” from his suicidal wife also described himself as “a person who keeps agreements.”

Much of the discussion in the weekly Family and Friends group is about letting go without guilt. One of the respondents recruited from the self-help group recounted in our interview the same feelings that she had been expressing to her caregiving colleagues. Living with the constant worry that their daughter would need them in a time of crisis, she and her husband had been unable to take an extended vacation. She said,

I think she needs us. Maybe it’s wishful thinking on my part [that] if we are there for her she won’t hurt herself. . . . If anything happened to her, I’d never forgive myself because if I were here I might have been able to prevent it.

After months of gentle prodding from the group, she decided to take a 2-week Florida vacation. On the evening that she announced her plans, the group responded with applause, and some individuals with hugs. The successful trip brought her one step closer to the thinking of a few people who no longer believed that they were primarily responsible for an ill family member:

I can be there and I can be supportive, but the bottom line is that there is plenty of opportunity for her to kill herself, and if she wants to, she can. I mean, I can’t be with her 24 hours a day, 7 days a week for the rest of our lives.

Last night, her stepsister was over, and they were watching TV. . . . Her stepsister has a tendency to drink, so I’ve already told [her] that if she chooses to drink that’s
her choice. But my choice is that I’ll be washing my hand from the whole thing because you can’t drink and take the kind of medication [she’s taking]. And if she chooses to do it, she chooses to get sick again. And I [also] said, “You’re an adult. I don’t want to have to be coming out and cleaning your apartment, sorting through your bills, calling your creditors, and doing all that. I don’t want to do it.” . . . I mean, I absolutely refuse to pamper her. I said, “No, mommy is not going be here to take care of you. I’ll help when I can, but only if you’re helping yourself. Because if you’re not going to do anything to help yourself, I can’t help you.”

Accepting the idea that they cannot control another person’s illness and that, ultimately, they are not responsible for the fate of a sick child, spouse, or parent leads to a fundamental renegotiation of obligation boundaries. The resigned acceptance of their ineffectuality in changing the course of a loved one’s mental illness substantially relieves caregivers’ emotional discomfort. A few interviewees, however, have achieved a more affirmative kind of acceptance. Earlier, we described the chronic sorrow that caregivers feel as they try to relinquish their hopes and aspirations for a child, parent, or spouse lost to mental illness. Once beyond their profound loss, some people come to a deep admiration and respect for their family members who bravely struggle with the unimaginable pain of mental illness. They no longer measure their loved ones in terms of pre-illness potentials now gone. Their new aspiration is to help them to become as happy and productive as their illness will allow:

You know, I just want him [to be] happy and stable. I mean, at this point, I don’t have any [grand] expectations. He is a wonderful kid. He’s pure. I just look at him as this innocent, good kid. This is how I see him, and it doesn’t matter to me what he does in life. . . . I just want him to stabilize, accept his illness, and just get on with his life.

I’m just in awe of [him] and his abilities to deal with circumstances and to keep a kind of patience, a kind of perspective, and a willingness to work with things, things that are not his first choices, needless to say. . . . [There is still] intense sadness that [he] has to do this, has to have this. I mean, that will bring tears to my eyes but [also] an incredible admiration for his attitude toward dealing with it.

Of course, “to accept [a] person for who they are and love them for who they are” is the most unalloyed kind of acceptance and love because it is given unconditionally. The words of the respondents immediately above also remind us not to shortchange the role of love, along with a profound sense of obligation and responsibility, in producing caregiving commitment to severely ill people. Finally, although it would be wrong to romanticize sickness, our respondents persuade us that a family member’s life-altering illness can provide caregivers the opportunity to feel a depth of acceptance for a child, spouse, parent, or sibling that might not otherwise be possible.

CONCLUSION

Efforts to deal with a mentally ill family member arouse especially strong emotions because people suffering from depression, manic-depression, or schizophrenia pose such distinctive threats to the order and coherence of daily life. The behaviors
of mentally ill people are nearly always incomprehensible. They may also be socially objectionable, threatening, and dangerous. In addition, mentally ill people are often unable to understand their own circumstance, are sometimes unwilling to accept medical diagnoses, may not comply with medical treatment, and frequently cannot express appropriate gratitude for the care accorded to them. These contingencies require that family caregivers engage in especially arduous interpretive efforts to make sense of their obligations and feelings. Moreover, we have shown that there is a pattern to the way in which caregivers’ emotions unfold over time. That is, the link between a family member’s emotional illness and a caregiver’s emotions has a decidedly historical dimension.

We identified four interpretive junctures in the parallel social trajectories of mentally ill people and their family caregivers. Before medical diagnosis, family members feel utterly bewildered by an ill person’s behaviors and do not know how to react, behaviorally or emotionally. We have characterized this initial moment in the joint career of ill people and family caregivers as one of emotional anomie. Following diagnosis, caregivers make valiant efforts to empathize with their ill spouse, child, parent, or sibling, often believing that a combination of medical treatment and their own loving care will solve the problem. Once it becomes clear that a family member’s illness is chronic and probably unsolvable, the kinder emotions of sympathy and concern typically recede and darker feelings of frustration, anger, and resentment surface. These negative emotions are especially likely to arise if caregivers come to believe that their sick family member is not assuming appropriate responsibility for getting well. Finally, some caregivers conclude that a person’s illness is well beyond their control. Such recognition may liberate them by legitimating their withdrawal without guilt.

Aside from clarifying the particular emotions related to caring for a mentally ill person, the analysis offered in this article has broader implications for the study of emotion management. Following Hochschild’s (1979) early lead, sociologists have largely tried to uncover the feeling rules that dictate appropriate emotions in a given situation. One profitable line of inquiry has been on the emotion work necessitated by a disjunction between what one feels and what he or she ought to feel. Because the notion of the definition of the situation is a cornerstone of symbolic interactionist thought, the primary focus on the negotiation of feeling rules in particular situations is understandable. However, the emphasis of symbolic interaction theory on process also requires that the emergence of emotions in any group, setting, or organization be understood over time, and that the definition of any particular situation is contingent on a prior history of definitions. Oddly, students of emotion have neglected the processes through which feelings in the present articulate both with past interpretations and current interpretations of the past.

The need to see any emotional expression in terms of a whole history of incidences and affects meets the test of personal introspection. For example, a worker’s outburst of anger will ordinarily be connected to a complex history of perceived slights or ill treatment by colleagues or superiors. As therapists have always argued, displays of strongly negative emotions between spouses rarely reflect only the circumstances of the moment. Rather, such feelings, like solidified geologic formations, arise from an accretion of hurts, injuries, and perceived injustices built up over years. Equally, warm feelings and moments of tenderness between a husband and wife are inseparable from the marital history that they have jointly produced. Although there are surely dramatic time-limited moments of high emotion, an
exclusive focus on the immediacy of feelings distracts attention from the important conceptual task of seeing emotions as emergent properties of a broader stream of social experience.

Greater attention to the historical properties of emotion evolution is important on theoretical grounds alone. However, studies that show how emotions shift in predictable ways through the life course of any important process may also have significant practical value. Just as we have shown that caregiver careers proceed through a predictable series of feeling frames, we imagine that a wide range of important phenomena can be described in the same way analytically. For example, such an approach might be used to illuminate the emotions characterizing the different phases of social movements, political campaigns, undergraduate college careers, family-run businesses, marriages, or for that matter, the production of journal articles. If we could know in advance the likely sequence of emotions in these and similar social processes, we could better prepare people who will experience them by choice or chance. In the end, a research agenda of the sort proposed here is required by the mandates of the sociological imagination itself. Emotions, like all social things, arise through the “interplay of man and society, of biography and history, of self and world” (Mills, 1959, p. 4). Theories of emotion that do not attend to these connections are simply incomplete.

REFERENCES


David Karp received his Ph.D. from New York University in 1971. His earlier writing on cities, everyday life, and aging reflect his enduring interest in how people invest their daily worlds with meaning. His book *Speaking of sadness: Depression, Disconnection, and the Meanings of Illness* was the recipient of the 1996 Charles Horton Cooley award given by the Society for the Study of Symbolic Interaction.

Valaya Tanarugsachock received a Master’s degree in communication and human relationships from the University of North Carolina at Chapel Hill in 1994. She is currently a doctoral student in the Department of Sociology at Boston College. Her central teaching and research interests are in the areas of gender and ethnic minority relations.