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"The women's sense of self as good mothers was so deeply dependent on the needs and provisions of others that their options were severely constrained."

"BUT I *AM* A GOOD MOM"

The Social Construction of Motherhood through Health-Care Conversations

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Examining the impact of health information seeking among informal, interpersonal networks, this article focuses specifically on the extent to which these conversations serve to identify role boundaries, specifically that of motherhood. Drawing on Goffman's work on region and regional behaviors, this ethnographic analysis of women in a moms and tots play group reveals boundaries between the public and private presentation of self. The regions of front stage, backstage, and "back"-backstage are used here to discuss how talk regarding health issues, and particularly inappropriate or taboo talk, defines and exemplifies the role of the "good" mother. The implications for the accessibility of information are discussed in light of the cultural contradictions women face in fulfilling this role.

In 1953, Simone De Beauvoir wrote the following about women's talk and friendships:

> The female friendships that she succeeds in keeping or forming are precious to a woman, but they are very different from relations between men. The latter communicate as individuals through ideas and projects of personal interest, while women are confined within their general feminine lot and bound together by a kind of immanent complicity. And what they look for first of all among themselves is an affirmation of the universe they have in common. They do not discuss opinions and general ideas, but exchange confidences and recipes; they are in league to create a kind of counter-universe, the values of which will outweigh masculine values. Collectively they find strength to shake off their chains; they negate the sexual domination of the males by admitting their frigidity to one another, while deriding the men's desires or their clumsiness; and they question ironically the moral and intellectual superiority of men in general.
>
> They compare experiences: pregnancies, births, their own and their children's illnesses, and household cares become the essential events of the human story. Their work is not a technique; by passing on recipes for cooking and the like, they endow it with the dignity of a secret science founded on oral tradition. (p. 542)

More than 40 years later, De Beauvoir's observations are, at first glance, an accurate description of the "backstage" (Goffman 1959) conversations of the women in this study. Characterized by specific language or

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collection of behaviors, the performance in this region, the backstage, refers to those events in which the reality that is presented publicly to others is fabricated or contradicted. As Goffman explains, "Throughout Western society there tends to be one informal or backstage language of behavior, and another language of behavior for occasions when a performance is being presented" (p. 128). It is in this backstage that expectations about performance in the front stage are discussed, and even put aside, to be replaced with intimacies and behaviors otherwise considered inappropriate or contradictory to the front-stage performance.

The "counter-universe" De Beauvoir (1953) claims women seek to create, where the inhibiting values of men, ostensibly, are discarded, is a backstage. However, as this article will discuss, the challenge for women, as mothers, is not just to question the values of men but also the values that the women themselves have adopted in behaving as "good" mothers. The topics that they discuss, their pregnancies, births, and so on, are not without boundaries; indeed, there are even more sensitive topics and issues, relevant to the fulfillment of this role, that are only discussed in even more private settings. The reason behind this secrecy, as this report will attempt to explain, is because these issues are not consistent with cultural beliefs regarding the role of being a good mother.

This report is but one portion of a larger study exploring health information seeking in informal, interpersonal networks, specifically among a group of women in a moms and tots play group. The overall intent was to extend the rather limited scope of health communication research past formal, institutional settings to other venues, as identified by Arntson (1989), Nussbaum (1989), McKnight (1988), and Smith (1989), by demonstrating how one might examine the structure, content, and impact of mundane conversations among interpersonal networks, especially with regard to health care decision making. The goal was to study an intact network of interactants who did not meet for the purpose of discussing health care issues but for whom health care was a salient topic. The health topics of interest were not predefined by the researcher, with the exception of identifying taboo topics. The topics, even the taboo, were expected to be emergent, a result of need and/or concern, in everyday life. That is, relevant talk was not limited to any particular illness or condition but to any and all talk that related to the provision, maintenance, and protection of health, either of self or one's family members.

The notion of taboo topics is borrowed from interpersonal communication research, as there is evidence that taboo topics serve to identify various stages of relational development and one's role within that relationship (see Baxter and Wilmot 1985). For example, "state of the relationship" talk is considered to be a common taboo topic in romantic relationships and is generally only discussed during times of relationship change, either to progress toward a more intimate or committed relationship stage or to deteriorate toward a less intimate stage, such as termination. In considering that health care talk might serve an interpersonal need, as a form of social support (Albrecht and Adelman 1987), the idea, initially, was that what was claimed by the participants to be socially inappropriate topics might reveal something significant about the relationships of the interactants. The question was mostly speculative but served to provide one of the most unanticipated and informative findings of this overall study.

The moms and tots play group turned out to be a perfect group, not only in pursuit of the information initially sought but also as a subject of societal interest, the role of acquiring health services in the social construction of motherhood. An emergent question from that study was how these mundane health care conversations served to construct the women's identities, particularly as mothers. That is, it was determined that simply engaging in the talk, regardless of the outcomes of the talk, was seen as evidence of being a good mother, a central identity issue for these particular women. This role of motherhood was their primary occupation, their job, and accessing quality health services was a key requirement (Tardy and Hale 1998b). These relationships were essential to fulfilling the major job requirement as a mom, cracking the code of our current health service system.

Although what the women openly discussed was indicative of the expectations they held for themselves and each other in fulfilling the role of mother, what was even more provocative was the identification of what they did *not* discuss. Initially, the concern was that if these not-discussed issues were also relevant, as the label of taboo indicated, then there was, ostensibly, an unmet need, perhaps of great importance. Such logic is the guidance for this article in considering that if women seek each other out to support their roles as mothers, and the more information the better, then why were these particular topics taboo? To further understand this apparent contradiction with regard to freedom and inhibition, first, extant literature on motherhood was reviewed.

Subsequently, using this literature and Goffman's (1959) work on regions and regional behavior, the data collected with regard to taboo topics were analyzed and are presented here, using front stage, backstage, and "back"-backstage as an organizational template.

MOTHERHOOD

Motherhood is an idealized role (c.f. Hays 1996; Dally 1983; McMahon 1995; Rabuzzi 1988; Rubin 1984; Sebald 1976). As Dally (1983) describes idealization, it is "a feeling of love towards something or somebody towards whom one actually has feelings of both love and hate. The hate is ignored and so kept from consciousness. The love is unrealistic because it is separated from the hate with which it is inextricably connected" (p. 93). This literature, especially pertaining to the social construction of motherhood, was found to be supportive of the conclusions of this overall study.

In particular, work by Coontz (1992, 1997), Thurer (1994), Hays (1996), Dally (1983), as well as seminal work by Ruddick and Daniels (1977), Rich (1976), Chodorow (1978), and Chodorow and Contratto (1982) provide excellent discussions of the history of this construction, as well as current economic, societal, and political factors. Mostly, these various texts discuss the dilemmas for women with regard to child rearing, with some mention of health care issues (mental as well as physical), especially with regard to the guilt and blame associated with failure, evidenced by an ill child or "bad" child. Yet, how this idealization affects their health care decision making was not, to this scholar and mother, fully covered. In short, while there is much that women do share and discuss, maintaining this ideal prevents them from discussing issues that are as equally inherent to their own health as the ones that they do discuss.

However, before exploring that issue, extant literature is presented. There are several themes in this literature that are relevant to this study. First, there is the issue of how "motherhood" has been manipulated for political/economic reasons, both for and against women's rights. Second, during the twentieth century, there have been great technological advances directly affecting work in the home and women's reproductive choices, ultimately creating a divide between and within women. Third, greater mobility by family members has resulted in the isolation

of families and privileging the nuclear-type family, reducing the availability of a support system in parenting. Finally, there is the resulting issue of guilt and blame attached to mothering that can affect all the opportunities and choices women may experience, especially their decisions regarding health care. These areas are presented here to create more insight with regard to why women would pursue health care issues so avidly and why this pursuit actually inhibits them from some discussions.

THE MANIPULATION OF MOTHERHOOD

Rubin (1984) explains the progression of motherhood during the past three centuries, beginning with work by Mary Wollstonecraft in 1792, *Vindication of the Rights of Women*, as her message "sparked the beginnings of the modern feminist movement" (p. 50). Wollstonecraft's message was that children were actually delicate, sinless beings deserving of their mother's sole attention, not to be parceled out to servants, family members, and the community. To create and maintain a revered place in society, women were to take on much more wholeheartedly their roles as mothers and wives, rather than to be mere dependents on their husbands.

Facilitating this notion, during the late 1800s, through the early 1900s and onward, as technological advancements made their way into the home, women were freed from many time-consuming domestic duties (Sebald 1976), enabling them to devote more time and energy to considering how best to rear children. As Rubin (1984) explains,

> The child and his caretaker mother became symbols of an untainted humanity so powerful as to infatuate a century of European writers, philosophers, and thinkers—an inspiration to such men as Freud, Darwin, Marx, and Engels as they formulated their theories of psychoanalysis, evolution, and socialism; a dyad so compelling that it ultimately produced the first humanitarian attempts at child labor law reform and improved educational opportunities for youth. A generation of young women willingly retreated to their homes to assume greater responsibility for the upbringing of their children than women of any previous generation. (pp. 50-51)

Childbirth and child care took on a previously unknown tone of joy, celebration, and esteem. As marriage became less a means for establishing

connections for protection from enemies and more an act born out of love, domesticity and family life acquired greater sentimentalism. The idea was that embracing motherhood, becoming the ruler of one's home, was the pinnacle of a woman's life. Motherhood is what created a place of honor for a woman; otherwise, she was simply a burden.

Wollstonecraft's advice and reverence for motherhood aside, in the early 1940s, women who were not already members of the workforce were called out of their motherhood careers to the public workplace, replacing men who were at war. When World War II was over, however, the question arose as to how to get women to return happily to their places in the home. Having tasted the freedom of working outside the home and the autonomy that came with earning their own income, many women were reticent to return. As wonderful as motherhood was, it was not for all women to fulfill, whether or not they were mothers. Dally (1983), along with Richardson (1993), claims that it was the work of Bowlby (1951, 1953) on the mental health of the homeless and orphaned children from World War II that revitalized the myth of motherhood. The Social Commission of the United Nations in April 1948 requested research on the needs of these children, resulting in sponsorship of Bowlby's study by the World Health Organization. As a Freudian psychoanalyst, Bowlby understandably directed his focus on the detriments of the children lacking "mother love." His report, in 1951, asserting that mother love was as essential to infant and childhood mental health as were vitamins to physical health, Dally (1983) explains, was "mis"used by political entities, ostensibly to lure women back to their abandoned roles as mothers. The result of the report was the placement of "almost mystical importance on the mother and to regard love as the only important element in child rearing" (Dally 1983, 98).

This increased appreciation for the mother-child bond did lead to enhancing some of women's rights, as children were no longer automatically given over to their fathers on the still rare divorce. In centuries past, fathers were overwhelmingly given custody of their children (see Derdeyn 1976; Saposneck 1983). Not able to provide financially for her child(ren), a woman who left her marriage or was discarded by her husband was denied the revered role of mother.

Beginning in 1839 with the doctrine of *parens patriae*, otherwise known as *Talfourd's Act*, through to the *Guardianship of Infants Act of 1925*, the courts were empowered "to determine custody of children under the age of seven" (Saposnek 1983, 3). The courts, as the

"homeland" (*patriae*) were given the right to determine who best to award custody of the child(ren). Enacting what became known as the "tender years" doctrine (King 1979), the courts began giving women custody of their young child(ren) as they were seen as most suitably equipped to provide the love necessary for a child, particularly those under the age of seven, hence the term. Instead of continuing the same rationale as before (property and earning ability), the father's contribution was financial, whereas the mother's was her capacity to love. However, fathers at that time were not directed to provide financial support. It was some time later that the notion of child support was conceptualized (Derdeyn 1976).

On the surface, with mothers being granted custody, along with increased enforcement of financial support, being a mother has brought women more power and rights than it has anything detrimental. There are two problems relevant to this study. First, there is the issue that most women are totally unaware of how motherhood has been a tool of political manipulation. Subsequently, not being aware has also resulted in blind acceptance, hidden frustrations, and obliviousness with regard to their own power, political or otherwise. Second, being a mother is not just a mystical relationship; it is hard work, and not work that all women are equally qualified for or predisposed toward doing. That is, in their nescient acquiescence, they risk not only perpetuating this mystical notion of motherhood but also reinforcing an expectation that may not be to their advantage personally, politically, societally, or economically. In fact, this idealized notion of motherhood has tended to pit women against each other rather than join them against the structures that have created the idealization.

THE GREAT DIVIDE

Infertility and abstinence notwithstanding, the advent of birth control in the 1960s provided women with freedom from forced motherhood. The issue for women became less one of "*When* will I be a mother" than "*Will* I be a mother at all?" However, the powerful and constraining social construction of motherhood, as research clearly shows that it is a social construction, has continued to create a dilemma for contemporary women. Rather than reducing problems for women, birth control has been instrumental in creating divisions between women, as they are inadvertently threatening to each other in their

justifications of their inherent worth. This problem, despite all that we now know, continues today. Acknowledging that there have always been women, who have had to work for pay outside their homes, the focus of much that is discussed here concerns mostly women with a middle-class income and cultural status. As the women of this study were generally from this social and economic grouping, that literature is what is focused on here.

Hays (1996) discusses our current problem as "the mommy wars," reflecting cultural contradictions, pitting traditional stay-at-home moms and paid working moms against each other, not to mention women who do not or cannot have children (see Wollett 1991), whether or not they work outside the home. They all face cultural expectations to be both productive members of an adult society *and* to take care of their children's needs. Most of all, women are faced with justifying the desire to fulfill their own dreams, including careers outside of motherhood. As Lewis (1991) explains, "the 'ideal' mother does not work outside the home when her children are very young, nor does she ever allow paid work to take precedence over mothering" (p. 196).

Furthermore, as Hays (1996) asserts,

> Mothers surely try to balance their own desires against the requirements of appropriate child rearing, but in the world of mothering, it is socially unacceptable for them (in word if not in deed) to place their own needs *above* the needs of their children. (p. 150)

In addition, "A good mother would never simply put her child aside for her own convenience. And placing material wealth or power on a higher plane than the well-being of children is strictly forbidden" (p. 150). Rubin (1984) states, "The mother who put herself first was unnatural, a belief unchallenged by the older women around us or by our own scared, tired contemporaries" (p. 18). As such, the stay-at-home mom justifies her actions for not working outside the home, in that she is meeting the needs of her children; she is taking care of her children, doing what is natural (Hays 1996).

Interestingly, the paid working mom justifies her actions in a similar way (Hays 1996). She strives to show how working is actually better for her children. Because she is not with them all day, she enjoys them more. Her working serves as an effective role model, as well as the fact that increased income provides the child(ren) with more material goods, such as toys, clothes, activities, and education. Having skills is

important should the mother ever become the sole breadwinner in the household. Children being in day care is also reframed as a positive event, as children are exposed to other children and adults, learning independence, adaptability, and how to be members of a community (Hays 1996). Since the majority of families have both parents working outside the home, there are fewer children at home in neighborhoods during the day. Anyone who does stay at home is not likely to find ready companionship for her child(ren). Finally, a woman who has an advanced education and does not use it can be seen as wasting her educational opportunities (Lewis 1991).

In summary, the dilemma women as mothers face is how to justify their actions in response to the overwhelming societal pressure to engage in "intense mothering" (Hays 1996). Ironically, the mothers who most seek out, engage in, and defend intense mothering are those who work outside the home for pay. Instead of rejecting the model, they strive even more to espouse it, showing how they hold up to the expectations. Mothers today must find ways to reconcile societal expectations that they be good mothers, while also meeting expectations to fulfill their roles as members of society. The stakes have been raised. As Rubin (1984) explains her own experiences in wanting to work outside her home,

> . . . we were ashamed to admit such stirrings in ourselves, to recognize that mixed in with the joy and wonder of motherhood was also fear and resentment, a sense that with the birth of this child, our own individuality was blurred forever. . . . To cast off that maternal guilt was an awesome task in the 1970s, one with grave social and personal consequences few women were willing to risk. A mother's task was to sacrifice. Any admission of failure or perplexity in assuming the maternal role was shameful, a dirtiness to be hidden away and washed with the diapers, bleached until it too had become a modest white presence. (pp. 17, 19)

Friday (1977) supports this claim in her book, *My Mother/My Self.* The idealization of motherly instincts was tyrannical: "A dangerous gap is set up. Mother feels the mixture of love and resentment, affection and anger she has for her child, but she cannot afford to know it" (p. 16). With this idea, a woman is doomed to have feelings of hopelessness and helplessness, as she is unable to manage flawlessly the complicated and unrealistic world of a woman as mother, homemaker, wife, and paid worker. With the increased acceptance of divorce, a woman might also

have to be father, as well. Indeed, a single, working mother, due to the many demands on her time, may experience a great deal of isolation.

ISOLATION AND THE NUCLEAR FAMILY

With the many technological advancements of the nineteenth and twentieth centuries, and the accompanying movement away from an agrarian lifestyle, access to extended family members was constrained by distance; families became smaller and more isolated, resulting in the nuclear family. This notion of family life was privileged, placing great emphasis on the role of mothers and fathers to be the primary, and often only, caregivers and role models for their children. However, rather ironically, these inventions also expanded the workload by increasing expectations for cleanliness, hygiene, and comfort. Ultimately, women were expected to do more tasks than their recent ancestors accomplished in the same amount of time, with less help.

With her arsenal of appliances, the mother, queen of her household, carried the load of chores, as well as taking on the entire task of "converting" a child "into a competent and normal member of the community. . . . [She] pondered the *meaning* of child raising, and experienced an awakening!" (Sebald 1976, 25, 26). This mythical awakening resulted in women focusing less on their roles as cooks or housekeepers, and more on their roles as mothers.

> No longer was she solely an auxiliary to the father. The gradual accentuation of this new status culminated in a myth, an almost cultic devotion to the new "specialized career" of motherhood. Apparently, a profound need had been at work to replenish with meaningfulness the void created by the dwindling away of the daily survival chores mothers had tended to for ages. The Myth was the answer to the Need. Young mothers became mother-entrepreneurs. (Sebald 1976, 26-27)

In their entrepreneurial roles, mothers could embrace their own ideas of mothering; that is, Bowlby's and Winnicott's advice about mothering was that it was an instinctual ability that women should let guide them in their abilities. As Richardson (1993) explains,

> In their view, whether a woman was a good or a bad mother depended less on her personal experience and knowledge of bringing up her children than on the strength of her instinctual feelings towards her infant.

> Successful mothering was removed from the control of the child's mother and placed firmly and squarely in the hands of Mother Nature. (p. 47)

A woman who did not have the natural feelings that she should have was a failure not only as a mother but also as a woman—indeed, even as a person. The idealization of motherhood had reached an all-time high, leaving a woman in total isolation, unable even to voice her fears, ask any questions, or express any doubts. Most of all, as the results of her endeavors, her child(ren) were on stage for all to see and evaluate. Their goodness and success, including their health, were the results of her maternal instincts, her worth as a human being.

This idealization, a perfect example of hegemony perpetuated by the disempowered, creates a paradox for women. They are socialized to place aside their own desires, dreams, and even basic needs for sleep, creativity, and personal accomplishment, to fulfill the myth of motherhood. The myth is seductive; what was originally planned to empower women (c.f. Wollstonecraft) instead has beguiled them into an impossible dialectical struggle, one that others can manipulate at will, silencing all declarations of personal aspirations and desire. The message is simple: you are so special that it is not possible for the world to continue without you sacrificing yourself.

GUILT AND DECISION MAKING

Idealization, politics, guilt, economics, family life, and identity/role conflict have all been the focus of discussions regarding motherhood in the past three centuries. Although responsibility for the health and well-being of one's family has been an important issue with regard to defining the good mother, what has not been discussed is how this image plays out or is demonstrated with regard to obtaining health care services. Although it has been shown that women seek each other out, wanting assurances regarding their ideas about child rearing (see Hays 1996), extant research does not address how women cope with meeting the needs of their families, juggling career/work and motherhood, along with maneuvering through the current health care system. Until much into the nineteenth century, health care needs typically were handled in the home by women. Along with child rearing becoming the domain of scientific experts, pregnancy and childbirth were also moved

totally away from the home and the comfort of other women into hospitals. Over time, as we have increased our knowledge regarding identifying and curing diseases, healing as women's work has been replaced by the sanitary, masculine world of medicine. It is not that hospitals are bad places; it is that some life events, such as a fairly normal pregnancy and delivery, or even an expected death, do not benefit from hospitalization (e.g., iatrogenic or nosocomial illnesses). Endeavors to emulate a homelike atmosphere can be seen in many facilities with natural birthing and hospice rooms. Likewise, the increased acceptance and popularity of midwifery can also be seen as an attempt to reembrace a more feminine mode of treating pregnancy and childbirth. Nonetheless, these events are typically done through the auspices of a physician, just in case there are any complications.

Despite the dominance of medicine, what has remained is the responsibility of women to ensure their family members' healthfulness. But this responsibility includes more than temperature taking and medicine dispensing: a mother must be savvy to ways of maneuvering through insurance claims and of weighing the advice of doctor, nurse, pharmacist and her books on child care along with her mother's, aunt's, or grandmother's suggestions (Hays 1996; Tardy and Hale 1998b). To complicate matters, from the strict advice of the 1920s and 1930s with regard to child rearing, to the maternal instinct philosophy of the 1950s, how one is supposed to take care of one's child(ren) has become a confusing maze of information. Mothers are caught in a struggle between following family practices, her own instincts, and institutional directives, between a desire to fulfill the role of motherhood and to fulfill her own dreams and ambitions. This confusion has real consequences: if the mother fails, if her child becomes ill, then not only does she hold herself responsible but others hold her responsible as well.

Of course, there is the question of why not strive to have as healthy a family as is possible. Just as in health communication, there is no direct connection between communication and an individual's state of healthfulness (Zook 1994); simply striving for good health does not mean that disease and illness will not occur. Sickness is not a result of sinfulness, despite all myth to the contrary; a mother cannot totally prevent anyone from becoming ill. As illness is inevitable, it is then possible that there are issues that are avoided in discussion, as they would bring on shame and humiliation. Subsequently, as this study focuses on stay-at-home mothers living in a world constructed by the events just discussed, what

are these topics that they must avoid? What do these topics—taboo topics—convey about their interpretations of motherhood and their subsequent use of health services?

The question of what can be discussed, as well as what cannot be discussed, is important not only to women and scholars of women's studies but also to health care providers, including insurance providers. These avoided topics are indicative of the types of health topics that women, seeking a counter-universe, probably most need to discuss. As the findings will show, the topics reported to be taboo are those that would negatively affect the fulfillment of the idealized image of motherhood. To identify these choices, the discourse to examine should not be limited to that occurring at the physician's office or at play group meetings but expanded to include other, more exclusive and private gatherings. Unfortunately, observation of these gatherings is, by definition, not very likely to occur. Instead, accessing this notion has had to be done largely via interviews and surveys.

METHOD

The fundamental goal of this study was to observe, to collect, and to analyze mundane conversations (c.f. Duck 1990) regarding health issues by members of a social system. Therefore, I used ethnographic methods typical of anthropological explorations (i.e., Basso 1990; Carbaugh and Hastings 1992; Geertz 1973; Fetterman 1989; Philippsen [1975] 1990) including participant observation, personal interviews, and an open-ended survey.

The setting for this study was in a relatively small town, dominated by a fairly large state university, located in rural Appalachia. Few amenities were available as there were only two major grocery stores, one mall, one hospital, and two department stores. Most notably, there was no Wal-Mart within 45 miles. The population of the town (about 20,000) nearly doubled when the university was in session, creating two distinctive groups: the "townies" and the students. Faculty and graduate students tended to fit in between these two disparate groups; the play-group members were a sort of microcosm of the general community but managed their differences very well. The only discord appeared with regard to the inclusion of two international women, as

one townie commented in her thick Appalachian accent that she could not understand these women due to the strange way that they spoke.

The group was started by a mother who, as a new arrival due to her husband's admission to a graduate program, felt isolated and wanted to make contact with other new mothers. Membership to the group was contingent on the recency of motherhood or residence. The group had been in existence for approximately five years. A local woman could join with the birth of a child, regardless of whether she had other children; otherwise, membership was intended for those who were without a social network. There was a minimal fee for joining. Membership in the play group was not discussed or presented as prestigious; in fact, many of these women were desperate for friendship. Newcomers were always welcomed. Likewise, a new mother who was also a working mother was not excluded. Unfortunately, of course, as the play group met on a weekday morning, it was unlikely that many paid working mothers could attend. Some did attend, however, the "mom's night-out" gatherings.

A coordinator was elected from among the women every six months. She took care of locating places for the play group to meet, as well as mom's night-out functions. She put together the membership list and generally kept track of who were regularly in attendance. She made the announcements regarding births or any other such news. It was the coordinator who agreed to cooperate with this study.

The members met every week for approximately two to two and a half hours, first in a church basement, and then, with the change in seasons from winter to spring, alternating between a park and a restaurant chain with a playground. The members also met once a month for a mom's night out, varying between members' homes on two occasions and restaurants on the other two occasions. In all, the primary researcher attended fourteen play-group meetings and four mom's night-out meetings. I announced the nature of the research and participants' rights to deny access at three consecutive meetings, with newcomers introduced and informed of the research as needed.

PARTICIPANTS

There were approximately 30 women involved in this play group at any given time; however, only 24 women were identified as regular participants for the interviews and surveys. The women in this study were

predominantly stay-at-home moms who had given up work or a career (some temporarily) to rear their children. Former occupations ranged from cosmetology, social-services management, computer operations, X-ray technology, obstetrical nursing, elementary education, and advanced biological research. The women were all Caucasian, with only two women from other countries (Russia and Chile), and ranged in age from 23 to 43. All of the women had at least one child, with a maximum of three children. Income levels ranged from lower class, such as graduate students' wives, to upper middle class, such as the spouses of lawyers. Those whose husbands were in graduate school (3 women) did receive public assistance, mostly in the form of WIC vouchers (supplements for women, infants, and children). Income levels were not explicitly discussed. Half of the women were native to the location, while the rest had been relocated because of their husbands' occupations.

Other analysis (Tardy and Hale 1998b) included in the overall study indicated the existence of several cliques (c.f. Rogers's diffusion of innovation theory, 1983) as the women gravitated toward those with whom they were similar regarding parenting philosophies, age of children, or stage of pregnancies. Some just happened to be from the same neighborhoods. Analysis included the identification of opinion leaders and networks of communication, including isolates. Women who had a background in conventional medicine were most likely to be opinion leaders, while women who tended to espouse controversial views (without previous medical experience) were more likely to be isolates. Interestingly, the founder was never in attendance during the study (she was interviewed in her home) but was identified as an opinion leader via network analysis (Rogers 1983; Tardy and Hale 1998b). Her influence was very strong despite her lack of involvement directly with the play group.

PROCEDURES

This study used ethnographic methods to study the phenomenon of health information seeking. As Fetterman (1989) defines ethnography, the primary purpose is to provide a cultural interpretation that describes local practices. However, the researcher does not make these observations in isolation; that is, she relates her observations to the participants and seeks verification. Therefore, the data are not collected via a single observation but through repeated observations and

conversations with the participants. As such, the researcher serves as the instrument, refining her observations and using the participants' perspectives to develop a contextualized theory. Inherent to this process is the identification of key informants who assist the researcher in refining observations. Fetterman (1989) explains this process as using the subjective experiences of the observed participants inductively to discover cultural patterns. In this study, specifically, I engaged in participant observation and personal interviews and created a survey to gather data.

Participant Observation

At the weekly play-group meetings, the women typically gathered in small groups, sitting or standing, talking with each other and playing with their children. The noise level at all of the sites precluded any possibility of audiotaping the interactions. As such, I tried to sit as unobtrusively as possible near conversations and essentially eavesdropped. With a notebook on my lap, I wrote comments regarding how they gathered, who gathered with whom most often, the tone of conversations, and the content of their interactions. Furthermore, I openly displayed my notes so that anyone could read the notes, thereby lessening any reservations about what I was really doing.

To ensure cooperation and reduce the participants' anxiety about being observed, as mentioned, I explained the nature of this research and obtained consent via an approved form. There were none who refused to allow the observation. Also, gaining admission into the counter-universe included my sharing my own stories and joining in conversations about taking care of children, as well as engaging in the group activities by bringing refreshments, dressing casually, and playing with the children.

The mom's night-out gatherings occurred in four different locations, twice in restaurants, and twice in members' homes. When at the restaurants, reservations were made ahead of time, allowing the women to be seated at one large table in a more private setting than the main dining area. Everyone ordered her own meal, which was also paid for individually. Undoubtedly, women who could not arrange/afford child care, including the father not being able or willing to watch the child(ren) or those who could not afford to dine out, found themselves excluded. As identified in another report (Tardy and Hale 1998a), women who were

isolates oftentimes did not attend the mom's night- out functions. Sadly, as the coordinator noted in her interview, it was at the mom's night-out gatherings that the women really bonded. Subsequently, those who could not attend were left out of participating in the counter-universe.

When in the homes, the attendance tended to be higher, as children could attend, if necessary, and were sent to play in another room. At these occasions, the meal was potluck and a much less formal event. Interestingly, the attire was different from at the play-group meetings, as the women wore much nicer clothing, such as skirts and dresses instead of jeans and a T-shirt. Alcohol consumption was higher than at the restaurants as the hostess provided the beverages. Also, the events lasted longer. Overall, in the homes, mom's night out was much more informal and sociable. The women were able to move about, maneuvering in and out of small groups, as well as collecting in a sort of huddle around the kitchen table.

At both of these events, in light of Fetterman's (1989) observations of ethnography, I informed the women of my hunches and asked what they thought. Subsequently, the women would clarify what was going on in their interactions. Furthermore, they began to engage in their own observations and report with such comments as "Oh, I heard a lot of interesting health talk going on tonight!" (this comment was made at a mom's night out).

Interviews

In addition to observation, I conducted personal interviews to solicit narratives of health concerns and examples of information-seeking behaviors. The participants were offered a sign-up sheet if they were interested in assisting in the research by agreeing to a personal interview. The women provided their telephone numbers and I subsequently contacted them and made appointments for the interviews at their convenience. I made concerted efforts to have a representative sample of the overall group composition, for example, purposefully seeking out those who appeared to be isolates.

The personal interviews occurred in the participants' homes for their convenience and lasted a minimum of one hour to a maximum of three hours. I was able to audiotape all of the interviews with the participants' consent. In all, thirteen women and one man participated in interviews. The one man was included as the husband of one of the participants who

happened to be present during the interview. Although I had prepared and used a protocol (see Appendix A), the nature of the interviews was more of a dialogue or conversation, as opposed to a formal question-and- answer session. Subsequently, I transcribed all relevant dialogue and conducted an inductive analysis.

Survey

The third step of this study included a survey to solicit both information about the participants' contact with each other and more specific information regarding their impressions of health-information seeking (see Appendix B). I distributed the survey to the members individually at a play-group meeting including a self-addressed, stamped envelope for them to return at their convenience. Four weeks after the distribution of the survey, I contacted by telephone those women who had not yet returned their surveys, requesting that they fill out and return the survey; the response rate was 62.5 percent (15 out of 24 surveys). These responses were also transcribed according to each question and coded for analysis. Finally, I included the field notes, interview transcripts, and survey responses in my analysis, coding for emergent themes and/or topics. My focus for this article is on the notion of socially inappropriate, or taboo, medical/health care topics, in the social construction of motherhood.

SOCIALLY CONSTRUCTING MOTHERHOOD VIA HEALTH CARE CONVERSATIONS

The question of which health topics were considered socially inappropriate was consistently met with a response of "I can talk about anything!" As pregnancy and delivery required women to expose their bodies to rather intimate scrutiny by practitioners, there was the prevailing sense of being uninhibited afterward. As Betty explained,

> Oh, I tell everybody—every detail—there's no modesty in that! I lost all my inhibitions giving birth. You want to know anything—sure. And that is funny—that is—I don't know anybody who is not forthcoming with their birth stories—in grocery stores—people feel like they can just walk up to you and—Oh, I have a baby too—and how did yours go?

Others, particularly fathers and husbands, know that this "anything" is not quite true as they are not allowed to discuss a very important issue related to the pregnancy and delivery—that of money. The idea with insurance and cost was that it commodified life. Carolyn and her husband, Roger, explained,

R: Something that is taboo, umm . . . for men not to talk to women about is insurance and how much it is going to cost. It offends—from a male perspective—the women to find out the father is upset about spending 3 or 4 or 5 thousand dollars when the insurance isn't going to kick in.
C: That's putting a price tag on a life—how could you even be concerned about that?
R: But that's not the issue for both Sam [friend] and I. Sam indicated that he just—all the men at the church he went to had the same kinds of problems—that the whole issue of fighting with the insurance company about it—the women were just appalled at that. Oh! It's not that it's not worth it—it's just that you've got to fight with the insurance company.
ER: The idea is that the moms and dads don't talk to each other about it?
R: The dads know better than to speak to moms about it because [it will upset them]—and that is an overgeneralization—but that is the issue.

Although the women discussed how to manage the intricacies of insurance, such as getting a referral, they did not discuss the costs of treatments or premiums. As Hays's (1996) research also indicates, discussion of money and the cost being more important than the needs of the children commodified life. If anything, this issue was "men's" work and is probably one of the most enduring roles that fathers play in a child's life (Hays 1996; Hochschild 1989). It is precisely the distinction between women's work as noncommercial and men's as totally commercial that is at the root of the current dilemma for most women as mothers. For, even as fathers are encouraged to parent, the cultural expectations with regard to material wealth would still require that someone be involved in intensive parenting as a separate lifestyle than being a member of the workforce (Hochschild 1989). Extremely pervasive and evident in everyday conversation, the members of this group did not discuss this dichotomy in a negative way.

In fact, at one point, after months of participation in the group, I was feeling the pull to return to the home, to return to full-time care of my own three children. When I commented on this fantasy to one mother, she responded that I would not like it, that I would be bored. Not that she

was bored but that I was a different type of woman who could not be satisfied with the lifestyle of the stay-at-home mom. She was probably correct in her assessment, and she did not apologize for the tone of superiority in saying that it takes a special kind of woman to do this kind of intensive mothering. In presenting my impressions and interpretations to the women, and even sharing an initial draft of the results, most of the women were pleased with the reflection they perceived. They enjoyed thinking that their intensive mothering was a sort of profession, that they were distinctive in their endeavors.

The taboo topics ascertained via interviews and surveys were shared with the women at various times. They confirmed the restrictive nature of the talk but did not recant from the declaration that they could discuss anything with other women. The conclusion of this analysis, using Goffman's (1959) ideas regarding regions and regional behavior, especially with regard to the backstage, was that the women did indeed create a sort of counter-universe where they shared stories about their pregnancies, births, their own and their children's illnesses, as well as some household concerns. However, where this backstage occurred was not in the setting expected. That is, the backstage was not the play group but was the mom's night-out gatherings, thereby making the play group a sort of front stage, wherein the motherhood role was enacted, not for the benefit of others (nonmothers) but for the benefit of each other as mothers.

Although the play-group meetings probably would have been very different if men had been present, it was the removal of the children that allowed the women to step away from the show of motherhood and return to being women first and mothers second. Furthermore, while the mom's night-out gatherings allowed the women freedoms they did not have at the play-group meetings, there were still topics, reportedly, that were not to be discussed openly. They were only discussed with one's most trusted friends. The enactment of motherhood was found not just to occur in public outside of the play-group meetings but also within the play-group meetings. As stay-at-home moms, in a community filled with professional working mothers, they needed assurances that their efforts were suitable and important (see Hays 1996).

The women also needed the community to provide them with knowledge so important to their identities as effective mothers. Inherently, through the many choices they made (e.g., which hospital to use, practicing natural childbirth, circumcision, breast- or bottle-feeding, using

antibiotics, reducing fat and sugar in their families' diets), they reinforced cultural expectations and ensured network support. If the advice they received was consistent with their own philosophies of child rearing, then there was little contradiction; if, however, they were not, the women risked losing their autonomy or their network support. This struggle was not discussed but was enacted in the front stage, the weekly play-group meetings.

FRONT STAGE: DEFINING WHAT MOTHERHOOD *IS*

The finding that the primary cultural pattern of the women's health care talk was to facilitate their roles as mothers is reported in other studies and is assumed herein as well (Tardy and Hale 1998a, 1998b). The way in which the women shared information and talked about their health-oriented experiences, especially with regard to their children, served as a sort of job requirement and standard for evaluation as good mothers. Many of these women had once had jobs/careers before becoming stay-at-home moms. With this change, they needed to make new friends and create new roles for themselves. The talk was noted as serving a vital role in their adaptation. As Betty observed, talk about pregnancy, childbirth, and child development is what "bonds us women together."

Outwardly, the women formed a social support network (cf. Albrecht and Adelman 1987; Cutrona, Suhr, and MacFarlane 1990; House 1981; House and Kahn 1985). They engaged in supportive talk and action, helping each other out when needed. For example, when one woman severely broke her arm and could not tend to her son who was still in diapers, or any other household task as she was heavily medicated for the pain, the women in the play group organized an around-the-clock schedule to help her. They cooked meals, bathed and changed the children, and watched them until the father was home. She had no family in the area, so the play group filled this role. This tangible support went on for several weeks until her arm was healed enough that she could return to action.

As this example reflects theoretical suppositions, people are thought to need a social support network to be healthier. In one sense, it is simply to provide tangible assistance when needed. In another sense, these relationships are important, as having close relationships is inherently

tied to being known and understood (Derlega et al. 1993), which is deemed essential to being a healthy person. Indeed, the present research supports this view. The women's interactions not only provided assistance and created relationships but also provided the women with a sense that their experiences were normal. Sharing their experiences with women of similar values and lifestyles provided them with the assurance that they were usual, that they were identifiable not only as mothers but as good mothers.

Talk at this level included information exchange about which physicians and hospitals to use and which to avoid. The women also discussed what tests and procedures they deemed necessary, such as amniocentesis, ultrasound, and anesthesia (during delivery). The women regularly revealed and conferred about situations they had encountered, often seeking advice, support, or even absolution. They discussed recent appointments for their children and themselves, whether for pregnancy or for some illness. They discussed which doctors they preferred and which they did not like at all.

For example, Betty told of a time when she had to take her son to a pediatrician for a couple of problems, including an inflammation of the foreskin of his uncircumcised penis. Her decision not to have her son circumcised was based on her naturalistic values of health and parenting. However, the physician did not consider her values and, instead, challenged her role as a good mother. The physician explained the nature of the inflammation and further made the statement that the inflammation was why he always recommended circumcision. As Betty said, "He made me feel like it was my fault [the inflammation] because I didn't have him circumcised." The physician prescribed antibiotics, which Betty did not believe in using and did not fill; the inflammation was gone the next morning, at least affirming Betty's views regarding not using the antibiotics.

Betty received support for her feelings regarding the manner in which the physician treated her, if not for the actual decisions regarding circumcision or the use of antibiotics. The use of antibiotics was discussed, with the women freely claiming whether they would or would not use antibiotics. However, whether to circumcise was not a subject to be debated openly, as will be discussed. The use or nonuse of antibiotics can be justified either way, continuing to claim the good mother role and status, as each has its merits with regard to the continued health of the child. That Betty's child recovered justified her choice, leaving the

women free from evaluating her decision. As Betty shared in our interview, if he had not, she most likely would not have discussed the issue at all—not at the play-group meeting, that is.

The dilemma for the mothers was not just a matter of making the right decision but also one of how rapidly the mothers could get their child(ren) well. They had to be aware of any change in their child's health, wherein even the child getting ill was evidence of being a bad mother. Ear infections are a prime example, as they are not visible except in the sense that the child cries and pulls on his or her ears. One woman, Annie, with three young children, regularly attended with her six-month-old baby girl and toddler son. Her children were very well behaved, with the baby, in particular, receiving much attention for her pleasant nature. Annie was worrying about her daughter's most recent well-baby checkup and how the doctor had discovered an ear infection. She expressed her frustration and guilt that her daughter had not shown any evidence of being ill, leading to defending herself: "But I *am* a good mom!"

Most of all, a mother "does no harm." As mentioned, Annie had a three-year-old toddler boy as well, who regularly had a bandage wrapped around one of his forearms. Throughout the winter months, the bandage was hidden by his long sleeves. It was when the season changed that his bandage became visible; however, no one commented on this bandage. Not knowing the history, I assumed that there had been a recent injury and asked another mother about it. She told me that she would tell me later, as we had an interview scheduled for later that week. Subsequent interviews with both Annie and the other mother revealed that the toddler had been burned when a hot iron fell on his forearm. Annie had just finished ironing, had unplugged it, and turned away for just a moment, when the child tripped over the cord, bringing the hot iron down on himself. The story was relayed not as gossip but with genuine concern for both the child and mother. As the other mother explained, the issue was not openly discussed at the play-group meeting due to the shame associated with the event, protecting the mother from scrutiny and the subsequent judgment in not being a good mom. That is, no good mother would be so careless as to allow her child to injure himself in such a manner. Injuries for which the mother can be totally absolved of blame are those that are totally unpredictable or actions that were done despite the mother's admonitions. Even then, there is the notion of "if only"—if only she had tried harder.

In the event that an "if only" occurred, the situation was discussed and the solution or guidance was shared to help prevent the same occurrence for others. For example, there was the event of the bitten tongue. During one meeting, a child tripped and bit her tongue. The gash was deep, going almost all the way through, but was not very wide. It was bleeding quite a bit, causing alarm for the child and her mother. The question was whether stitches were needed. As it turned out, another mother had had the same thing happen to one of her daughters and knew exactly what to do. Coincidentally, the same thing had happened to one of my children, and I was able to corroborate the guidance (provide acetaminophen, cool drinks, and food such as Popsicles™, avoiding regular food—mouth wounds heal very quickly—no need for stitches). Since no one can prevent all accidents or illnesses, the key is to be prepared and forewarned, which does not alleviate the problem altogether but in actuality returns a mother back to her original source of angst, getting all the information possible.

The women in the play-group network were told, implicitly and explicitly, not only what it meant to be a good mom but also what was most constructive and beneficial to the community of stay-at-home moms. Through the many choices they made (e.g., which hospital to use, practicing natural childbirth, circumcision, breast- or bottle-feeding, using antibiotics, reducing fat and sugar in their families' diets), it was evident how the social order constrained these women into choosing practices that would not isolate them from their networks of support.

Breast- versus bottle-feeding provides an example of the kind of controversy a woman can experience. During our interview, Annie explained how her former network of friends in her previous hometown had not breast-fed their children, so her decision to bottle-feed was shaped by that exposure. She had given birth to two boys during that time. Even though she had resided in her new home for several years and developed affiliations through the play group, in which the women predominantly breast-fed, she still chose not to breast-feed her baby girl. The practice was simply not in keeping with her own level of comfort and former role models; however, the choice was not without repercussions, real or perceived.

ER: Did you breast-feed her at all?

A: No, I never did . . . I thought about her—it's just something that—my family never did it—and none of my friends ever did—I really didn't understand anything about it and I would have felt like an outcast—and

here—I feel like an outcast because I feed her with a bottle. It's just how different just from here to there.

ER: But you were here when she was born.

A: Yea, and I thought about it . . . but I never did with them two and I was like . . . so I just didn't. When they were little, no one I was around ever nursed. I never knew anybody that ever . . . you know . . . so that was just the thing to do. And here—everybody does! And you feel like such an outcast because she drinks from a bottle!

The practice of breast-feeding, although ancient, is not without controversy on a larger scale (see Richardson 1993 for a discussion). There was a story reported in the newspaper during this study about a woman being escorted out of a mall because she was breast-feeding; the event created a protest. Women staged a sit-in at the mall, openly breast-feeding their babies. The complaint was that it was tantamount to toplessness, but it was found not to be against any laws. The women were allowed to remain and nurse their babies. The mothers in this study expressed praise for these women.

Likewise, many women reported not receiving support from their physicians to continue nursing or to breast-feed their children past infancy. Patty told of her traumatic experiences of trying to maintain breast-feeding her daughter through two surgeries. The hospital staff was apparently outraged that she sought to continue pumping her milk and that she expected their assistance in doing so. The decision to breast-feed, while seemingly just a matter of selecting a primary means for feeding an infant, has a host of social, moral, and physical implications. As such, a woman's decision is shaped by her social network and her own emergent philosophies regarding child rearing. As Betty expressed her views:

I just knew that it was the right thing for me to do. Because I am a scientist—I have been trained in science. I am an evolutionarily oriented person and I know that things happen in our bodies for a reason—there is a need. There was no question . . . you cannot improve on breast milk. . . . To not nurse is to go against what our bodies were meant for. . . . In one Scandinavian country they have milk banks—where you can purchase breast milk by the liter. . . . Yea, sell your milk! I wonder how much you could get for that?

Although reflective of the play group's popular practices, this comment did not occur at a play-group meeting but at an interview. She

would not have said this openly at a play-group gathering for fear of offending any mom, especially Annie. Although Annie felt censure for not breast-feeding, it was not that she was lectured on the benefits of breast versus bottle; it was conveyed simply with the question of "You aren't breast-feeding her?" The women reported feeling more comfortable expressing ideas as themselves, rather than as moms, when in a private conversation with those whom they trusted. These moments are identified here as backstage conversations, where the women were able to be themselves, and not just moms.

BACKSTAGE: BEING A WOMAN AMONG MOMS

As the coordinator of the play group noted, it was through the mom's night-out activity that the women truly bonded with each other. Although the unstructured nature of the play-group gathering was conducive to the women conversing, their children were present and required constant attention. Only when they removed themselves from their obligations of motherhood could they truly relax and share what might otherwise be inappropriate information. What is important to realize, however, is that the women did not stop being moms just because their children were not present. Whether in one of the women's homes or a restaurant, the backstage was constructed when the mothers could relieve themselves of their constant responsibilities and surveillance of their children and share their discomforts, but mostly share their humor about their experiences as mothers.

The nature of this talk is best illustrated by a mom's night out that occurred in one woman's home. At first, the conversation was just another in a series of interesting dilemmas such as rocks up the nose, swallowing money, or gum in the hair. The event involved the women sitting around the kitchen table after a potluck dinner, with those who could consume wine and beer doing so. With the crowd diminished to the diehards, conversation took on an air of entertainment. Stories were shared not for facts but for laughter. Without their children or husbands present, the women were able to discuss topics otherwise not discussed among their husbands or children. The sense that it was taboo became evident when the women not only realized that I was writing down the conversation but also exclaimed aloud, "Oh, look, she's writing this all down!" Instead of stopping or asking that I not report the story, the women regaled each other with more intimate details. The talk took on a

tone of storytelling, with exaggerated gestures, prolonged pauses, and variations in volume and rate of speech.

Susan, the woman with the broken arm, was probably more expressive than most of the other women. It was a mom's night out held in her home, and she told a story about changing her daughter's diaper when she was a toddler and finding a bracelet in her daughter's vagina. As her two-year-old son was present, she put her hands over his ears, so that he would not hear her whispered comments. The child had put it there apparently after seeing her mother insert a tampon (mothers have very little privacy). The conversation turned to other such experiences of children engaging in self-stimulation. Audrey shared how her little girl had quite a fondness for a particular large stuffed animal and that she feared moving her out of diapers as she would have more "access." Diapers, at least, kept her hands away from her own genitalia, most of the time.

Another example of such ribald discussion occurred when Sylvia showed off her ultrasound pictures very clearly indicating that her unborn baby was a much-wanted boy. The ultrasound pictures became a source of humor in that the word *boy* had been printed in the picture near an enlarged view of his genitalia. Sharon, also pregnant, expressed her admiration as he would make some woman very happy one day. Accompanied by laughter, Sylvia responded that he must have gotten it from her side of the family but that her husband was very proud. What is important to note in distinguishing this talk from that at the play-group meetings is that not only did the women never share such details at the play-group meetings but that unlike the talk at the play group, these conversations had nothing to do with soliciting advice, support, or validation. These conversations were the regaling of details that these women were not afraid would reveal them as bad mothers.

Other conversation acceptable at the mom's night-out functions but not at the play-group meetings included the rather explicit details of anyone's delivery. Since the children were present at the play group, only the typical details were provided. One reason for this restriction is that children tend to repeat what they hear and could reveal aspects of their mothers' existence that was not appropriate. At the mom's night-out gatherings, however, details of how many hours, how many tears, what kind of anesthetic, how long was she in transition, and so on were shared with great relish, as illustrated by Sylvia's performance. Heavy with her own pregnancy, Sylvia climbed up onto a chair so that she

could see and be seen by everyone present. No one told her that she should not be standing on a chair "in her condition." Sylvia raised her arms and said loudly that she had an announcement. The crowd of women quieted and looked at her with anticipation. She paused for everyone to quiet and then said, "Marsha has had her baby." Pausing again for the questions and expressions of excitement, she announced that Marsha had an 8-pound, 14-ounce boy—again pausing for expressions of concern since he was a big baby—and 21 inches long: "He was born this morning and his Apgar score was at first an 8 but then was up to 10 within a few minutes. Marsha is doing well; she only had grade 4 tears." At that point, there was little more to say until more information was obtained.

The front stage, the play group and almost any event when the children or others were present, was typified by conversations indicative of being a good mom. The mom's night-out gatherings and the private interviews revealed talk not necessarily reflective or congruent with this mother image. Instead, it was as De Beauvoir (1953) commented, "They do not discuss opinions and general ideas, but exchange confidences and recipes; they are in a league to create a counter-universe, the values of which will outweigh masculine values" (p. 542). The women discussed topics they would not reveal even to their own mothers, unless they had a totally nonjudgmental relationship with them. Only with their peers could they share the unseemly details and thoughts of their lives as mothers. They gloried in the details of childbearing and birth; they shared and laughed about their own embarrassing experiences, and reflected on others' experiences.

That this talk was not acceptable at the play-group meetings was evident when Deborah was disclosing her suspicions that she was pregnant to a few mothers. The crowd was small as it was at the beginning of the play-group meeting. She was asked a couple of "diagnostic" questions, to which she received approval that "yep, you sound like you're pregnant to me!" There was an inquiry as to her desire to be pregnant then, given that her husband was in the final stages of his dissertation. She commented on how difficult it had been for him to work on his dissertation and facilitate her desire to get pregnant. "Poor man, he has had to work so hard," she commented with laughter. As if the children were magnets and the mothers' eyes made of metal, their gaze went down to the little ones underfoot, silently reminding us all of where we were and what was appropriate. The topic was changed to one more mundane

than her sex life, such as how she thought her daughter would handle another baby in the household. What Deborah had not realized was that the topic of her sex life was not to be discussed in the front stage, at the play-group meetings, and maybe not even at the backstage, the mom's night-out gatherings, as the topic of one's sex life, particularly the enjoyment of one's sex life, was taboo.

BACK-BACKSTAGE: WHAT MOTHERHOOD DEFINITELY IS *NOT*

If discussed at all, the taboo topics discerned in this study were reportedly only discussed in very private conversations, which precluded any observation. All information about these disclosures is therefore strictly from interviews and open-ended survey responses. These conversations were explained as occurring only with their most trusted confidantes and those who would not judge or criticize them. The avoidance of topics is usual, as Hays (1996) explains in her study of child-rearing practices, of a woman who did not accept the advice of her own mother and, therefore, did not discuss the issue with her mother. While defining motherhood by what it is not may be stretching the importance of these topics, the point is that in the responses, we see the pain experienced by these women in their pursuit of the idealized role of a mother.

In the counter-universe, motherhood, despite the obvious absurdity of such a claim, is not about sex. It was not that the women simply did not openly discuss their sex practices; it was that when discussed at the play group meetings or mom's night-out gatherings, they were usually done in a joking manner. As Sylvia asserted at a mom's night-out gathering: "Show me a man with small children who is happy with his sex life, and I'll show you a man who is having an affair." The notion embedded in this comment is that no woman with small children feels like having sex, and therefore, the man who is content is probably adulterous. The woman's life and all her energies become focused on her children. She is exhausted and not even remotely interested in such a frivolous event as sex.

Likewise, from an interview: "Sex is a hard topic sometimes. But I guess that isn't a health issue. No one understands what I go through, so it is hard to get answers from someone else." This "someone else" was not just her friends or family members but her doctor as well. A survey

response read: "A taboo subject seems to be the intimate sexual relations between a husband and wife. We often joke about sex or make comments about sex, but very rarely do you hear anyone discussing their specific sex life." This same respondent commented during her interview that while so many women seemed to lose interest in sex during their pregnancies due to exhaustion, she felt an increase both in her energy level and libido. However, she did not feel comfortable revealing this change to any of the network members. Given the exhaustion of most women during pregnancy, not being exhausted raises the standard of expectation. The last thing those who have struggled to have their depleted physical state legitimated need is to be confronted by someone who seems not to be negatively affected.

Prior to medical intervention (e.g., drugs, epidural anesthesia, etc.), women suffered among themselves. Along with remedies intended to ease the pain, the symptoms experienced without succor were reframed into a positive image—the mother who suffers in silence; she would rather sacrifice herself than have harm come to her child. Even now, pregnancy and breast-feeding are two conditions that preclude the use of many medications, even for a cold or flu. The actions of a silently suffering mother may raise her in others' esteem but does little to reduce her actual suffering.

Furthermore, women are reduced to asexual beings, as sex is the antithesis of archetypal motherhood images, such as the Christian Madonna. The Madonna became pregnant without sex; a sexually active, pregnant woman constitutes an archetypal paradox. Subsequently, discussions of sex life after the onset of pregnancy must be told in a joking or critical manner, devoid of any sense that the woman actually enjoys it. This virginal motherhood image devalues a woman's rights as a person, as the image repositions all her worth in her role as nurturer and sufferer for others' needs. For instance, a common health issue, not life threatening but certainly significant, was the bloody discharge women have after delivery. In an interview:

> I had no idea that I would bleed after having my baby! I was there in the bed worrying that I was dying. . . . I asked the doctor to make it stop and she just shrugged it off, saying that it was supposed to happen. . . . I never knew that! Why didn't anyone ever tell me?

Very simply, the women in this study did not talk about this event. At the end of the pregnancy, the woman's body is no longer the vessel, and

what occurs within it is of no real consequence. In essence, her health is secondary to that of the child.

Other topics discovered via interviews and survey responses included sexually transmitted diseases (except for AIDS as a current event); abortion; miscarriage; stillbirth; death, particularly of a child; sexual abuse; explicit details of non-pregnancy-related surgery; or problems with early childhood development. Direct observation corroborated these findings by noting that once the subject matter turned to these particular topics, the conversations waned, tension developed (not making eye contact, lack of laughter, blushing), or topics were meta- communicated ("we can talk about that later").

An example of how earnestly these topics were avoided was evident in a discussion regarding amniocentesis. One day, two women were sharing why they chose not to have an amniocentesis done, convincing a third also not to put her baby at risk. They were all women approximately 40, concerned about their babies and possible birth defects. Their position was that if the woman could not be influenced to abort, given a negative evaluation of the condition of the fetus, then why take even a 2 percent risk of losing the baby due to amniocentesis. They all agreed that they would do nothing to harm their babies, and that no matter what shape her baby was in, she wanted it. As such, miscarriage, stillbirth, and abortion were taboo topics; they represented behaviors not indicative of a good mother, even though a miscarriage is beyond a woman's control. The tragedy of the event is not the primary reason, as much as is the guilt and implication that somehow the mother could have done something to prevent it or did something to cause the miscarriage or stillbirth. One mother who was identified as an isolate had just had her first child at age 40; the baby was only one month old at the time of this study. She commented that she did not feel that there was much that she had in common with the women, citing that issues such as high-risk pregnancies, such as her own, were "unappreciated" topics, despite evidence to the contrary.

A few women, like Deborah, seemed to walk the line between the backstage and the back-backstage very closely, often innocently crossing over into the taboo. How they knew they had crossed over is evident in the discussion of Doris and circumcision. As Betty experienced criticism from her physician for not having her son circumcised in keeping with prevailing customs and recommendations, so, too, did Doris in seeking to influence others on this issue. The debate centered on

wanting to protect the child from pain, not being in total control of the decision (as the father having been circumcised weighed heavily in the decision making), as well as the confusing medical evidence regarding the necessity of the procedure.

Doris was from Russia and was quite disappointed to find that circumcision was still being practiced in what she thought was the most advanced medical system in the world. To do her part, Doris was diligent in trying to inform the women about the dangers of circumcision. She had brochures and pamphlets, which she had left in waiting rooms and had handed out to everyone at the play-group meetings who would accept one. Initially, the women tried to listen, but Doris's passion for the issue, as well as her thick accent and foreign ways, reduced the impact of her good intentions. As she observed from her many attempts to inform women, if the woman had already had a son (and he had been circumcised), there was very little likelihood that she would even listen. In addition, even if the woman had not already had a son, very likely her husband's view on the matter would be the final word. To resolve the dilemma, the women simply did not listen to Doris. The coordinator, Sylvia, expecting her son (the aforementioned ultrasound picture), related her discomfort with Doris in our interview. Although she wished that Doris would attend the mom's night-out functions, she felt that Doris had been offended by Sylvia's disinterest in the topic.

Doris's choice, subsequently, was to not discuss the issue unless asked, for two reasons. First, she did not want her oldest son (who had been circumcised) to hear her conversations for fear that it would somehow harm him. Second, she found the rejection and isolation from other women to be too painful. When she read the early drafts of this study and this discussion, she commented that the representation of her plight was sad and that she did not want to be seen as a victim. Indeed, she made her decision consciously and powerfully. Her first choice, however, was not her own pain but the potential for her son's pain. Likewise, Betty made her decisions without seeking to influence others; what she was seeking was support for following her own values. Doris was supported for following her own values as well, but not for creating a dilemma for other women. In this case, more information, and certainly unsolicited information, was not appreciated.

Sadly, women who have to face these issues are the very ones who need support. They need to be able to discuss their feelings and to reason through the events, finding solace in at least possibly better under-

standing the reasons for the event. For example, another topic not discussed was the development of one's child, unless that child was developing normally, that is, normal according to established sources. A child who was delayed at all in development was not discussed. The mother did not share her feelings about the issue, the reasons why the child was behind, or what was being done about the problem. Instead, the women, in general, only relayed positive information. If her child was not walking or talking according to schedule, she simply did not share this information; in contrast, a mother whose child was walking very young, say at seven months, could not only express pride at her child's progress but also receive sympathy for trying to keep up with the child. The mother whose child was not walking, who had to carry her child everywhere, was not given comfort for her child's delay and the burden of carrying a heavy child (should that be the case) but was almost silenced in light of not having to chase after the child. This pattern exists beyond early childhood development, past toilet training, into the progress of a child's education. The mother of an advanced or gifted child can boast, whereas the mother of a child who is normal must console herself in realizing that there is nothing wrong with being normal. Of course, this sense of what is normal is not a scientific conclusion but a socially constructed determination.

The end result of this socialization, of seeing one's value through the actions and accomplishments of one's children, is not novel. Likewise, it is not necessarily tragic. What is important to recognize is that first, mothers who really need support are not very likely to receive it; second, the identity issues involved for women as mothers serve both to motivate them for the benefit of their children and families, and to put them in an untenable situation of which they are not in control. That is, while the women may strive to be as effective as they have been directed to be, they cannot totally prevent the onset of illness or an accident. In addition, they must enter into relationships with health care providers who may or may not reinforce their own values. The result is a sort of catch-22 for these women as they attempt to navigate the intricacies of our modern health care delivery system.

THE CATCH-22 OF MOTHERHOOD

The talk these women engaged in, from the acceptable to the taboo, reflects a number of issues relevant to developing health care plans for

women. The difficulty for the mothers, evident from this study, is that taking good care of their children and family is inexplicably tied to their sense of self-worth. However, they had little control over the quality of health services provided. Essentially, the women had very few options that did not somehow result in some infringement of societal expectations. Nevertheless, it is important to understand how the institutionalized order, particularly in the location of this study, presents a contradiction in choice. The location, as previously explained, was rather unique in the juxtaposition of urban values and rather rural health service facilities. Even though there was a college of medicine located at the site, the health facilities were generally considered to be abysmal.

Evidence for this assessment is largely anecdotal but consistent. Only two women in this study (out of the twenty-four involved) delivered a child in the local hospital. One of the major subjects for conversation was what other options were available for hospital care (especially delivery and obstetrical care). Two of the women delivered in town because of very pressing, practical situations. One woman's husband was a diabetic and, while he assisted her in the delivery of their child, the thought of traveling one to two hours for delivery was precluded by concern for convenience. The woman tended to deliver very quickly and did not want the added strain of traveling while in labor. The second woman had previously delivered her children in a local hospital, was new to the town, also delivered quickly, and was not in contact with a network in the new town. However, while the first woman was fairly satisfied with the services, her expectations were low. The second woman was appalled by the service and would not recommend anyone to deliver her baby there.

In addition to the poor reputation of the local hospital, there was a lack of available physicians, and many were not taking new patients. Due to perceived need, the local physicians had little motivation to provide better services because of a lack of competition. Given these circumstances, when a woman sought health services either in the community or in nearby cities, she was faced with an uncomfortable position. Since her choice affected expectations that she be a good mother in meeting her family's health care needs expediently and effectively, the greater the delays in attaining diagnosis, treatment, and a cure, the more her identity was threatened. In addition, to attain treatment, she might have to violate her own personal philosophy of child rearing. As such, if the health care provider did not consider the mother's voice to be a

crucial matter in the adoption of any particular health practice, then the likelihood of designing a successful health care plan was severely limited, threatening the mother's identity needs.

Regarding this study, what was even more disconcerting than the lack of physicians' concerns for the women's views was the women's own lack of awareness regarding their individual and collective power. If they chose to form a coalition, the women in this play-group network could have demanded changes in the community's provision of health services. Unfortunately, because the acquisition of health services was so intertwined with their identities, if they chose to wield their power, they would risk considerable threat to their roles as good mothers. If they were to make, for example, demands on the local hospital to improve their obstetrics care by more publicly and politically seeking treatment elsewhere, what would they do if there was an extreme emergency and they needed to go to the hospital? Their families' needs would ultimately have to be met, regardless of their political pursuits. Since the women could not risk having their families' health needs not be fulfilled, their power was limited. The women's sense of self as good mothers was so deeply dependent on the needs and provisions of others that their options were severely constrained. The identities prescribed to them by their culture and each other precluded them from exercising their power and fully meeting their identity needs.

The dominant voice of institutionalized medicine has silenced women to the point where they are trapped in their dedication to being a good mother. Hegemony works best when the oppressed enforce the very rules that serve to keep them in their place. As Lorde (1984) once asserted,

> For we have, built into all of us, old blueprints of expectation and response, old structures of oppression, and these must be altered at the same time as we alter the living conditions which are a result of those structures. *For the master's tools will never dismantle the master's house.* (p. 28, italics added)

CONCLUSION

"They are in league to create a kind of counter-universe, the values of which will outweigh masculine values. Collectively they find strength to shake off their chains" (De Beauvoir 1953, 542). The focus

of this study was to discover how mundane conversations facilitated or affected making health care decisions. Through an exploration of socially inappropriate or taboo topics, it was discovered that these conversations could not be understood merely in light of their function and outcomes regarding access to health care. Instead, it was essential to understand that talk about health care, first, was essential to women's roles as stay-at-home moms because the talk serves to assist them in breaking through the literal and figurative maze of health service organizations (Tardy and Hale 1998b); second, the talk is also a topic that "bonds" women together (Tardy and Hale 1998a). Last, the talk creates and reinforces requirements for the role of the good mother.

Wherever women gather and one or more is pregnant, they are very likely to create a counter-universe. Even to themselves, the reasons they do so is likely to be a mystery. They readily understand that they do it, but the multiple roles it serves is unlikely to be analyzed beyond the obvious—it bonds them and they get information that they need, sometimes. Unfortunately, not all women gain access to such supportive conversations. The examination of socially inappropriate topics reveals a sad situation for many women. In their isolation, they suffer from loneliness and ignorance, the physical (medical) consequences of which are not necessarily more important than the social and emotional consequences.

Even on gaining admission into a counter-universe there are restrictions. This exploration reveals the limitations of even the most seemingly unhampered discussions, the complications of being an effective mother, the maintenance of her own beliefs and values, while facing the contradictions of an archetypal paradox—the good mother. Our adoption of societal beliefs about mothering inhibit us from truly creating a counter-universe, where our "work is not a technique" but is endowed "with the dignity of a secret science founded on oral tradition" (De Beauvoir 1953, 542). In our health-oriented conversations, in what we say as well as what we refrain from saying, we are likely to reveal idealizations of ourselves and others. In sum, then, we are not operating as our true selves, as women, but as socially constructed selves, as mothers. Of course, one might ask, can a woman be authentically herself as a mother, or is she forever bound to social conventions?

Subsequently, when we discuss women's health solely in light of the physical experience, whether it is pregnancy, childbirth, or even breast cancer or heart disease, we reduce ourselves to mere physiological

beings, devoid of mystery and candor, fear and bravery, dedication and self-absorption. That we are in need of, that we crave, the company of other women precludes our physical condition. While it is in the company of women that we construct and play out our roles, it is also possible that it is in the company of women that we can deconstruct the barriers between the front stage, backstage, and even the back-backstage of motherhood and perhaps other idealized roles.

APPENDIX A
Interview Protocol

Health issues have become extremely popular, especially in light of the current political health reform movement. Given the proposed changes, people are thought to need to become better consumers of health services. One way of looking at consumerism in health services is to find out more about the advice and referrals that friends, family members, and coworkers give on a daily basis.

1. Can you tell me about a recent experience when you wanted health care information?
2. Tell me about conversations you have had regarding exercising, dieting, taking vitamins, or over-the-counter medications.
3. What other types of health issues do you talk about?
4. What health-related issues do you talk about to only a few people? What health-related issues do you talk about freely?
5. Where do these conversations take place? How often do you think they happen—is this a daily, weekly, monthly activity?
6. What do you want to hear from people about health issues?
7. What do you feel/think about these conversations? What purpose do they serve for you? Do they help you?
8. What have you done with the information they have given you?
9. Can you tell me about a time when what someone said made you seek medical care?
10. Tell me about any myths or old wives' tales that you have heard and that you follow.
11. Who are you most likely to talk to when you feel sick? What are they like (characteristics)—why do you talk to them?
12. Do people ever ask you questions about their health care concerns or tell you stories? Why do you suppose people talk to you?

APPENDIX B
Survey Questions

1. Please think about people with whom you frequently discuss health issues and explain why you talk with this person or these people (they do not have to be members of this network). Are they more informed? How? Are they more approachable? How so? What are the characteristics of this person or these people?
2. In light of your health-oriented discussions, what is it that you want most? Information? Emotional support? Real assistance or help? Connections to other people? Assurances? Please explain.
3. What are "taboo," inappropriate, or difficult health topics to discuss—even among close friends and family members?

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