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## **Cooling the Mother Out: Revisiting and Revising Goffman's Account**

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*This article revisits Erving Goffman's important yet neglected metaphor of "cooling the mark out." Drawing on a study of mothers whose child has Down's syndrome, I explore the value of Goffman's work for capturing how mothers interpret their child's diagnosis as a loss and rectify this breach by constructing an acceptance of their new situation. The mothers' accounts highlight how Goffman's contentions can be enriched by acknowledging the gendered, temporal, and public character of a loss. This article, thus, can be read both as a celebration and critical revision of his theoretical contribution.*

Keywords: cooling the mark out, disability, Goffman, mothers, stigma

“In cases of criminal-fraud, victims find they must suddenly adapt themselves to the loss of sources of security and status which they had taken for granted. A consideration of this adaptation to loss can lead us to an understanding of some relations in our society between involvements and the selves that are involved.”  
(Goffman 1952:451)

Much ink has been spilled over Goffman’s hold on the sociological imagination yet little attention has been afforded to his metaphor of “cooling the mark out” (Goffman 1952). In his seminal paper of the same name, Goffman unpacks the nuances of a confidence operation, a way of obtaining money under false pretenses by exercising deceit and fraud. The analogy becomes a framework to explore how a “mark,” the victim or potential victim of planned exploitation, comes to accept their loss and resolve taken-for-granted expectations (how they are “cooled out”). He acknowledges whilst those participating in a confidence game are found in only a few social settings, the concept of cooling the mark out becomes an analogy for how individuals contend with “adaptations to loss; with defenses, strategies, consolations, mitigations, compensations, and the like” (1952:462).

A small number of studies have explored Goffman’s concept in singular areas of inquiry. Whilst some offer passing references (Mäkitalo 2006; Paolucci and Richardson 2006; Smith 2011), others have tendered – much of it dated – a more sustained engagement with Goffman’s analysis of loss and consolation including in the field of sport (Ball 1976), alcoholism (Petrunik 1972), employment (Becker and Strauss 1956), education (Clark 1960), medicine (Akerstrom 1997), and the night-time economy (Snow, Robinson and McCall 1999). Outside of this, however, no sufficient attention has been devoted to the problem of cooling the mark out, perhaps reflecting sociology’s “collective amnesia” whereby the

founding principles of Goffmanian sociology and interactionism are often seldom recognized or celebrated (Atkinson and Housley 2003).

In conjunction with his other writings (Goffman 1959; 1961; 1963; 1974), Goffman's account provides an appropriate apparatus for exploring the experiences of mothers who have a child with Down's syndrome, an incurable chromosomal condition affecting approximately 2 of every 1000 live births in the UK (Morris 2013). Symptoms of the condition include learning difficulties and health complications together with distinctive physical markers such as restricted physical growth, reduced muscle tone, an upward eye slant, a large tongue, and a flat profile of the face. The negative reactions of mothers following a diagnosis of Down's syndrome have been well-rehearsed, occasionally in studies (Hoddapp 2007; Skotko 2005) and overwhelmingly in autobiographical accounts (Clark 2008; Lewis 2008). Concurrently, studies (and the same autobiographies) suggest rather than promising an injurious and stigmatized existence, the presence of child disability – not limited Down's syndrome – within families can be a great source of happiness, strength, and personal growth (Rocque 2010; Sousa 2011; Voysey 1975). Whilst mothers in my study recounted rueful reactions following their child's diagnosis, interpreting Down's syndrome as a loss of maternal expectations and a death of the imagined child, they universally articulated how more positive emotions were experienced later in their child's life. The study focused on *how* mothers rectified their situation (or cooled out) by transforming feelings pertaining to a disruption of self – and of maternal expectations – into a position of acceptance. The child's diagnosis provokes a “transcendence of self”, a constructed self-acceptance rather than any acceptance “cloaked in stigmatized images and expectations of resignation” (Charmaz 1991:258).

In what follows, I initially sketch out Goffman's cooling the mark out metaphor. I subsequently offer an outline of the study to establish its suitability for fleshing out

Goffman's theoretical propositions. After providing this description, I capture how a diagnosis of Down's syndrome can be interpreted by mothers as a loss and how they cool out in three ways: 1) blowing her top; 2) accessing "coolers," and; 3) constructing a "courtesy identity." Finally, I reflect on how these findings enrich Goffman's theory by highlighting the gendered, temporal, and public dimensions of a loss.

## COOLING THE MARK OUT

In his paper *On Cooling the Mark Out* (1952), Goffman describes how practitioners of a confidence game (a con) operate their racket. The mark is identified by one member of the con team and after the confidence of the mark is won over, they are given the opportunity to invest their money in a gambling venture believed to be fixed in his/her favor. The venture is fixed but not in the mark's favor; the mark is allowed to win some money, essentially encouraging them to invest a larger sum of money into the game, and the confidence men claim an accident or mistake has occurred, meaning the mark has lost his/her total investment. The operators depart in a ceremony known as the "blow-off"; they leave the mark without his/her money and he/she "is expected to go on [his/her] way, a little wiser and a lot poorer" (1952:451).

Goffman's metaphor serves as a device to describe a person's adaptation to loss/failure. In this status story, Goffman (1952:454) suggests a person's experience of loss, of being "involuntarily deprived of [his/her] position or involvement and made in return something that is considered a lesser thing to be," prompts an occasion for cooling the mark out. He identifies two kinds of involuntary loss: 1) a person loses a status which, whilst altering self-conceptions as well as the conceptions of others, is not "treated as a symbol of the fate [he/she] deserves to receive" (e.g. a bereavement in the family); 2) a person may be

deprived of a role under circumstances reflecting unfavorably on their capacity for it, in which the “loss of substance” is supplemented with a “loss of face” (1952:454). Goffman concerns himself with the second kind of loss, “the kind that involves humiliation,” which calls for the need to cool the mark out and ensure a mark accepts their loss (1952:454). In such situations, their self is shifted to something other than being a victim.

The art of consolation, for Goffman, is executed by a “cooler,” he or she who instructs them in “the philosophy of taking a loss” (1952:452). The cooler can cool the mark out in various ways, one being the designation of the task “to someone whose status relative to the mark will serve to ease the situation” based on the assumption that they know how to rationalize and control the mark (1952:456). The second solution is to offer the mark a status which differs from the one lost but provides trappings of the lost status (e.g. a lover becomes a friend). A third way of handling the mark is to “offer [him/her] another chance to qualify for the role at which he has failed”, meaning the mark’s fall from grace is restored by allowing him/her to retrace his/her steps and try again (1952:457).

In sum, Goffman’s (1952:462) paper reveals how a mark who requires cooling out is a “person who can no longer sustain one of [his/her] social roles and is about to be removed from it.” He ultimately considers how loss, as socially situated, is resolved by persons and how they come to accept the great injury done to their sense of self. A self is defined here as “an individual who becomes involved in a value of some kind – a role, a status, a relationship, an ideology – and then makes a public claim that [he/she] is to be defined and treated as someone who possesses the value or property in question” (1952:461). When this is disturbed, the individual must accept that the set of discourses previously used to organize the self may vanish.

After introducing Goffman’s (1952) main contentions, attention can be directed toward my study to demonstrate how mothers cool out after perceiving their child’s disability

as a loss of self, together with a loss of maternal expectations pertaining to the idealized child.

## THE STUDY: NOTES ON METHOD

Data are drawn from semi-structured interviews with 14 mothers who have a child with Down's syndrome. As with most qualitative endeavors, I was guided by an interest in producing an in-depth evaluation of individual lives whereby participants could convey events, experiences, and feelings they lived. Guided by the interpretative repertoires functioning in their social world, mothers were afforded with a space to provide valuable insights into life as experienced and to explore the meanings of their child's condition. I secured access to mothers through Wendy<sup>1</sup>, a close family-friend and mother of a daughter with Down's syndrome, who acted as gatekeeper by enabling recruitment via social-networking website Facebook. Participants, as such, were part of a snowball sample whereby Wendy would approach mothers, who would approach other mothers, potentially interested in taking part in interviews. It is through my interactions with both Wendy and her daughter that my initial interest in this topic was ignited<sup>2</sup>.

I conducted eight interviews with mothers by telephone, five using online instant-messaging services, and one face-to-face<sup>3</sup>. Whilst I selected telephone and online interviews were largely for concerns over geographical distance, they also served methodological benefits in that the hidden nature of such interviews arguably eliminated any discomfort felt when disclosing sensitive information (Author 2012). I expected the sensitivity of the topic to prevent some mothers from revealing the delicate details of their personal worlds. However, this worry appeared to be precluded once the mother was concealed from my view; the stranger "often receives the most surprising openness – confidences which sometimes have

the character of a confessional and which would be carefully withheld from a more closely related person” (Simmel 1950:404). The mothers and I, as the stranger, entered into a situation in which they felt comfortable discussing topics which may become distressing, even taboo, in conversation with intimate others. I asked broad questions such as “when did you receive your child’s diagnosis?” and “can you describe how you and your partner reacted to this news?” to direct conversation without coercing interviewees into providing pre-determined answers. Interviews ranged from 30 minutes to over 2 hours in length and I focused mainly on mothers’ adjustment to a child’s diagnosis, particularly in terms of identity-work, discourse, and constructions of the self and others as of particular types.

Transcripts were analyzed using “situational analysis” (Clarke 2003:571), a renovation of grounded theory in which the researcher “becomes not only analyst and bricoleur but also a cartographer of sorts.” Here, all the key elements of the situation, the interrelations, the social worlds in which these are embedded, and the discursive positions taken by mothers became the focus of my analysis. I explored the meanings that the child’s disability had for mothers, the processes by which they negotiated and upheld these meanings, and how they constructed and managed their conception of self. My analysis was read alongside existing literature, allowing for an inductive and processual approach, until intricacies and relationships were identified. I was granted ethical approval for the study by the University research ethics committee.

## LOSS, EXPECTATIONS, AND THE (IM)PERFECT CHILD

During interviews, mothers detailed the blow and disappointment felt on hearing their child’s diagnosis regardless of whether it was received prenatally or postnatally. Mothers framed this



news as a loss, the child having disrupted the pre-constructed expectations of their child and the mother role. Chloe describes her desolation when confronted with her child's diagnosis:

My initial emotion was absolute devastation. I held it together when on the phone with the midwife and as soon as I hung up I just broke down crying.

Lindsay describes her feelings of "rejection":

When I actually gave birth, I looked at her and I felt a little bit of rejection toward her where I felt like I really don't want to pick her up. And I think that's when reality hit that we were going to take this baby home.

Mothers regularly detailed their initial reluctance to parent a child who has Down's syndrome, reactions which constructed the baby as contaminating, unwanted, and tragic. Ann viewed her child as something other and cast the child into the realm of non-personage, illuminating how she wanted to "run away" since she felt "horrible," "dirty," and "not on this planet." Janice similarly suggests that after discovering her child's diagnosis, the shock threw her into a "fragile physical state" initially unbearable to her.

Feelings of "sadness," "grief," "sickness," "fear," "failure," "blame," "anger," and "devastation" were common discourses expressed by mothers when discussing the initial reactions to their child's diagnosis. Two mothers described their child as a "monster," an individual outside the norm; "[i]t is only because, as human beings, we are living beings, that a morphological defect is, to our living eyes, a monster" (Canguilhem 2005:187). For many mothers, it was the physical markers of Down's syndrome, a "discredited stigma" whereby the perceived stigma is visible (Goffman 1963:49), which initially contributed toward

feelings of “alien kinship” since the child disrupted normative maternal/familial expectations (Rapp 1995:81).

The emotions described emanated exclusively from mothers’ interpretations that a diagnosis of Down’s syndrome was a loss, that is, the loss of expected motherhood and of a “perfect” child. Pam explains:

The image of the perfect child, I guess it’s what you want isn’t it? It’s the dreams and happy families that get whisked away.

For Pam, a sense of loss corresponds to the “whisking away” of parental dreams of an imagined “happy family” perturbed by the intrusion of a child with Down’s syndrome. Angela describes her child as a “stranger,” interpreting the situation as her imagined child “having died” and as having “lost our little girl.” This sense of loss was similarly encountered by Lindsay:

It was like someone had just told me my child had died. It was like a real raw, gut-wrenching grief I felt and I just couldn’t stop crying. [. . .] This child that I was carrying was not my child. The one I was carrying had gone somewhere [. . .] I felt I’d been cheated of a baby and I was going to be given this stupid, not even a child. I didn’t even think of her as a child at that time. [. . .] I thought I don’t want this baby, this isn’t my baby, how am I going to walk the streets with this child? How embarrassing. I felt awful but I think that’s the initial shock for any mother or father: it’s not going to be the child you expected.

Lindsay feels that she was “cheated of a baby,” identifying her baby as “not my child” and as non-child. After highlighting the “embarrassment” she associates with the public character of the condition, she recognizes how her child will not be the one she “expected.” Since mothers formulate aspirations for their child before birth, a diagnosis of Down’s syndrome disrupts normative expectations; the idealized child nurtured in their imagination fails to arrive, a feat encapsulated by Elaine who described her baby as “different” from what she “ordered from the catalogue.”

Children with a disability are here viewed as “impaired, imperfect, damaged goods, unsatisfactory merchandise on the commodity exchange of conventional kid culture” (Rapp 1999:xiii). Mothers expected to receive the perfect child; in Goffman’s (1952:454) words, “assumption becomes presumption.” Since a child becomes a key site for constructing the maternal self, a diagnosis becomes framed by mothers as a loss; “parents struggled to recover from the loss not only of their-children-as-normal but also of themselves-as-normal” (Fields 2001:171). As such, mothers engage in activities intent on repairing their sense of self and establishing a positive relationship with their child, a relationship expected by the wider social audience. As articulated below, Goffman’s (1952:456) understanding of loss provides an apt framework for capturing how mothers contend with their new situation arising from the individual “having defined [him/her]self in a way which the social facts come to contradict.”

## COOLING THE MOTHER OUT

In *Asylums* (1961:453), Goffman remarks a person’s sense of self brings him/her into appropriate alignment with the basic values of society, yet a person cannot sustain a “conception of self” once the stable arrangements for this are abruptly removed. Similarly,

mothers of children with Down's syndrome suffer a "personal defacement" and infringement against norms of identity on receiving their child's diagnosis, a situation not so readily integrated into the expected mothering scripts (1961:130). A consideration of cooling, therefore, is important in the knowledge that mothers described their loss as initially prompting feelings of rejection, fear, devastation, and sadness. The value of the cooling out metaphor in this context, by drawing a parallel between mothers and con victims, is given extra credence when considering some mothers described their situation as being cheated of an expected outcome.

So how do mothers of children with Down's syndrome cool out in the face of a loss and accept their fate<sup>4</sup>? Three cooling techniques are outlined here: 1) blowing her top; 2) accessing "coolers," and; 3) constructing a "courtesy identity."

#### 1) BLOWING HER TOP

One means of cooling out established by Goffman (1952:457), which he suggests is often employed in conjunction with other methods, involves allowing the mark "to explode, to break down, to cause a scene, to give full vent to [his/her] reactions and feelings, to blow [his/her] top". In this study, many mothers reported how they grieved for their loss – the loss of the imagined child and expected maternal role – after receiving their child's diagnosis. This became a means of cooling out, of confronting the situation and giving full vent to the shock in the hope of resurrecting some form of acceptance. Elaine makes this point clear:

I told [my husband] what had happened. Obviously he broke down and I broke down [crying]. I'm saying sorry I didn't give him the perfect daughter and he's saying don't be stupid, the usual things people do. And when the reality sort of hits, there are those

moments of grief and mourning because the child you were expecting to have isn't there anymore. [. . .] And I think that's as far as we went with it really. That was all the grieving we did.

Elaine describes her “moments of grief and mourning” owing to her loss, together with how her child's diagnosis upset her to the point of apologizing to her partner for not bearing the “perfect daughter.” The idea of not producing the “perfect daughter” denotes how mothers, often more than men, claim responsibility – and internalize blame – for a child's problems (Landsman 1999; Landsman 2009; Sousa 2011). The notion of grief is explained further by Chloe:

After about a week of feeling like I was in a pit, I just had to dust myself down and prepare to meet this little baby who would need me so much. I allowed myself to grieve and talked [to my partner and my family] when I needed to which really helped.

Chloe explains how she allowed time to “grieve” for the (un)expected child so she felt comfortable in “meet[ing] this little baby.” She later added that her physical grief meant she “let it all out” in light of her “ideal picture of [her] family” not being realized, meaning she was now ready to share this news with intimate others. Some mothers who received a prenatal diagnosis of Down's syndrome (via amniocentesis or chorionic villus sampling) established the test as a device affording mothers with an appropriate period for blowing their top and subsequently cooling out. Holly claims:

[The amniocentesis] was really what me and my partner needed because by that stage, we had both come to a decision that we'd like to be prepared for what lay ahead but did not really have the courage to say it aloud. My own thinking was I knew I would be devastated with a diagnosis of Down's syndrome but in years to come, I would hate to think my first emotion on meeting my child had been one of disappointment. So I would rather know and get back to the normal birth emotions, like was my child a boy or a girl.

Together with implying that the prospect of parenting a child with Down's syndrome requires "courage," Holly welcomed amniocentesis as a cooling technique which prompts grief and subsequently provides a route back to "normal birth emotions." Kelly similarly describes how amniocentesis prevents "the shock of not knowing" which would have provoked "crying and grieving and all that"; the diagnostic test, hence, offered an appropriate timeframe in which Kelly could cool out, to "do all of my crying" so she was "ready to get on with it."

At the very least, allowing their woe to reveal itself in a physical display of frustration and despair "serves a cathartic function" for mothers (Goffman 1952:457). More commonly, it allows them to cool out and accept their personal loss. Interestingly, mothers often suggest they blew their top in the presence of an intimate other, supporting Goffman's (1952:458) claim that the mark blows their top "under suitable guidance." The case of Kelly, however, shows how giving full vent to her initial shock was accomplished in the absence of a cooler. This is what I call the "cooler-less cool," whereby a loss is reconciled by the lone-acting mark who instigates and redefines the self along defensible lines. This highlights how a loss does not always have to be inflicted by another person nor must it be a product of ill will. I speculate Goffman did not specifically address the "cooler-less cool" since it points toward a more psychological rather than social reconciliation of loss. The social audience is important

for Goffman since the self (and any adjustments thereof) is not a property of the individual but arises in and through interactions with others. However, his contentions in *Frame Analysis* (1974) suggest persons can re-frame and “key” events and experiences individually or collectively<sup>5</sup>. Nonetheless, in this study, I acknowledge the cooler-less cool is a much rarer occurrence than a mother blowing their top in front of another person who authorizes this performance. This reliance on others is outlined in more detail below.

## 2) ACCESSING COOLERS

After their loss, mothers commonly turned to family members, partners, and parents of children with Down’s syndrome for support and encouragement that the child’s diagnosis was not the tragedy they initially imagined it to be. Karen explains:

[My partner] was there to keep me grounded and to talk to. [. . .] He would work all evening, then drive to the hospital and spend the night and day with us until it was time for him to go back to work. My mother [helped me] too. She was there for me to lean on when I needed it. Or for me to cry on, just like [my partner] was.

Karen acknowledges that her partner and mother provided support which helped her to accept her child’s diagnosis. Janice similarly identifies her partner, “after his own grieving process,” as “playing an important role in keeping me from emotionally unraveling when we received the diagnosis,” allowing her to “love my son for what he is and stop grieving about what he isn’t.” Holly suggests whilst she was worried about the potentially stigmatizing public reactions toward her child, the family network “were all fantastic” and readily embraced the new family addition.

In this way, partners and family members took on the role of a “cooler” who exercises upon a mark the art of consolation (Goffman 1952:455). The “necessity of disappointing the expectations that a person has taken for granted” is a difficult exercise, meaning the cooler must pacify and reorient the disorganized person (1952:456). For mothers, this initially became the task of partners and family members.

Mothers also came to accept their loss through establishing contact with other parents who have children with Down’s syndrome. With their expectations fractured, mothers chronically relied upon these “sympathetic others” who share or are privy to their situation (Goffman 1963:20). Rachel explains how sympathetic (m)others provided inside knowledge and emotional support during organized support group sessions:

When you receive that diagnosis, whatever the timing, you feel very isolated and alone. Contact with other parents helps overcome that. Parents can find others who are facing or have faced the same issues be they medical, developmental, educational, and this is really beneficial to both [mothers and fathers].

Similarly, whilst Karen highlights the benefits of befriending others who experience “the same things as you” and can provide training in tricks in the trade when confronted with a diagnosis, Angela identifies how formulating affiliations with (m)others helped her to “fit in” and “feel more comfortable” in everyday interactions. This behavior within support groups (as a cooling institution) is replicated on Facebook. Rita draws attention to its value:

I have formed some good friendships with some of the mothers on Facebook. We talk about things way beyond Down’s syndrome and I wish they lived closer. Others are more like a support system, sharing information and that.



Whilst Rita shows how this support is additionally accessed later in a child's life, it becomes a primary means by which mothers seek (m)others/information and subsequently cool out after initially receiving their child's diagnosis. Interactions and connections with privy others normalize mothers' position and help them to recover from their loss by constructing a positive acceptance of their new situation (Thompson 2013). Indeed, Rita describes how despite her initial disappointment that she would not have a "perfect child," contact with others allowed her to reconstruct her child as "a gift." Whilst not all mothers explicitly ascribe to the "gift" discourse (Landsman 1999), they suggest that meeting others could help them to reframe their loss. Angela explains:

I was very fortunate in that a neighbor had a teenager with Down's syndrome and she was very helpful. [ . . . ] She came around my house [after the diagnosis] and said 'oh she's lovely.' There was nothing negative said. And she said every time she walked into her [child's] bedroom in the morning, it was like opening a present on Christmas morning. Every day was a surprise. And every day you do notice something. They do something different every day and I thought that was a lovely way of looking at it and I remembered it with [my child].

Similar to Angela reconstructing her child as a "surprise," Nicola describes how attending her first support group meeting was "just lovely" since "everyone was just cooing over photographs of [my daughter]." Nicola identifies how after the meeting, she was subsequently able to view her child as "lovely" and herself as "lucky" and "proud." These feelings are attended to further in the next chapter.

Interestingly, healthcare professionals were seldom recognized as coolers, with mothers often complaining they reacted negatively to their child's diagnosis by not providing consolation or redirection. During his study of consultations within pediatric clinics, Strong (1979:225) describes how doctors "did very little to help" parents of children with disabilities, perhaps indicative of their preference for performing acute medicine which offers "the speedy resolution of organic problems." Strong urges doctors to tender comfort if cures are impossible; for mothers of children with Down's syndrome, an incurable condition, doctors and other healthcare professionals similarly did not offer reassurance or practical help following a diagnosis. Mothers associated this "failed cool," as I call it, with an alleged poor knowledge of – and stigmatizing attitudes toward – Down's syndrome within medicine<sup>6</sup>.

No mothers suggested they failed to be cooled out or experienced a "sustained personal disorganization" (Goffman 1952:459)<sup>7</sup>. Nonetheless, the failed cool in the context of healthcare seemingly contradicts Goffman's (1952:457) suggestion that the cooler will usually be of higher status "on the assumption that words of consolation and redirection will have a greater power to convince if they come from high places." Incidentally, mothers often sought out geneticists following a diagnosis to determine the cause of the condition, an attempt to cool out by absolving themselves of responsibility for the child's condition; "persons protect themselves with all kinds of rationalizations when they have a buried image of themselves which the facts of their status do not support" (1952:452). However, since Down's syndrome is often not hereditary<sup>8</sup> and so not attributable to genetic legacies, mothers often resorted to looking inwards and blaming themselves for their child's condition (Landsman 2009; Strong 1979)<sup>9</sup>. This failed cool, in turn, meant mothers pursued other means of cooling out including accessing different coolers.

### 3) CONSTRUCTING A "COURTESY IDENTITY"

Once confronted with a loss, Goffman suggests a mark must be provided with “a new framework in which to see [him/her]self and judge [him/her]self” (1952:456). Faced with their child’s diagnosis of Down’s syndrome, many mothers suggest they experience role dispossession, a “curtailment of self” in which they feel dejected and stripped of the supports usually relied upon for organizing the self (Goffman 1961:25). In response, they construct what I call a “courtesy identity.” This identity-work is similar to, yet at variance with, Goffman’s (1963:30) concept of “courtesy stigma”; rather than feeling “obliged to share some of the discredit of the stigmatized person to whom they are related,” mothers can reframe their self and construct a new identity focused largely around their child. This contradicts other commonplace arguments on how mothers encounter stigmatizing reactions from the wider public, and can subsequently assume a stigmatized identity, based on their child’s condition (Gray 2002; Green 2003). Ann describes her relationship with her son:

[My son] gave me a purpose in life. He brought a different perspective to how life can be and brought out qualities in me that I didn’t know I had. [. . .] I’m a mother, teacher, cook, cleaner, therapist, psychologist. I’m his intuition, his middle man, his speaker. I would be lost without him, with so much time to spare and no purpose in life.

Ann identifies several roles here, identity markers which would promise “no purpose in life” should they be removed. Other mothers like Charlotte and Chloe have described such identities in relation to their advocacy commitments; Charlotte describes how her “special needs parenting has become part of my identity,” whilst Janice articulates the “positive ways” in which her son has “affected my own identity.” This “ennoblement” frames the child in a

positive manner, sustaining the idea that the mother's child should be embraced primarily *because* of their attributes (Fields 2001:166).

A courtesy identity often exhibits itself in how mothers construct, and are ascribed, a known-about status. Holly explains this further:

I'm [my son's] mother! That's how I'm known by quite a lot of other people as well so everything I do, I do it for him basically! I get phone-calls now from special needs [resource organizations] and they say 'hello is that [my son's] mother?' not 'hello is that Holly?' It's funny and quite nice really!

Holly playfully describes how her known-about identity as a mother who has a child with Down's syndrome, rather having a stigmatizing quality, is an integral component of her self-construction. In place of carrying the "courtesy card" (Goffman 1963:97), mothers can additionally become advocates or political activists for their children (Johnson and Best 2012; Sousa 2011); Rocque (2010) suggests how mothers of children with a disability produce proxy selves by attempting to construct and uphold positive identities for their children during everyday interactions. Fields (2001) provides a parallel contention in her work on straight parents responding to their children's gay and lesbian identities. She identifies how parents engage in "de-stigmatizing identity work" which allows them to redefine their children's deviance and restore a view of the self as a successful parent (2001:165). Similarly, mothers of children with Down's syndrome are cooled out by assuming a status which provides "a somebody for [him/her] to become" (Goffman 1952:457). They surmount the initially-professed personal defacement by reframing their identity kit, with some mothers embracing their status of being, as Linda claims, a "Down's syndrome mother." The discourse of the "Down's syndrome mother" is often supplemented with mothers *becoming*

*mother* to other children with the condition whereby they articulate an inclusive and collective sense of parental responsibility, the restitution of kinship here serving to enlarge what Holly calls the “Down’s syndrome family.” This construction of a courtesy identity is sustained through discourse (“us,” “we,” “Down’s syndrome Mums”), spaces (Facebook, support groups), and practices (maintaining contact, organizing events), highlighting how the self is created and upheld through cultural scripts, language, sites, symbols, and other persons. Whilst not all mothers explicitly identified themselves along these lines, they certainly acknowledged their advocacy role, how their child has changed how they see the world, and how they have become “better parents” *because* of their child (Fields 2001:173). Indeed, mothers reiterate child disability, as Voysey (1975) contends, does not promise a “constant burden,” the courtesy identity here representing one means of doing, representing, and reconstituting the family in everyday life.

The maternal self is understood in processual terms emerging out of the *things we do*; identity is situated and routinely created in everyday activities of persons, an “ongoing work-in-progress found within the scenes in which we act” (Thompson 2013:32). Mothers require a sense of biographical continuity and, in light of the diagnostic disruption which threatens the self, cool out by (re)producing a fulfilling sense of self focused largely around the child. This self-renovation, endowing the self with meaning, contests Gray’s (2002) contention that social stigma sustains a situationally sensitive biography of an individual in which their known-about identity, as a mother of a child with a disability, produces courtesy stigma. Instead of assuming a deviant status, mothers transform discrediting identities into crediting ones by seeing the child as offering them “the gift of their own self-knowledge” (Rapp 1999:xiii).

## DISCUSSION

To conclude, I initially turn to the two of the four general problems related to the self in society established by Goffman<sup>10</sup>:

“First, where in modern life does one find persons conducting themselves as though they were entitled to the rights of a particular status and then having to face up to the fact that they do not possess the qualification for the status? [. . .] Secondly, what are the typical ways in which persons who find themselves in this difficult position can be cooled out; how can they be made to accept the great injury that has been done to their image of themselves, regroup their defenses, and carry on without raising a squawk?” (1952:455)

First, I suggest the empirical case described above, revealing how mothers reorganize themselves once disengaged from one of their involvements, has served as an ideal microcosm for exploring Goffman’s metaphor of cooling the mark out and how persons contend with a loss/failure. Second, I capture how mothers can cool out in a number of ways including blowing her top, accessing “coolers,” and constructing a “courtesy identity.” The loss described here is a curious combination of the two types of involuntary loss described by Goffman. He suggests the mark experiences a loss either as undeserved (e.g. a bereavement) or as reflecting unfavorably on them, claiming only the latter calls for occasions in which the mark must be cooled out. In the case of mothers of children with Down’s syndrome, they often interpreted this fate, despite the nonexistence of hereditariness and thus undeservingness, as a personal failure. As such, they were in need of being pacified and resigned to their loss, that is, of being cooled out.

The pertinence of Goffman’s paper, together with his wider corpus, for capturing the consistent and socially situated experiences of taking a loss is clear. However, this study

highlights areas which can enrich Goffman's account including a more clearly refined gendered analysis. Throughout his paper, Goffman's (1952:452) only sustained engagement with gender concerns how a mark's readiness to participate in the play "comes near to being a sign of masculinity and a test of fulfilling the male role" since they demonstrate a capacity for high finance. He suggests the mark has no defense "for not being a shrewd man," leading to a "self-destruction of the self" (1952:451-2). However, the case of mothers reveals how loss can be experienced as a disruption of one of the central tenets of Western motherhood: to meet the expectation of "attaining perfection in fetal outcome" (Landsman 1999:135). Since their fate could not be attributable to genetic inheritance, mothers often sought another rationalization for their child's condition and reached the conclusion that they were personally responsible for it, thereby prompting the pursuit of other means for cooling out. In sum, whilst Goffman recognizes how a loss can threaten a performance of masculinity, I reveal how a loss can threaten a performance of (normative) motherhood. Importantly, whilst mothers commented on their male partner's reaction to the diagnosis, I cannot claim a *fully-formed* gender refinement of Goffman's metaphor since I did not attend directly to fathers. Whether such a loss intersects with notions of masculinity, as Goffman predicts, would be a fascinating area of future enquiry.

Together with revealing how cooling a mark out can be achieved *by association* (i.e. by a person holding a relationship with another person) and how a loss can be reconciled by an individual (in what might be termed a "cooler-less cool"), I also acknowledge a temporal quality of cooling the mark out. Whilst I cannot lay claim to a concrete chronological order in which parents rectified their loss, mothers blowing their top often occurred days after their child's diagnosis, whereas accessing coolers and constructing courtesy identities tended to occur later in the mother's life. However, I resist describing experiences in rigid "stages" (Johnson and Best 2012) since such neat categorizations are unlikely to fully account for the

messiness of personal worlds. Rather, the analysis highlights how cooling out, rather than becoming a particular ceremony or ritual as Goffman envisions, reflects an extended process with interchangeable phases and fluctuating success rates at different periods of time.

Finally, I contend the accounts of mothers expose the public character of a loss. When initially encountering their loss, mothers commonly described feelings, among others, of rejection and dirtiness together with a fear about potentially negative reactions from family members and the wider public. The discourse of dirt, in particular, points toward the besmearing nature of a loss and the prominence of the social audience<sup>11</sup>. Whereas the loss that Goffman describes is often invisible (very few individuals witness or know of a con, although he does give examples of other loss scenarios) and the product of individual experience, I highlight how a loss is drawn into the public realm, with mothers encountering “felt stigma” in their initial perception that others will stigmatize their child (Scambler and Hopkins 1986:26). As such, mothers reframed their loss and, in so doing, performed the (public) role of the *good mother* by constructing a courtesy identity and accessing (m)others who have children with Down’s syndrome, the latter becoming a space in which the necessary discourses for the appropriate mother narrative can be learnt and taught (e.g. the child being embraced as a “gift”).

By using a study as the focal point for revisiting and revising the theoretical apparatus provided by Goffman, the article acknowledges the contribution his work has for understanding how individuals resolve a loss and accept perceived failure in everyday practices. Few studies have engaged with Goffman’s early analysis yet the social scenes which could make use of this analysis – involving denial, consolation, disengagement, and substitution – are endless. Goffman has even generously offered some suggestions: service industry professionals appeasing customers, demoting/firing an employee, pacifying a failing student, de-courtting lovers, offering a new role to retiring athletes, amongst others. Given my



own research interests, I would urge an analysis of mothers' interactions with healthcare professionals (Strong 1979) and whether the "failed cool," as earlier described, is indeed attributable to poor knowledge of and a stigma held toward Down's syndrome. Exploring the practicalities of this failed cool and how this intersects with interpretations of disability within medical culture deserves further attention beyond the brevity it is afforded here. Future analyses may also consider how the mark may not be the only object to which cooling-out efforts need to be directed. In line with the case study outlined above, for example, attention could be directed toward how fathers and other family members are cooled out in receipt of a child's diagnosis. Whatever the chosen area of study, the continued relevance of Goffman's conceptual scaffolding deserves further critical attention.

## ENDNOTES

1. Pseudonyms are used throughout this article.
2. Whilst my positionality was likely to shape the structure and substance of my study (McCorkel and Myers 2003), a restricted word count prohibits a more extensive deliberation of the possible affects this produces.
3. The face-to-face interview was the first conducted. Thereafter, mothers were interviewed online or by telephone for different reasons (see chapter "The Study: Notes on Method").
4. Because Down's syndrome is a "discredited" condition, opportunities for "passing", meaning a person can conceal a stigma, are limited (Goffman 1963:42). As such, the visibility of Down's syndrome could arguably accelerate the process of cooling out. In addition, it is worth noting no clear differences in cooling techniques were recognized between mothers who received a prenatal or postnatal diagnosis.
5. I thank Robin James Smith (personal communication) for this insight.

6. The failed cool becomes particularly pertinent in the knowledge that around 91% of fetuses/unborn babies prenatally diagnosed with Down's syndrome in the UK are aborted (Morris 2013). However, further research is needed on why this is the case.
7. I suspect a mother who cannot cool out has two options: abort a fetus/unborn baby (if they have received a prenatal diagnosis) or put a child up for adoption/seek new guardians (if they have received a postnatal diagnosis).
8. There are three types of Down's syndrome: Trisomy 21 Down's Syndrome (94% of cases); Mosaic Down's Syndrome (2% of cases), and; Translocation Down's syndrome (4% of cases). Only Translocation Down's syndrome is hereditary. The child of each respective mother in this study had Trisomy 21 Down's Syndrome.
9. Paradoxically, some mothers did not seek a genetic/hereditary explanation as they believed this may reveal who had "passed on" the genetic disorder and could lead to feelings of culpability for either parent.
10. The third and fourth questions established by Goffman (1952:455) are: "Thirdly, what, in general, can happen when a person refuses to be cooled out [. . .]? Fourthly, what arrangements are made by operators and marks to avoid entirely the process of consolation?" Neither question can be sufficiently answered with respect to my study.
11. I thank Robin James Smith (personal communication) for this insight.

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