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I am submitting herewith a dissertation written by Carol Merritt Walton entitled "Expectant Fatherhood: An Investigation of the Couvade Syndrome and an Exploration of Anticipating Childbirth for Fathers." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Psychology.

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# EXPECTANT FATHERHOOD: AN INVESTIGATION OF THE COUVADE SYNDROME AND AN EXPLORATION OF ANTICIPATING CHILDBIRTH FOR FATHERS

A Dissertation

Presented for the

Doctor of Philosophy

Degree

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Carol Merritt Walton

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For in the baby lies the future of the world:
Mother must hold the baby close so that the baby
knows that it is his world;
Father must take him to the highest hill so that
he can see what his world is like.

Mayan Indian Proverb

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It is to Barry and Alicia that this work is dedicated.

ABSTRACT

This study explored three aspects of expectant fatherhood: (1) the couvade syndrome, or male pregnancy symptoms, (2) fathers' views on their participation in childbirth, and (3) a phenomenological analysis of "anticipating childbirth" for the father. Forty-four (44) married men whose wives were in the third trimester of pregnancy were obtained through obstetricians and LaMaze childbirth classes. They were given an MMPI, the Early Memories test, a general background questionnaire and a forty-minute interview which explored their thoughts and feelings on childbirth, their decision to participate, and their health.

Based on a couvade syndrome scale derived from MMPI items, high, medium, and low symptom groups were distinguished. Couvade syndrome incidence was 32.6% of the sample. High symptom group fathers had significantly higher scores on MMPI scales 1 (Hs), 2 (D), and 7 (Pt), and on the Ego Strength scale than other groups. Early Memory data and early father absence did not differ significantly between groups. Sibling patterns and family constellation patterns differed significantly for the three groups, especially for high and low symptom groups. High symptom fathers were usually younger brothers of

older sisters or older brothers of all brothers. Low symptom fathers usually came from families larger than two siblings and had younger sisters.

A model for the origin of the couvade syndrome was suggested, involving a somewhat infantilizing mother-boy relationship. Its early disruption leaves the boy with a sense of being the "baby" who is excluded from the mother's new focus.

Fathers' views towards their participation in childbirth were explored, yielding a description of four types of fathers, (1) eager, (2) willing, (3) reluctant, and (4) non-attending. Fathers' reasons for attending the birth (e.g., to satisfy curiosity, to help wife) and sources of their hesitations (e.g., being a hindrance, or an intruder) were listed. No relationship was found between the couvade syndrome and a father's attitudes toward his participation at birth.

The phenomenological analysis yielded six major areas of focus and five general themes. The foci were: (1) self as father; (2) physical body, (3) emotions/reactions, (4) wife/fetus, (5) baby, (6) birth event. The themes were: (1) handling/being overwhelmed, (2) reflecting/experiencing, (3) relaxing/attending, (4) waiting/anticipating, (5) missing out/being there.

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# INTRODUCTION

A human being is born into a family. He arrives already related to a host of people, especially his parents. As he becomes Baby, the man and woman who conceived him become Father and Mother. A child grows to human individuality in the psychological womb of his parents' relationships. The parents grow into fatherhood and motherhood as they love and care for their child.

Motherhood, as a special relationship to infant and child, has received considerable attention from researchers, including studies of how a woman's sense of motherhood emerges from the life experiences of the woman who becomes mother (Arbeit, 1975; Ballou, 1978). Fatherhood, however, has received far less attention from investigators. The father-child relationship is receiving more study now than in the past, but remains less known than the mother-child relationship. Other aspects of fatherhood, especially the roots of fatherhood in a man's life and background, are unknown.

Recent trends in family-centered childbirth have brought increased attention to the father and to his experience and role during pregnancy and childbirth. While the studies of the expectant father's experience are few

in number, it is possible to begin to delineate some of his experience.

An expectant father does not experience the same physical and psychological changes a pregnant woman undergoes. Research (Coleman and Coleman, 1971), however, clearly shows that he is an involved participant in his mate's pregnancy--physically, emotionally, and intellectually. His own involvement may range from minimal observed or reported changes to major physical and/or severe psychological reactions to the pregnancy (Curtis, 1955). The present study will explore both physical and psychological aspects of an expectant father's experience to clarify his involvement in and reactions to pregnancy and childbirth.

An expectant father's experience of physical symptoms related to pregnancy--the couvade syndrome--will be explored as one aspect of an expectant father's experience of pregnancy. A father's expressed ideas and feelings about the birth will be analyzed to clarify his views of childbirth. Also, fathers' descriptions of their decisions to participate in the birth will be explored. These aspects will be analyzed as clues to a father's sense of involvement in pregnancy and childbirth and to his growing and/or changing sense of himself as a father--his emerging sense of fatherhood.

The couvade syndrome and attitudes toward the birth relate specifically to the birth cycle and to the role of

the expectant father. Expectant fathers, along with other family members and friends, may share in numerous other preparation plans as well as in the anxieties, excitements, and changes their wives undergo. But the couvade syndrome and anticipation of the birth as a father are experiences of the expectant father, alone. The study will focus on fathers whose wives are in the third trimester of pregnancy because these phenomena are most clearly evident by that period.

These phenomena are also directly related to pregnancy and birth and can be expected to affect a man's focus on his emerging role of father, with some focus on his shifting relationship of husband. Themes and ideas about the birth and symptom manifestation may relate to the man's other relationships (of son, co-worker, friend, etc.) but only as such relationships form part of the background from which fatherhood emerges.

The couvade syndrome and expressed ideas about the birth also indicate a moderate to deep level of participation and involvement in the pregnancy on the part of the expectant father. His involvement in the pregnancy may be an indication of a man's move toward fatherhood. The choices a man makes about how he will be involved in the pregnancy and birth may indicate the specific patterns his emerging fatherhood will take. It is these patterns of involvement which will give us useful clues about how

fatherhood is experienced and in what direction it is developing, in an expectant father. From such clues, we can learn to spot patterns which indicate ease or difficulty for a man's emerging relationship to his child.

One of the most revealing clues to a man's sense of his experience of fatherhood may be his approach to the birth, and his decision to be present and participate in his child's birth. As a growing number of studies demonstrate, a father's presence at birth has a number of beneficial effects for him, his wife, and his child (Cronenwett and Newmark, 1974; Henneborn and Cogan, 1975). Thus, how a man approaches his child's birth may express his basic confidence (or lack of it) in his ability to "be there" as a father.

Interestingly enough, there are very few investigations of a man's choice of attending his child's birth and of his general outlook toward the approaching birth. Only general demographic data have been gathered on the differences between men who have and have not chosen to attend their wives in the labor room, (Zussman, 1969) and on men who have chosen to be present at delivery (Moore, 1975; Wapner, 1975). Zussman (1969) found that men who chose to be present during labor were older and better-educated than those who were not present and were more likely to engage in service occupations.

The second phenomenon which may express something of a man's emerging sense of fatherhood is any "pregnancy symptoms" or couvade syndrome symptoms he experiences. The symptoms, apparently based on non-organic processes,[1] are related to pregnancy (Lipkin and Lamb, 1982; Trethowan, 1972) but it is not clear in what way. It is likely that such symptoms emerge from the same general background as do other aspects of emerging fatherhood. Thus, an investigation of the couvade syndrome may help us learn more about the experience of fatherhood for expectant fathers.

Couvade derives from a Basque term couver, meaning to sit as on eggs--to brood or to hatch. It refers to the custom of male birth rituals practiced in many societies since ancient times. The couvade ritual has fascinated anthropologists and sociologists for more than a century, and has recently rekindled interest among social scientists as a contrast to a newer phenomenon--the couvade syndrome. The couvade syndrome, as described by Trethowan and Conlon (1965), involves a set of physical symptoms in expectant fathers which mimic pregnancy symptoms and have no organic cause. With the recent trend of fathers attending childbirth, psychologists and physicians have become interested

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[1] I know of no study which suggests an organic or biological basis for the couvade syndrome. But recent research on the placebo effect and other research on the power of pheromones in sexual behavior or animals including primates (Allen, 1981) does not rule out a possible biological factor in the couvade syndrome among humans.

in fathers and their experience of childbirth, including their experience of the couvade syndrome. In noting the ancient couvade ritual, such investigators have suggested a possible relationship between ritual and/or syndrome and the current trend of a father's involvement in childbirth (Chertok, 1959; Davis, 1977; Wapner, 1975; Zussman, 1969).

The investigator expected to discover a relationship between a father's outlook about the birth and his physical symptoms (couvade syndrome) by questioning expectant fathers. An expectant father's tendency to have "pregnancy symptoms" may be related to his involvement, or lack of it, in other areas of planning for the new child (e.g., attendance of childbirth preparation classes and birth participation). It may be that classes and birth attendance help fathers channel their anxiety which might otherwise be manifest in symptoms if such symptoms are related to anxiety. Such plans may also help their families by providing a culturally sanctioned transition to involved fatherhood. Such involvement may even foster symptom formation by encouraging closer identification with the experience of the pregnant wife and/or greater empathetic expressions of closeness to the wife.

Some involvement with the pregnancy appears inevitable for an expectant father. His own personal history, his attitudes, his relationships, and the options open to him in his society will help determine the level and the

experience of his involvement in his wife's pregnancy. There are strong indications that men are quite involved in pregnancies, beyond their initial biological contribution and also beyond reactive responses to life with a pregnant woman (Chertok, 1959; Jacobson, 1950; Malinowsky, 1927; Mead, 1949; Munroe and Munroe, 1973b).

In some societies, the father's participation has taken the form of a couvade ritual. In mid-twentieth century American society, some expectant fathers have drawn opprobrium for their negative involvement. At worst, they have been noted for their aberrant behavior and emotional disturbance (Curtis, 1955; Freeman, 1951; Hartman and Nicolay, 1966; Jarvis, 1962; LaCoursiere, 1972; Town and Afterman, 1955; Wainwright, 1966; Zilboorg, 1931). At best, they have been noted for "flight" or "fight" behavior (Leinbenberg, 1969; Coley and James, 1976) and for their heightened anxiety (Dyer, 1963; Hobbs, 1965, 1968, 1976; Hogenboom, 1966; Larson, 1966; LeMasters, 1957).

Until about 1975 there was a complete lack of literature addressing any happier aspects of new or impending fatherhood, a fact that has been noted by several recent authors (Earls, 1976; Fein, 1976; Heinowitz, 1977; Gayton, 1975; Lamb and Lamb, 1976; Wapner, 1975). Perhaps it is not coincidental that most of the "fathers in crisis" literature was written during the period of American history dominated by anesthetized hospital births. Interestingly

enough, the present generation of younger writers, many of whom are now parents, were born after World War II while their older colleagues may have been born to families whose fathers were absent for long periods during the war or seeking work during the depression. It may be that the fathers studied during the 1950's and early 1960's were viewed as more anxious and in "crisis" if they experienced physical symptoms. Such symptoms may have related to many factors, including early father absence and/or fathers' exclusion from an important role at the time of birth. Liebenberg's study (1969) lends support to the suggestion of a relationship between early father absence and couvade syndrome symptoms. In her study, whose subjects also reported the highest incidence of couvade syndrome symptoms (67%) in an American population, almost one-half of the men reported early and prolonged father absences due to World War II.

Any investigation of the relationship between pregnancy symptoms (as a means of involvement in a pregnancy) and planning for delivery and participation in the delivery itself may indicate that men are involved in pregnancy at a fundamental level. Their involvement may express itself in the richest channel that society (and a man's family and background) allows. For some men, physical symptoms may be a way to express involvement for the father, and/or reflect a father's ambivalence and conflict about the

birth as suggested by investigators who thus explain the couvade syndrome. The trend allowing fathers to follow their wives and doctors into the labor and delivery rooms makes clearer and more direct participation possible and may affect a father's tendency to develop physical symptoms. A father who attends the birth may have less need to deal with his desire for involvement on a physical level.

Investigation of the couvade syndrome also provides a useful background for an investigation of the emergence of fatherhood. It provides tangible clues about an expectant father's experience. But it is the father's own words about the birth which provide the richest background for discovering and describing the themes that shape and form the viewpoint of an expectant father. Such themes will be used to describe part of the expectant father's experience.

Phenomenological analysis lends itself to a description of the themes which surround a child's birth for expectant fathers and points toward the ways in which fathers view one of the most profound experiences in their lives. Such analysis seeks to understand and articulate a phenomenon which is often beyond easy verbal description because the depth of experience may be beyond verbal language. Such attempts at clarification and articulation help us understand the phenomenon and pull it from beyond

the veil of mystery and individual experience to the realm of articulated and shared experience.

By articulating phenomena which often lay beyond ordinary articulated experience, yet are part of ordinary human experience, we also gain ways to share the depth and richness of individual human experience rather than reduce that experience to less meaningful summaries or numbers. At the same time we can bring the experience of several individuals together to focus on the shared phenomena surrounding, for example, human birth, rather than focus on the uniqueness of each case. Two aspects are tied together in this method--the rich and varied experience (here of being an expectant father) of one individual, and the commonalities and differences experienced by several individuals with the same general human task (that is, expectant fatherhood). This situation allows both formal articulation of experience and a sharing of several viewpoints to create the phemonena and also walk around it, seeing it fully as through the eyes of a variety of viewpoints. In this way, the phenomena of birth can become a focus for a matrix of meaning and experience.

# CHAPTER I

## PURPOSE OF THE STUDY

The present project will focus on physical and psychological aspects of the third trimester expectant father as he approaches his child's birth. Data were gathered and analyzed both statistically and phenomenologically to clarify the experience of expectant fatherhood. The impact of pregnancy and childbirth on a man is of interest here, rather than the man's role or how he fits into a broader picture of childbirth. Therefore only tangential attention will be given to the pregnant wife, other family members, and the child. The couvade syndrome, a father's view of childbirth, and his decision to participate have been chosen as appropriate areas of investigation to gain a clearer understanding of how pregnancy and childbirth affect a father and of how he experiences them. Both first-time and experienced fathers are included in the study.

Investigators have gathered various bits of information about fathers who do and do not choose to attend the birth of their children. Other researchers have found evidence of the couvade syndrome among large groups of prospective fathers from several cultures, including the United States. Of the men in U.S. studies, between 11% and 65% of the fathers reported symptoms of the couvade syndrome (Davis, 1977, citing Trenthowan, 1971; Dick and

Trenthowan, 1972; Liebenberg, 1969). In the largest study to date, Lipkin and Lamb (1982) report that 22.5% of 267 expectant fathers experienced couvade syndrome symptoms. Several studies have clarified some of the factors which may influence both a father's involvement and participation at birth (socio-economic status, education), and his tendency to develop couvade syndrome symptoms (socio-economic class, unplanned pregnancy); (Davis, 1977; Lipkin and Lamb, 1982; Trenthowan, 1972; Trenthowan and Conlon, 1965; Wapner, 1975; Zussman, 1969). Some variables (age, race, color) may be influential, but present studies report conflicting results (Davis, 1977; Lipkin and Lamb, 1982).

No investigator, however, has looked at both the couvade syndrome and the decision about participation in the same study. Based on evidence from the above studies, it is possible that they may be related. It is also possible that an expectant father may benefit from planning for his direct involvement in childbirth. Such involvement may help him focus on the growing child and move him toward his own role as a father with greater ease, as well as help direct his anxieties into constructive channels. The present study, by focusing on the period before the birth, may help clarify the role of planned involvement and participation for fathers at the birth of their children. It will also clarify the importance of a man's outlook and viewpoint for the birth as a factor in his experience of the birth.

It is expected that men with high and low symptom manifestation will have differing ways of involving themselves in pregnancy and childbirth. These two groups of men may demonstrate different involvement patterns reflected in differences in their views of birth and their decisions to participate. Such differences may only relate to different personality styles. The use of clinical diagnostic instruments will help rule out differences based on general personality styles and tendencies to somatize. If personality styles are related to the differences among groups, it would indicate that such differences predate the childbirth experience, and may lend perspective to recent studies which emphasize the birth experience itself as the major component in parent-child attachment and early relationship.

It is likely that men who look forward to their participation in the birth experience can use such involvement as a focus for their experience and rely less on somatic symptoms, or other means of dealing with anxieties. The symptoms themselves may also be sympathetic expressions of "closeness" to their wives. Fathers who are eagerly planning to participate in the birth may be more "primed" or ready for early involvement and attachment to their child as a continuation of their ongoing involvement in the pregnancy and birth processes. It may not be solely because they have been present at the birth itself.

The present study can also help clarify the importance of some type of direct involvement for fathers at birth. The fact that many men tend to develop "pregnancy symptoms" suggests the intensity of the experience of either the pregnancy, or of becoming fathers, or of both. Symptoms, themselves may relate to a man's closeness to his wife or to a man's poor ego functions, or to other aspects of his personal adjustment. The couvade ritual and the recognition of a couvade syndrome both point toward individual and social awareness of the importance and involvement of fathers in the birth cycle and process. The present study will help clarify this apparently fundamental sense of involvement as a part of the emergence of fatherhood.

## Purposes of the Study

Specifically, the purposes of the study are these:

1. To explore the relationship of a father's psychological involvement and couvade syndrome to personality variables of expectant fathers.
2. To discover the relationship between birth involvement and couvade syndrome manifestation in expectant fathers.
3. To discover if the couvade syndrome and planned birth attendance are different and mutually exclusive modes of involvement in pregnancy and

childbirth for expectant fathers, or if they occur together and enhance the expectant father's greater psychic participation in pregnancy and childbirth.

4. To provide data on factors which relate to choice about birth attendance in expectant fathers.
5. To provide additional data on the incidence of the couvade syndrome among expectant fathers.
6. To explore other possible factors affecting both planned birth attendance and pregnancy symptom frequency which have been suggested by literature on expectant fathers. These include:
    (a) family position (related to sibling rivalry as a component of couvade syndrome)
    (b) attitudes toward the father's own parenting
    (c) identification with mother or father (related to sexual identity conflicts as reason for symptoms)
    (d) cross-sex or feminine identification problems
7. To explore the personal adjustment level of expectant fathers in general and their adjustment level as it relates to planned birth attendance and sense of involvement and couvade syndrome in particular.
8. To describe the structure of the world view of the expectant father.

Need for the Study

If the couvade syndrome does affect one of every five expectant fathers, it deserves our attention. Medical professionals need to be alerted to its presence to avoid improper diagnosis and treatment of expectant fathers. Families expecting a child need information and support to clarify what is happening to them psychologically as well as physically. To date there are no reliable explanations of the couvade syndrome although it affects a large number of men.

In addition to information about the couvade syndrome, the present study will help fill the large gaps in knowledge about expectant fathers. We need information about expectant fathers to help fathers gain a clearer picture of their roles and to help parents relate to their families and their children. As fathers take on more of the emotional and physical burden of parenting in a society of working mothers and single-parent families, and in view of the widespread disorder of families and individuals we need to know a great deal more about how fatherhood emerges and is experienced. We also need more information about how fathering relationships develop, even before birth, so men can be helped to experience greater richness in their relationships as fathers.

# CHAPTER II

# REVIEW OF THE LITERATURE

## A. The Emergence of Fatherhood

Theresa Benedek (1959) has suggested that parenthood is a developmental phase, or process, much like the earlier psychosexual stages of character development. She argues that both a man and a woman prepare for and become parents by undergoing an uprooting and change. The change allows them another chance to master earlier conflicts and become good parents. Helene Deutsch's work on woman suggests that the oedipal resolution is incomplete for women until she becomes a mother. She thus emphasizes motherhood as extremely important for a woman's sexual identity (Deutsch, 1944). From another angle, Selma Fraiberg (1980), in reporting on therapeutic interventions with infants at risk, remarks on the incredible progress of the child once the parent can be helped. She also notes how quickly a parent can open herself to loving and caring for her child once some of the "ghosts" of the parent's past have been driven out of the child's nursery, if not out of the parent's home altogether. Her descriptions certainly support the idea of parenthood, especially the period of early parenthood, as a special time for parents to create new relationships by mastering old ones.

The emergence of fatherhood has received less attention than the roots of motherhood. But Edith Jacobson (1950) has written specifically about the wish for a child in boys. Jacobson suggests that boys develop a wish to have a child, as girls do, from their early relationship with their mothers. Their discovery of sexual differences at the oedipal stage and their castration fears increase their identification with their father. At this point, a boy must give up his former wish to have a baby. A boy must, according to Jacobson, cope with his oedipal stage issues. The birth of a younger sibling at this time in a boy's life may make it more difficult for him to move toward identification with his father. Jacobson suggests that the boy may identify with the mother as a means of dealing with the conflict, and use reaction formation as a defense against his envy of a woman's capacity to give birth (1950, p. 143). His early envy and the conflicts surrounding it re-emerge when he is confronted with his wife's pregnancy. Jacobson sees the birth as the process which allows the man to grow from child to father.

> It is the actual birth of the child which enables him, if he is normal, gradually to eliminate disturbing infantile and narcissistic elements and to transform his fantasies into healthy paternal love relationships to his children (Jacobson, 1950, p. 145).

Grossman, Eichler, and Winickoff (1980), in a careful, extensive study on expectant and early parenthood, found that a man's identification with his nurturant,

caring mother was a major variable contributing to his adaptation to fatherhood. The study of over ninety families during pregnancy, birth, and the first year was based on data from interviews, written clinical instruments, and observations. At each point of evaluation, the father's perceptions of his own mother as a nurturant caregiver, and his own identification with her were significant variables in predicting the father's generally good adjustment to the pregnancy and his child. Men who identified with nurturant mothers adjusted better to the pregnancy, the changes in the marriage, felt better about themselves, and were judged to be better fathers compared with other fathers in the study. The authors suggest that identification with one nurturant parent may be an important basis for good fathering because many fathers, including those described above, felt they had not been "well fathered" and were determined to be better fathers than their own fathers had been (Grossman, Eichler, and Winickoff, 1980). The above findings suggest that a man's "fatherliness" and "fatherhood" do indeed emerge from his background and perhaps from his identification with his parents. It is not necessarily clear that a man's "fatherliness" proceeds from identification with his father, at least as a father. Such findings do not point to the period of early parenthood as a developmental phase, however, but suggest that

early parenthood allows for the emergence of qualities already in existence in parents.

If, as it seems, a boy learns to be a father by being a son, a lack of one parent may create problems for him as a man, and as a father. A large body of literature exists on the variety of effects of an absent father on children and families (Biller, 1976). But studies have not investigated how such boys do as fathers.

The findings of Grossman, Eichler, and Winickoff (1980), suggest that at least one parent must be experienced as nurturant. Men whose fathers were absent, for example, during war had only one parent available which greatly reduced their opportunity for one nurturant parent.

Irene Josselyn (1956), writing about "fatherliness," suggests that fatherliness is "a component of mature, masculine psychological development," but is often "crippled" in American society (p. 268). She argues that men are forced to "repress fatherliness in order to avoid an implication of being feminine" (p. 270). Her views are useful to keep in mind as the couvade ritual and syndrome are discussed. Couvade, in both forms, has been linked to sexual role identity by some authors.

The theories explaining the background and roots of human sexual identity touch on the roots of fatherhood, as fatherhood is related to male sexual identity. Psychoanalytic theories of a male's sexual identification with

his father through the various psychosexual stages and the oedipal stage suggest that a man's attitudes about parenting would develop from identification with his father.

The more recent interpretations of object-relations theorists would emphasize a little boy's relationship with both his parents. One such writer has suggested a theory of the emergence of fatherhood. Martin Richards (1982) suggests the following theory and pattern for the conventional nuclear family of contemporary Western industrialized society. For the infant, the mother, in her state of primary maternal preoccupation, represents passivity, dependancy, and isolation from the world. The father represents separateness, detachment, and the outside world. Fathers, as more distant and more subject to fantasy, are seen in more stereotyped ways. A boy grows toward autonomy and interest in people and things. As gender identity develops, the child perceives the world as organized along sexual lines and he works toward resolution of the oedipal situation, in which his gender identity becomes a basic component of his sense of self and his relations with others. According to Richards, boys define their masculinity "negatively," by what mother is not. They move away from her. A boy's gender identity is more "positional" than is a girl's gender identity. It is

> . . .more related to the abstract and nonpersonal aspects of the cultural norms and stereotypes. It involves the general characteristics of the

> male position and less the specific attitudes and values of the person identified with Richards, 1982, p. 69).

This leads to suppression of a man's emotional side and emphasis on external aspects, such as power, economic status, etc. Men go into the world of work, while their family and social life are secondary. A boy learns to see women's positions as less important than those of men which may lead to contempt, or hostility, toward women. Women can be seen as caring, but also as seductive and dangerous. Such ambivalent attitudes can lead to difficulties when a man's wife becomes a mother. The child may undermine a father's dependant relationship with his wife and raise old issues of sibling rivalry.

A father's desire to have a child, suggests Richards, comes from a desire to be in the position of father, not to create a relationship of father to son or daughter. Thus, a father can have a clear link to his children, but remain at a psychological and physical distance from them (Richards, 1982).

Richards' theory, while untested, does fit with the findings by Grossman, Eichler and Winickoff (1980). Fathers who reported that they were not well fathered, but who identified with and perceived their mothers as nurturant, were able to become good fathers themselves. These fathers may have retained the nurturant qualities of their

mother, and may have identified only with the position, not with the personal qualities of their fathers.

Two other studies also suggest that fathers do not gain their sense of fatherhood from their own fathers, at least not in any straightforward way. In a study of men's motivations for fatherhood, Colvin (1980) found that men reported that they wanted to have children because they did not have good relationships with their own parents and wanted to be a better parent than they had had. A similar finding was reported by Soule, Stanley and Copans (1979) in a study on father identity. In examining a father's own parenting as a factor in positive father identity measured during the pregnancy, fathers with high "father identity" reported either very distant relationships with their own fathers, or very close relationships.

On the other hand, Irving and Toby Bieber (1978) reported that a disturbed father-son relationship was an important contribution to the father's disturbed post-partum reaction in three case studies. The case studies also indicated disturbed mother-son relationships as well.

Machtlinger (1976, 1981) has provided a good review of the father in psychoanalytic theory. She notes the historical development of the father's importance in pre-oedipal development of the child. The father is seen as assisting the child in his or her individualization and separation from the mother. Various theorists (Abelin,

1980; Mahler, 1979) suggest different specific roles for the father in aiding a child's separation from the mother, including the suggestion that the father is a model of an autonomous person who can have an intimate relationship with the mother without fear of "engulfment" by her (Rotmann, 1980). Machtlinger, in summarizing literature on the father, discusses the idea that the father "functions . . . as a modulator of aggressive drive and fantasy," for the child (Machtlinger, 1981, p. 133). The father also acts as a protector from and balance to the mother's influence. Machtlinger notes that the relationship between parents is important.

> A common finding [in pathological families] is that fathers who are especially passive (and thus presumably insecure in their own gender identity) fail both as models of masculine identification for their male children and as protectors of children of both sexes against the mother's pathology (Machtlinger, 1981, p. 137).

A boy's early relationship with his mother would appear to help mold his eventual expression of fatherliness. It may be that his other early relationships to the age of four or five, with siblings, grandparents, and other caretakers, perhaps even neighbors, all have some effect on his role as a father. But his relationships with his parents would be the most significant ones for his sense of fatherhood.

Some writers suggest that men in our society have little chance to play with children or babies, which

severely limits their knowledge of children and presumably their skills and abilities as fathers of young children (Fraiberg, 1980). A study by Soule, Standley, and Copans (1979) supports Fraiberg's suggestion. It also may be that a boy's more typical play with animals teaches him as much about caring for and loving dependent creatures as girls who babysit or care for younger siblings. A relationship with a special pet might help a boy learn about intimacy and play in relationships. The relationship a child has with an animal may, in fact, foster the type of spontaneity and affection which emerges when a father plays with and enjoys his baby.

Machtlinger (1980) summarizes the most recent psychoanalytic literature which addresses the developmental aspects of becoming and being a parent, especially for the father. How a man's gender identity extends to include a father identity, the responsibility of provider and protector of a child, and the capacity for "empathetic 'fatherliness'," has received recent consideration (Ross, 1979b).

While Benedeck (1970) argues that fathers should not become involved in a material caretaking role, Ross (1975) suggests that reproduction and caretaking may help a man "come to terms with his hitherto repressed and disquieting 'maternal desires'" (p. 797). Ross traces the development of nurturant and procreative desires from a small boy's

early wish to bear children, through the young boy's care of plants and animals. His identification with a "caring, fatherly" father and a good relationship through the latency period allows the boy to discover his own skills as he explores the world, without being dominated by aggressive drives (Ross, 1979b). Again, the theme of the father as protector from aggressive impulses occurs.

In a study of fathers of premature infants, Hertzog (1978) noted that the fathers could be divided into three groups by their involvement in their wives' pregnancy. Their degree of involvement related to their "ongoing empathetic relationship with their wives." It also related to their own awareness of their own feelings and self-insight. Fathers who were most involved also tried hardest to resolve their conflicts with their own fathers. They were concerned that the relationship with their child would develop similar conflicts unless the conflicts were resolved with their fathers. Men who were least involved saw fatherhood as "irrelevant or accidental." These fathers also had suffered from the lack of a father as children. As Hertzog notes "If one is always searching for a father, it interferes with the ability to be one" (Machtlinger, 1981, p. 142).

Machtlinger's summary (1981) also discusses the analysis of a first-time expectant father (Gurwitt, 1976) which provides specific information on how pregnancy

organizes a man's sense of emerging fatherhood. The pregnancy and child are "new organizing foci" for the expectant father, around which he reworks past and current relationships with important others, and with his sense of himself. Machtlinger summarizes the analytic work with the following description:

> The result was a father who, at the birth of his infant, was intraphysically ready to enter into a relationship with her and to offer himself as an important libidinal object from the very beginning of the child's life (Machtlinger, 1981, p. 143).

Several theories and ideas suggested above point toward factors which may shape a man's eventual sense of fatherhood. But they await the research necessary for clarification.

## B. Fathers and Pregnancy

If we are less than certain about how fatherhood develops and emerges in a man, we know more specifically about a father's experience of his spouse's pregnancy. There is a body of literature which describes various expectant fathers' reactions to their situations. However, until the mid-1970's, the expectant fatherhood literature was characterized by crisis. The major theme among family researchers was that the "transition to parenthood" is a time of crisis. Several investigators debated this issue, and continue to do so. In the 1950's, LeMasters (1957) and others initiated the crisis theory by pointing to pregnancy

as a period of crisis. Since then, several authors refuted the idea of parenthood as a "crisis" (Fein, 1976; Davis, 1977, Jacoby, 1969; Meyerowitz, 1970; Rising, 1974; Russell, 1964). But the theme remains, and the dialectic continues.

Three recent studies report evidence which contradicts the crisis theory. Van House (1977), in a study of forty-two (42) expectant and actual fathers, found that the actual fathers were less emotionally stable than the expectant fathers. Dodendorf (1979), in a life satisfaction analysis of eighty-three (83) men at five stages before, during, and after pregnancy reported generally high life satisfaction scores throughout the pregnancies. Within the five stages, men reported a "clear and marked" lowered satisfaction score during the second trimester. While the second trimester often marks an upturn for the pregnant woman, apparently the opposite is true for her spouse. The second trimester is seen as more demanding and less rewarding for the expectant father (Dodendorf, 1979; Heinowitz, 1977). Fodor (1981), in another study of expectant and experienced non-expectant fathers, found that the two groups did not differ significantly in their physical and/or emotional experiences. Expectant fathers as a group reported more emphasis on life changes and less emphasis on continuity in their lives compared with non-expectant fathers.

Another study by Roberts (1979) of sixty-four (64) couples suggested that fathers and mothers differ in their ease of transition to parenthood. Roberts found that fathers had an easier transition compared with mothers, probably due to the fact that there were fewer changes in their lives and to their more realistic predictions of their abilities and the new demands made upon them.

At the same time that family researchers suggested that parenthood created a family "crisis," psychiatrists and psychologists began reporting data on expectant fathers who suffered from severe emotional problems relating to the pregnancies and births of their children. Both somatic (Liebenberg, 1969; Trethowan and Conlon, 1965; Trethowan, 1968, 1972), and emotional problems (Curtis, 1955; Freeman, 1951; Jarvis, 1962; LaCoursiere, 1972; Towne and Afterman, 1955; Wainwright, 1966) have been well documented. LaCoursiere, (1972), in fact, found evidence enough of such serious threat to the mental health of some fathers that he argued for a father's legal right to abortion to protect his mental health.

In the literature on expectant fathers, for both clinical and normal populations, writers have stressed the anxiety, somatic, and mental distress of expectant fathers. They have also noted sexual dissatisfaction, including a higher incidence of sexual crimes (Hartman and Nicolay, 1966) and marital problems (LeMasters, 1957; LaRossa,

1976), among expectant fathers. Researchers have documented a seriously disturbing side to the experience of expectant fathers.

Two recent studies reported on the serious reactions of fathers to pregnancy and/or childbirth. Gerzi and Berman (1981) compared fifty-one (51) Israeli expectant fathers in the third trimester of their wives' first pregnancies with fifty-one (51) non-expectant fathers. They found that expectant fathers had higher anxiety scores, and high levels of oedipal intensity, sibling rivalry and guilt feelings compared with non-expectant fathers, as measured on the Blacky Picture test. Birth order was not a factor for the variables tested. This study is in contrast to the studies of Fodor (1981) and Van House (1977) which suggested that expectant fathers either did not differ in their emotional reactions compared with other fathers, or had greater emotional stability compared with other fathers. It is likely that the studies are measuring different things, at different levels of awareness. Millet, Karkous, Jorda, and Cabal (1978) reported on the severe emotional reactions to pregnancy of twenty (20) fathers. They found that disturbed relationships with parents were significant in all cases. They noted that first-time fathers differed from experienced fathers in their immaturity and dependence on their own families. Experienced fathers demonstrated more problems with guilt than with immaturity. The authors

suggested that fathers with difficulties had powerful mothers, who either infantilized them or rejected them, and absent or inaccessible fathers who did not temper and balance their wives' power. The authors speculated that a boy's fear of the father's potential castration power may not be a correct understanding of the oedipal conflict in all cases, but in fact, the mother's power may be far more threatening for a boy who does not have the tempering, balancing protection from her influence of his father.

In the mid-1970's, however, researchers (Earls, 1976; Fein, 1976; Lamb and Lamb, 1976) began to remark on two things about the literature discussed above: (1) it was small--there was very little literature on expectant fathers, and (2) it was negative--what there was, focused exclusively on disturbance, with little attempt to note the happier aspects of expectant or actual fatherhood.

Several authors have begun to enlarge our knowledge of the experience of expectant fathers as well as note its more positive side.

Two recent studies have focused on descriptive aspects of the expectant father's experience. May (1980), in a study of twenty (20) expectant fathers, focused on a father's management of his own detachment and involvement in his wife's pregnancy. She found three distinct phases that the expectant father moved through: (1) the

announcement phase, (2) the moritorium phase, and (3) the focus/redefinition phase. The second phase is crucial for a father's management of his detachment/involvement. The less ready a man felt for pregnancy, the more detachment he needed, requiring a longer second phase. This left a man less time for the redefining phase he needed to adequately prepare for fatherhood. May also found three involvement styles among the fathers: (1) observer, (2) instrumental, (3) expressive. The styles reflect how a man sees himself in relation to the pregnancy. It is also likely that his style would extend to the childbirth process and early fatherhood as well, although these observations were beyond her study.

Soule, Stanley, and Copans (1979) studied 'father identity' in sixty-seven (67) expectant fathers. They identified several sources of a father's sense of his own identity as a father. A high score of father identity was related to higher marital satisfaction, shorter length of the marriage, a positively experienced pregnancy, and extensive experience with infants. They found that a father's relationship with his own father affected his score and that higher income fathers had lower father identity scores.

An increasing number of investigators have focused on expectant fathers. A large interest in fathers and expectant fatherhood has developed from the increasing

involvement of fathers in childbirth, and interest in human bonding and attachment during the first days and months of an infant's life. Fatherhood and childbirth have received even more attention, therefore, in recent years.

## C. Fathers and Childbirth

Very recently, since World War II and especially since 1970, fathers have increasingly been brought into the childbirth process to observe, to lend support to their wives, and finally to share in the experience of the birth of their children. Several researchers have investigated the experience of fathers who attend their wives' labor and deliveries, especially in relationship to their newborn children. The father's effect on the childbirth process has also been studied. Before more recent studies, however, most ideas about fathers and childbirth consisted of individual case studies witnessed by medical personnel and theoretical literature.

Early writers, speculating on the impact of the birth on fathers, provide striking perspective for later reports of fathers at the birth. Gayton (1975) cited several writers who thought the father should not participate in the delivery, and probably should not be present during labor because fathers, as laymen, would find it too anxious

and frightening. Stewart (1963) suggested that "normal" fathers would be horrified to witness their child's birth.

> The male attitude to the female genitalia is one of unconscious hostility. To him the charm of a woman is her mystery. It is inconceivable that a normal male watching the delivery of his wife could experience anything but revulsion at the vision of these genitalia exhibited under the worst and filthiest conditions (Stewart, 1963, p. 1066).

Gittleson (1961) quoted a nursing supervisor's comments on "prepared" fathers in childbirth.

> They are nervous and embarrassed; the younger ones are often frightened to death. All of them give me the distinct impression that the role of assistant midwife is one they cannot handle and never wanted (Gittleson, 1961, p. 137).

Stewart (1963) also suggested that women who want their husbands present during childbirth do so for their own sadistic reasons, with men participating out of their masochistic tendencies:

> It is not fear in a woman who desires her husband to be present during labor and delivery, but only basic, sadistic instincts in which she forces him to realize what he has done to her body, and the suffering and tearing of her tissues which she can endure, and thus prove that hers is the superior sex (Stewart, 1963, p. 1066-1067).

Although few authorities would completely agree with Stewart now, twenty years later, his comments may relate to Gayton's finding that fathers who attended the birth had a more negative body image while fathers who did not attend the birth had a more positive body image (Gayton, 1975). Gayton's finding may be related to sexual differences, or it may be that witnessing any graphic and exhausting

physical act involving blood and muscle reminds anyone of his physical vulnerability.

In addition to psychologically detrimental effects on fathers, several writers cited medical reasons for keeping fathers out of labor and delivery rooms. Distraction of the medical staff in having to deal with an anxious father (Fielding and Benjamin, 1962) and possibility of infection from the father (Stewart, 1963) were both cited by Gayton (1975). Zussman (1969) also noted critics of the practice of fathers in labor and delivery processes. Shaefer (1966) suggested that delivery might prove too "traumatic" to fathers for their inclusion except in rare cases. Zussman (1969) also quoted the obstetricians in her study who opposed the presence of husbands in the delivery room:

> They are usually nervous, tend to make everyone around uneasy, and they serve no useful purpose, so why should they be there? Even if the woman is conscious, she is not totally aware of her environment, and the husband's presence had no meaning for her (Zussman, 1969, pp. 71-72).

Another obstetrician found it a puzzling request:

> Perhaps there are a few couples for whom this might be a meaningful experience, but I think they are few and far between. My hunch is that it's the man who wants the experience for reasons of his own. I wouldn't ever suggest this--it stirs up too much that I don't feel is up to me to deal with. After all, the husband isn't my patient (Zussman, 1969, p. 72).

The comments above provide a sharp contrast to the comments of both fathers who attended childbirth and

medical professionals who have studied such attendance more recently. Comments from fathers are almost universally enthusiastic or at least positive. For example, from fathers present during labor:

> . . .actually I liked being there. . . . I felt involved--part of it (Zussman, 1969, p. 144).
>
> I felt a wonderful excitement. . . . I felt I was contributing to her ability to do this (i.e. stay calm) (Zussman, 1969, p. 145).
>
> I felt . . . we were giving the baby a head start (Zussman, 1969, p. 145).

and from those present during delivery as well:

> It was just a completely exhilerating and emotional experience (Gayton, 1975, p. 87).
>
> Then the baby's head came out. The next thing I knew my wife was crying and I was crying, just tears of happiness (Gayton, 1975, p. 87).
>
> We were so overcome with joy as the baby came out (Gayton, 1975, p. 88).

Other studies of the experience of fathers have reported similar comments and experiences. One study suggested that attendance at birth may reduce a father's anxiety and more quickly than the waiting room experience.

Gayton (1975), in studying the amount of anxiety reported by the two groups of fathers during birth found that attending fathers experienced a peak of anxiety during hard labor, which rapidly decreased. Non-attenders (who were present during labor but not for delivery) experienced more anxiety during labor than attenders, which

peaked while they were in the waiting room after witnessing their wives last in hard labor. Their anxiety did not drop until they were told of the baby's birth and knew both mother and baby were fine. Both groups were relaxed on first meeting their child, although 25% of the non-attending fathers made negative comments about the baby's appearance, in contrast to the attender group. Gayton found two further differences after the birth between the groups. Attending fathers' "feelings of worth" related to their sense of what others thought of them, (social adequacy) increased, while those of non-attending fathers decreased. Gayton suggests the difference may reflect their anxiety and sense of inadequacy due to their lack of knowledge about what was occurring during their wive's hard labor. The other difference was that attenders had a more negative body image after birth while non-attenders had a more positive body image. Gayton suggests this may reflect the exhaustion experienced by attending fathers who had participated in the labor and delivery process itself (Gayton, 1975).

Among a white, urban, middle-class, college-educated population, Zussman (1969) found that fathers who attended their wive's labors were older, better-educated, and were far more likely to engage in a "service" occupation and had worked with children more often than non-attending fathers. Non-attending fathers tended to come from

families where fathers dominated the family (Zussman, 1969). Interestingly enough, many of the same distinctions appear in the literature which has attempted to discriminate men who have male pregnancy symptoms during their wives' pregnancies from men who do not have such symptoms. Munroe and Munroe (1971) note that men who had symptoms were more likely to demonstrate "cross-sex identity." Their findings about men with symptoms appear similar to some of Zussman's findings for men who attended the births--(1) their mothers tended to dominate the family, and expectant fathers were in a service (expressive) occupation rather than an instrumental one, and (2) more expectant fathers had worked previously with children, which is similar to the greater feminine interests found among symptom group fathers (Munroe and Munroe, 1971, 1973, a and b, 1977).

In light of her other findings, it is notable that the men in Zussman's study did not report enough couvade symptoms for their responses to be analyzed. However, her questions about weight changes and illness during the pregnancy, and illness during labor and delivery, were included in her study. Another, less likely, possibility is that, because more than half her sample was Jewish, which has circumcision after birth as a custom, there may have been less likelihood of couvade symptoms. Munroe and Munroe (1977) and with Whiting (1973) argue that

cultures which have an initiation (i.e. puberty-circumcision) ceremony do have a couvade ritual, because the circumcision ritual emphasizes the masculine and replaces (or shifts) the feminine identification process in boys and men which develops unhindered in cultures practicing couvade. It is possible that any circumcision ritual would affect such a shift. Zussman (1969) also found that father attenders as a group produced more drawings considered "feminine," or representing a more "feminine" body image, than did non-attenders. This result may suggest a more feminine orientation for fathers who attended the labor. Again, her findings coincide with those of Munroe and Munroe (1971, 1977) who found men who had pregnancy symptoms, (1971) and/or practiced more intensive couvade rituals, (1977) displayed more types of feminine behavior than other fathers which suggests a relationship between such symptoms and a "cross-sex identity" found on several different measures (1971), (Munroe, Munroe and Whiting, 1973).

Researchers have also noted the variety of effects that a father's presence at childbirth may have. These effects include the positive impact on the father, child, and mother. Greenberg and Morris (1974) used the term "engrossment" to summarize a newborn's impact on his or her father. They found that fathers had a predictable, very positive reaction to their first encounter with their

child including visual and tactile awareness, and a sense of the child's uniqueness and "perfection." Their own feelings included focused, absorbed attention of the child, a sense of elation, increased self-esteem, and even early fantasies about future involvement with the child. The child's physical activity was also attractive to fathers. Gay (1980) found similar intense interest on the part of twenty (20) fathers observed with their newborn children. While the Greenberg and Morris (1974) study found similar effects among all new fathers, whether present at delivery or not, other studies like that of Gayton, (1975) in which 25% of the fathers not present at birth had negative comments about their child at first sight, have suggested that presence at delivery may enhance a father's "engrossment" with his child.

In addition to the father's experience of seeing his newborn child at birth, the father's own experience of the birth itself has been studied. Shapiro (1980) studied thirty-six (36) first-time fathers who attended their child's birth. He found that a father was more likely to have a strong "peak experience" at birth if he had more "readiness for fatherhood." Fathers also had more positive birth experiences if they had good relations with their spouses, if they preceived the hospital staff as supportive care-givers, and if their wives' labors were longer.

The well known studies of Klaus and Kennell (1976) have suggested the importance of early and prolonged contact between parents and newborn infants for their mutual "bonding" and for a richer, more affectionate later relationship. Their studies emphasize that the earliest possible contact between both parents and their child, beginning at birth, contributes to "bonding." In one study, a difference of thirty minutes of contact after birth made differences in later maternal-infant interactions (Klaus and Kennell, 1976), and the authors suggested that early contact between fathers and infants also facilitated a stronger bond from the father to the child.

Studies concerning the effects of the father's birth experience on his later involvement with his child have produced conflicting results. The father's experience of childbirth appears to have some effects on his later involvement with the child, but the effect and its direction are not clear.

Peterson, Mehl, and Liederman (1979) reported that father "attachment" after birth and three months later was affected by the specific experience of the birth itself. They found more "attachment" behavior and involvement with the infant among fathers who had a positive birth experience, usually in a home birth or natural hospital delivery, while men whose wives were anesthetized during

delivery with husbands absent had less involvement with their children three months later.

Brown (1977) studied eighty-four (84) first-time expectant fathers in four groups, including three groups of prenatal classes and one group of non-attending fathers. The fathers were interviewed at seven months into the pregnancy and at three months postpartum and were given a variety of tests before and after the baby's birth. Brown found that the four groups did not differ from one another in ratings of their babies or their reported involvement with their babies. While attendance at childbirth classes did not affect their involvement with their children, their birth experience did. Brown's study found results opposite those of Peterson, Mehl, and Liederman (1979). Brown found that fathers whose wives had obstetrical complications during childbirth were more actively involved with their babies at three months postpartum. The reason for the differences in findings is unclear.

Greenberg and Morris (1974) also found no difference between fathers who attended the birth and those who did not. The Greenberg study, however, was limited to the immediate after birth experience, without later follow-up.

Another study which also found no differences among fathers who had different birth experiences was done by Cronenwette and Newmark (1974). Based on questionnaire data gathered immediately after birth, (rather than the

observational data after birth and three months later used in the Peterson, Mehl, and Liederman study, 1979), they found "no measurable differences in the paternal-child relationship" among the different birth-experienced groups (1974, p. 215). It may be that any differences in father-infant relationships are detectable only through direct observation and cannot be obtained through self-report instruments. It is also possible that such differences are less detectable immediately after birth than they are later. However, Brown's findings (1977) may indicate that the relationship between later father-child involvement and birth experience is more complex than studies to date have assumed.

In addition to the birth experience as a factor in the father's attachment behavior toward his newborn child, Bowen (1978) found that the father's family size was also significantly related to his attachment behavior. Bowen observed forty-eight (48) men with their infants seventy-two (72) hours after birth. Bowen found that as the father's family size increased his attachment behavior scores decreased in a significant inverse correlation. A father who had been an only child, and a father with two siblings obtained the highest attachment scores while a father with one sibling, or with three siblings had lower attachment scores. Men with four or more siblings had far lower attachment scores. Bowen noted that the latter

group also tended to be from a lower socio-economic group and were less likely to be present during delivery. They were more likely to be having their second, third or fourth child, all of which affected attachment scores in her study. Therefore, it is difficult to pinpoint a specific factor for their lower scores. General socio-economic subcultural trends, including larger families, and more stereotyped role behavior, plus a loss of some early bonding mechanisms during the critical period immediately after birth may all have contributed to a father's lower attachment behavior with his child. Bowen's data, however, certainly raise questions about the importance and effect of the father's family background on his experience of pregnancy, childbirth and early fatherhood.

It is very likely that in large families with blue-collar backgrounds, there was less attention given to boys by a very busy, or very tired father who may or may not have dominated the home, but was very unlikely to form close, affectionate relationships with his sons. This pattern may contribute to a "low male salient" household for small boys, in which they have a great deal of proximity to women, especially their mothers, and much less proximity and/or positive closeness with males, especially their fathers, who may be present more as a threat than a support--or who may be too tired to be there at all beyond a silent physical presence. Often, mothers in such

situations are the overt and/or covert rulers of all household matters, including the children. Fathers in such situations appear powerless and acquiescent to female rule at home, even if they are not acquiescent in other areas, such as work and recreational activities outside the home and beyond maternal jurisdiction. The above description is similar to the family descriptions noted by Keniston (1965) by Millet, Karkous, Jorda and Cabal, (1978), and Richards (1982).

Another study on attachment (Shapiro, 1979) suggested that fathers and mothers have different attachment and differentiation patterns and that the patterns vary for first and second born children. Shapiro found that fathers had less complex attachments to their children, compared with, mothers which grew gradually during the early postpartum months. Fathers had less ambivalence toward the child, compared with, mothers whose loss of the pregnancy colored the attachment. Shapiro found that fathers differentiated their first child from themselves more successfully than did mothers. Thus, a father's attachment to his first child and second child may involve a greater ability on the father's part to see the child as he or she is, rather than as an extension (less differentiated) of himself. His presence may therefore help balance the mother's view, especially for the first child.

While the specific impact of birth on the father-child relationship continues to be studied, the effect of the father's presence at the delivery has appeared very beneficial to his wife and for the ease of delivery itself. Henneborn and Cogan (1975) reported that women had less reported pain, and used less medication than women whose husbands left after the end of early labor. The authors suggest that husbands' attendance at birth may help ease labor and delivery by lowering maternal stress. Because maternal stress affects an infant's irritability, hyperactivity, feeding, and sleeping problems, a father's presence at delivery may have far reaching effects on his child through his support to his wife. It is not clear whether the husband's active support, or his mere physical presence affects the ease of labor and delivery. The above positive effects would presumably occur only when the husband and wife were both willing and able to manage their respective roles.

Cronenwett and Newmark (1974) found that father-attended deliveries positively affected the couple's relationship, even if the father was not trained for the experience. Like Henneborn and Cogan (1975) they also found that women whose husbands were present had shorter labors and used less anesthesia.

The above studies and comments indicate the major changes in attitudes towards fathers as participants in

the childbirth process during the past twenty years. As more fathers participated, earlier speculations and theories have given way to observations and newer theories. The new outlook views the father as an increasingly integral part of the birth process.

In the flush of current good feelings about a father's involvement, it is also important to recognize some possible implications of this change. They are suggested by the following two comments, and are a reminder that any change, however "good," may have consequences which are completely unforseen. In a comment in Klaus and Kennell's Maternal-Infant Bonding (1976), T. Berry Brazeldon quotes Margaret Mead on fathers' attachment to infants, and society:

> No developing society that needs men to leave home and do his "thing" for the society ever allows young men in to handle or touch their newborns. There's always a taboo against it. For they know somewhere that, if they did, the new fathers would become so "hooked" that they would never get out and do their "thing" properly (Klaus and Kennell, p. 44).

Brazelton sees the shift toward early father involvement with infants as good for fathers and their families. But Theresa Benedek has another view, equally worthy of our thoughtful consideration. Benedek (1959) views the father's assumption of caretaking activities (presumably different from social and playing activities and not necessarily related to bonding behaviors) for infants as detrimental to the ultimate paternal role. Benedek sees this as

> . . .an unknowing process by which it will be difficult, if not impossible, for him to perform the patriarchal role of father. He becomes, in the child's mind, part of 'the mother image' (Benedek, 1959).

For Benedek, the patriarchal role of the father involves the father as the authority, the upholder of society's rules and standards.

Studies of early father-infant interactions have suggested that fathers and mothers tend to interact differently (Lamb and Lamb, 1976) so that the father may not be in serious danger of becoming "part of the mother image," even if he performs many caretaking tasks. But both these comments help remind us that if more and more fathers become increasingly involved with their children and families from birth on, our social and economic institutions may reflect such changes.

Richman (1982), in a study of expectant fathers, commented that "the social tide is running in the direction of fathers becoming more home-involved," for a variety of complex reasons. He noted that "marriage now involves more emotional interplay between partners. Pregnancy provides males with one opportunity for emotional involvement" (Richman, p. 103). Men, as fathers and husbands riding the "tide" of "home-involvement" may continue to involve themselves in more aspects of the home and family, in contrast to their own fathers--the fathers described by Roberts (1982) and Grossman, Eichler, and Winickoff (1980)

whose fathering skills have been criticized by current expectant fathers. It is not clear where and how the "social tide" of "home-involved" fathers will wash onto the shores of society.

In a study which may relate to father-infant attachment and the relationship of fathers to their children and its impact on society, the following authors echo the sentiments of Margaret Mead noted above, when she said societies which need their men to "do their thing" do not let them play with their children.

Mary West and Melvin Konner (1976) summarized a number of ethological and anthropological studies to find several noteworthy patterns of paternal behavior. On a continuum of parental investment in care of the young and other variables, man as a species can be compared to other animals. Parenting behaviors were related to the mating system [polygamy, monogamy, polyandry]; courtship patterns [competition among males for female with female choice, low intrasex competitions, female competition for males, male choice]; and adult sex differences [males as the more prominent sex (larger, stronger, more colorful), low sexual dimorphism, females as the more prominent]. Parental patterns included: male parental investment lower than that of females; nearly equal parental investment; female parental investment lower than that of males.

The authors noted that humans fall between monogamy and polygamy, since polyandry is very rare among humans. Vertebrate males, especially mammals, rarely invest themselves in care of young. Male mammals usually do no more than donate their sperm, while the females raise the young. It is interesting that humans, and primates and canids, go against the tide of low or no paternal involvement with their young by providing resources, defending, and sometimes playing with offspring. Several anthropologists and ethologists have speculated about the reasons why man, and dogs and some primates, developed higher paternal investment with their young compared with other mammals. First, they all have slowly developing or "altricial" young. But so do other species which do not display paternal involvement. West and Konner (1976) agree with others who suggest that males remained close to the female and young because of the scarcity of resources (i.e., food) and the need for defense against predators.

One study of orangutans in two settings (Barash, 1975), yielded important evidence for this hypothesis. In a setting with more predators and competitors, males lived with the mother and young. In another setting, with fewer predators and competitors, males lived separately from mothers and young. In a study of marmosets in two settings, (Barash, 1975), males lived and interacted with their young more in a less populated setting. In a more

populated setting, the males lived in separate burrows and were engaged in more "defense encounters" with other males. West and Konner (1976) suggest that resources and defense requirements are important factors in male proximity to their young in a species characterized by some paternal investment. "If defense or male-male competition are required, he [the father] may be distant or close; if caretaking is required, he is close" (p. 189). Their literature review also included a mouse study where male proximity and caretaking resulted in greater weight gain and survival of the pups, thereby underlining an evolutionary advantage of paternal caretaking activity.

West and Konner go on to argue that paternal behavior, even among human societies, remains very linked to the society's needs for defense and the scarcity, or abundance of resources. In societies in which aggressive warrior skills are seen as needed, fathers have distant relationships with children, and raise them to be "tough." Fathers in such societies have little to do with young children, and may teach them, but do not play with them. The children are either not indulged, or are not indulged beyond age three or five, but are trained to withstand pain in some form as befits a warrior. Societies which have little need for defense and are marked by an abundance of resources, promote close relationships between fathers and children; children and infants are greatly

indulged, and fathers are involved with the caretaking activities of infants, and also play with and are affectionate toward their children. There is little emphasis on "respect" due an authoritarian father, as is found in aggressive societies.

West and Konner base their ideas on studies of five nonindustrial societies which range on a continuum illustrating the above patterns. They note that in societies in which fathers have little contact with children, polygamy and warfare are common, with strong emphasis on paternal authority. "The role of the father is to procreate, defend, command, and punish" (West and Konner, p. 198). In societies in which women are "directly involved in subsistance activities," fathers were closer to both infants and children, often directly involved in caretaking. It is interesting to speculate that one outcome of the contemporary trend of working mothers is that it may allow for closer relationships between fathers and children, except, perhaps, for professional men who can usually make far more money than their wives, and therefore may be kept away from home by longer hours at work than lower middle-class men, who may be economically easier for mothers to enlist as child caretakers than the more costly professional and upper middle-class man.

West and Konner also note another pattern of child caretaking in a society where women are engaged in

providing basic resources (i.e., simple agriculture), but where polygamy is common and fathers are generally distant. Children are cared for by siblings and grandparents. Thus, the authors propose a third alternative model for predicting non-maternal caretakers, where the father is absent (during the day or in general, as among some subcultures marked by poverty) and the mother's work load is high. This third model also certainly sounds increasingly familiar for contemporary American families who use grandparents or day care personnel, and would be useful to investigate further.

In conclusion, West and Konner suggest that fathers play a "minor role" in child rearing, compared with mothers, but vary along the lines of both closeness to children and styles of fathering (indulgent and affectionate vs. harsh and aloof). They emphasize the "plasticity" of paternal involvement and investment within primate species and man, with limits on such plasticity set by hormonal and other biological systems.

West and Konner's study sheds interesting light on the relationships between fathering patterns and the political, economic, and social structures of some human societies. Contemporary American society contains aspects of both the aggressive and non-aggressive cultures West and Konner describe. Changes in fathering patterns in

contemporary society, such as the greater "home-involvement" trends among fathers seen by Richards (1982), and greater father involvement at childbirth probably reflect shifts in larger social patterns. Segments of modern society will continue to use traditional fathering patterns like those of West and Konner's "aggressive" societies, while other, increasingly larger sections of society may be shifting to the non-aggressive patterns described in their study.

## D. The Couvade Ritual

### Description

One phenomenon of fatherhood which crosses cultural lines and has been investigated as a separate aspect of expectant fatherhood is couvade. It is a term derived from the French couver meaning "to brood" or "to hatch." It comes from a Basque term which literally means "to sit on eggs." The couvade ritual is a ritual performed by fathers around their child's birth and in its classical usage, it refers to a male childbed or birthing ritual. In modern usage it now refers to both a dietary couvade and a pseudo-maternal couvade. During the pregnancy, or more often, after the child is born, a father has dietary restrictions, with the dietary couvade. In a pseudo-maternal couvade, the father's behavior is limited in some way, from minor restrictions (e.g., no knot tying) to

mimicking labor while the child is born, plus remaining in bed after the child has come. Often, both forms of couvade are practiced in a given society.

Among the descriptions of classical couvade ritual (extreme pseudo-maternal couvade), Munroe, Munroe, and Whiting (1973b) found three main features. These include (1) the idea of the father staying in bed either during the birth or immediately postpartum, (2) additional restrictions or taboos for the father beside a "male childbed", (3) the idea that the father is imitating or acting as a substitute for the mother (Munroe, Munroe, and Whiting, 1973, p. 31).

Munroe, Munroe and Whiting (1973) reject the features of the above description of couvade. They found the classical definition of couvade both narrow, and questionable in its actual existence. They noted that the second usage of couvade often refers to restrictions placed on both the father and mother, not just the father alone. The shared restrictions for both parents also undermine the third usage, with its "pervasive idea that the father is in some sense imitating the mother's role," or substituting himself for her. The following definition for couvade will be used in the present discussion:

> . . .typical usage indicates that the term "couvade" may be conveniently applied to a broad range of supernatural observance on the part of the father during the birth cycle. These observances vary widely in the degree to which the

father's life is restricted (Munroe, Munroe, and Whiting, 1973, p. 36).

Incidence

Some type of couvade ritual has been reported in numerous culture groups on every continent and has been described or alluded to for several centuries in both Occidental and Oriental literature and art (Dawson, 1929; Munroe, Munroe, and Whiting, 1973b; Trethowan, 1972).

Munroe, Munroe and Whiting (1972) and Dawson (1929) both note references to the couvade in Strabo (1903, observations in ancient Greece) and in Marco Polo's accounts of his travels in Chinese Turkestan (1938, p. 282, cited in Munroe, Munroe, and Whiting, 1973). Missionaries found it practiced in seventeenth century Brazil (Yves d'Evreux, cited by Metraux, 1949, p. 369). Observers in the nineteenth century found the couvade practiced among the Basques (Dawson, 1929; Munroe, Munroe, and Whiting, 1973), and during this century in the Baltic states and Holland (Driver, 1964).

But Munroe, Munroe, and Whiting (1973) have questioned the reliability of such reports, and in so doing, question whether a full blown, classical couvade, which includes a male imitation of labor, ever existed as widely as it has been reported. Their questions are quite reasonable. In a picture reprinted in Dawson (1929) and in Trethowan (1972), which has been used as evidence of

classical couvade, a Chinese father is holding his child inside a house while the mother (apparently) has left the house. This scene may have appeared extremely unusual to a nineteenth century Western observer, whose interpretation, therefore, may have attributed more to the scene, and ritual than existed. It is difficult to say how frequently a classical couvade was actually performed in a society and how much might have been inferred by Western writers.

Munroe, Munroe, and Whiting (1973), therefore, have broadened the definition of couvade to include the large number of religio-magical cultural birth practices expected of fathers beyond an imitation of labor or of a physical recovery period after birth.

Of these practices, food taboos and some other restriction on behavior, for both husband and wife, are among the most common forms of couvade (Munroe, Munroe, and Whiting, 1973; Trethowan, 1972). New parents of a Bolivian Sirono baby, for example, have several food taboos, must not leave their home and must perform certain ritual sacrifices in the three to four days after birth (Munroe, 1973). In Melanesia, the Kuratatchi people also observe food taboos during pregnancy, childbirth and after birth. The father must be indoors in a hut separate from the mother (in another wife's hut, for example) and must remain idle during the birth and for three to four days after it.

He must especially avoid sharp or heavy instruments and tools, or harm might come to the child. He cannot see the child until three days after its birth, when he can visit. On the fifth day he and his wife wash in the sea, and the father takes a knife, pretending to cut the baby, to break the taboo against sharp objects. It is interesting to note the characteristics of this culture and the implications suggested by West and Konner (1976) and M. Mead (1949). There is no early contact between father and infant, and there is a focus on sharp, heavy instruments suggesting aggressive themes of a warrior society.

In some societies the restrictions are minor, as noted by Munroe, Munroe, and Whiting (1973). The Tlingit Indian parents of the Pacific Northwest were expected to stay away from strawberries and thimbleberries (Jones, 1914) during pregnancy. Another group, the Tallensi, were not to attend funerals during the wife's pregnancy (Munroe, Munroe, and Whiting, 1973).

The above examples and others point out, according to Munroe, Munroe, and Whiting (1973), how misleading the idea of the father as substituting for the mother is. Most restrictions apply to both parents. The authors go on to suggest:

> . . .it may not be the degree of similarity between the parents' behavior which is important, instead the degree of involvement with the birth cycle on the part of the father. For clear, physical reasons, the mother is involved in the

> birth cycle and the question might become: Does a given society define the father as important too (Munroe, Munroe, and Whiting, 1973, p. 36).

Further incidence of couvade rituals have been reported in China, India, Vietnam, Borneo, Thailand, Africa, and the Americas (Driver, 1964). Zussman, (1969) cites Devereaux's study of the Mohave Indians, where transvestite men practice an imitation of labor and childbirth, (Devereaux, 1937). Zussman also quotes a passage from the medieval romance of Aucassin et Nicolette in which Aucassin meets a king at childbed in Carthage, while the king's wife is out leading the army in battle (Aucassin et Nicolette, Twelfth Century).

Sir Edmund Tylor (1878) reported observations of various couvade rituals among Carib people in the West Indies; Indians of eastern South America in Guiana and in Surinam; anong Land Dayaks of Borneo; people in Kamchatka (eastern U.S.S.R.); families in Greenland; people in West Africa, and among Indians in Madras and along the Malabar Coast. He also noted its reported appearance among the Basques in Spain, although he said a classical couvade was not practiced during his own time by the Basques. In France, Tylor reported that couvade was observed in Navarre and Biscay, and in ancient Corsica. Tylor also reported on a practice among contemporary German peasants of godparents observing special thought restrictions, especially

at the time of christening, so as not to harm the child's character.

Reik, in Ritual (1927) also noted a number of practices that are close to couvade, as does Trethowan (1972), which are superstitions rather than clearly couvade rituals. Trethowan noted that several magical practices and superstitions appear to fall in a continuum between ritual couvade practices and the couvade syndrome.

## Explanations

In several non-industrial societies, the couvade is a ritual with clearly defined expectations prescribed by tradition for the expectant father. It has been interpreted variously by Western observers as an indication of feminine identification among the men of a society (Munroe and Munroe, 1978); as an indication of ambivalence toward the mother and/or the child (Reik, 1927); as an anxiety-reducing mechanism in the face of the crisis of fatherhood (Wapner, 1975); as an indication of neurotic immaturity (Trethowan and Conlon, 1965; Trethowan, 1969, 1972); and as an acceptable role allowing strong participation by the father in a major event in this life, in which he is not directly, physically involved (Malinowski, 1927; Zussman, 1969).

Munroe, Munroe and Whiting (1973b) provide a summary of the major explanations suggested by various researchers for the couvade ritual. Ever since the observation of

couvade by travelers, missionaries, and later anthropologists, couvade rituals have been difficult to explain. The Munroes (1973b) note that authors trying to explain couvade have generally reflected the prevailing theory of explanation for their time, rather than produced a compelling explanation. The late nineteenth century writers, for example, were dominated by new ideas about evolution and social evolution. Among them, Tylor (1865, 1889), suggested that couvade involved a cultural change (social evolution) from maternal to paternal dominance patterns in societies, and that the couvade was a ceremony used to mark this change. Tylor built on the earlier view of Bachofen (1861) who, in an age concerned with the expression of law and political legitimacy in history, saw the couvade as a father's means of recognizing and legitimizing his role as father over the obvious role of mother. The Munroes (1973), note that these theories did not hold up with the weight of later information about social changes and couvade, although both theories suggest the tension between paternal and maternal roles which makes couvade rituals so fascinating.

Between 1900 and about 1920, several writers reflected their interest in the irrational, and magical, in the era permeated by the ideas of Sigmund Freud and other earlier writers interested in the irrational. Frazer (1910) emphasized the magical bond between the father and

his child extending to a physical bond that prompted the father to pay special attention to his diet and behavior so as not to hurt the child. The Munroes (1973b) suggest that the fatherbond explanation is powerful, and may be a necessary component of couvade, but it is not sufficient to explain couvade practices, in their view.

In 1929, Dawson and others suggested that couvade practices were so unusual that they could not have originated independently, and therefore, suggested a "diffusion of the custom" (pp. 67-68) from some original source. Dawson's theories have been discredited. At the same time, anthropologists of the functional school provided different explanations. Malinowski (1927) suggested that couvade serves to focus the father's attention on his child and family, and therefore helps bind the family together. He also suggested an idea which has been echoed by more recent researchers on families and fathers--that couvade may be "a necessary stimulus and expression for paternal tendencies" (1927, pp. 215-216). Although the Munroes (1973b) reject Malinowski's reasoning because it does not distinguish between societies which do and do not have a couvade, his ideas are similar to those who have studied fathers very recently (Wapner, 1975) and they have some similarities to the argument that the father's presence at birth and during the first postnatal hours and days fosters his

attachment of the child (Greenberg and Morris, 1973; Klaus and Kennel, 1976; Parke and Sawin, 1976).

In some couvade practices, fathers remain with the child, and are refrained from doing their normal work. A couvade which involves early and prolonged father-infant contact, rather than separation (as in the case of the Melanese Kuratatchi people, for example), might well foster attachment and a close, affectionate relationship between fathers and their children. Thus, in the study of couvade rituals, and expressions of the couvade syndrome, it may be extremely important to note whether the couvade practices involve a father's increased proximity to his baby, or separation from the infant.

Munroe, Munroe, and Whiting (1973) also summarize the conflicting studies confirming and reflecting the earlier theories of Tylor and Bachofen. In one early study, Summer and Keller (1927) found that couvade was linked with "father family" oriented societies. Simmons (1937) reviewed the work of Summer and Keller, and included a larger number of societies. By comparing customs in seventy-one (71) cultures, he found couvade practices tended to be found in societies with a "mother family" orientation.

Theorists from psychology (specifically psychoanalysis) have suggested their own ideas about couvade. Reik presented his view based on Freudian ideas in Ritual (1927). He suggests that the couvade ritual involves a

number of subconscious and unconscious processes. Reik sees the pseudomaternal couvade ritual as a manifestation of the ambivalence a man feels toward his wife. As a man acts out her labor pains to ease her birth by means of magic, he also reflects unconscious sadistic impulses toward his wife, which he (and his society) projects on to the demons from whom he seeks to protect his family (Reik, 1927).

Reik (drawing on Freudian oedipal theory and the theory of patricide in the primal horde) proposes that it is hostility toward the child, based on an unconscious fear of retaliation for his own patricide impulses as a child, which prompted the widespread dietary couvade. Reik argues that the father refrains from eating certain foods as an extension of and defense against an unconscious wish to sacrifice, or eat his child. He traces this idea through the use of sacrificing animals at the birth of a child, as replacement for a desire to kill the child itself (Reik, 1927).

Reik does not distinguish between men and societies which practice couvade and those which do not. He therefore does not distinguish elements which create the couvade. Presumably, noncouvade men also feel ambivalence toward their spouse and child, according to Freud's ideas of the universality of the primal patricide impulse and oedipal complex. Reik also does not deal with the fact

that women also practice dietary restrictions, often the same ones as their husbands. He was probably less aware of this phenomenon, as it related to couvade practices.

It is interesting to note in light of more recent theories, that Reik rejects the idea of feminine identification as an explanation for the couvade rituals.

> There is as little value in tracing male childbed to the "effeminacy" of the men--the very men who observe the severest abstinences and uncomplainingly endure the sharpest pains (Reik, 1927, p. 39).

Munroe, Munroe, and Whiting (1973), agree with Bettleheim's views on couvade (1954), that it is related to male envy of woman's creative power. Bettleheim, in a quote used by Munroe, Munroe, and Whiting (1973b, p. 38) suggests that a man is extremely curious about the experience of giving birth, and attempts to emulate it. But he can only copy the superficial aspects of the process, and remains envious of her real powers.

> Women, emotionally satisfied by having given birth and secure in their ability to produce life, can agree to the couvade which men need to fill the emotional vacuum created by their inability to bear children (Bettleheim, 1954, p. 211, cited by Munroe, Munroe, and Whiting, 1973, p. 38).

Munroe and Munroe, (1971, 1977), and Munroe, Munroe, and Whiting (1973), have studied couvade, both as a ritual practice, and as a syndrome (male pregnancy symptoms) for many years. They conclude that it is related to a "low-male salience" culture and involves a more feminine identification among men who are raised in a culture with

exclusive mother-infant sleeping arrangements within a "low-male salient" or "matri-oriented" (mother-family) society.

In a careful study of Black Carib men of the West Indies, Munroe, Munroe, and Whiting (1973) found clear indications of a cross-sex identification among men who practiced the culturally sanctioned couvade taboos more intensively than other men of the culture. Based on six separate sex-role preferences, plus the semantic differential, and child care reports (and in an earlier study, Frank's Drawing Completion Test, which discriminates between men and women; Munroe and Munroe, 1971), Black Carib men who reported more intense couvade practices differed from a control group of non-intensive couvade practitioners. They demonstrated more "female" choices, or in some cases, displayed hypermasculine or "defensive" masculine traits. For example, intensive couvade men all scored either very high or very low on child care (caretaking activities for their child), while non-intensive couvade men all scored in the medium range. In addition, the intensive couvade group spent significantly more time in the exclusive company of women during their first three years (18.9 months vs. 8.8 months for non-intensive couvade men). Although father absence was not significantly different for the two groups, apparently any sustained exposure to adult males in the early years made a

difference for these men, a point the authors also noted. Munroe, Munroe, and Whiting (1973) found no difference between the groups on a measure of mother-infant sleeping arrangements. They did question the reliability of the data, however, which was based on kinsmen and subjects' reports. They also noted that exclusive mother-infant sleeping for a year or more is the common practice among Black Caribs, along with residence with the mother's family and a male wage labor system which keeps men absent from the family for long periods of time.

The evidence from the Black Carib study supports the hypothesis of feminine or "cross-sex" identity for men practicing intense couvade, and for "low-male salience" in their early environment. In another part of the same study, the authors looked at the following variables in seventy-four (74) societies for which data was available: (1) frequency of exclusive mother-infant sleeping arrangements; (2) frequency of families living with or near the mother's family (matri-residence); (3) and absent, non-intensive and intensive couvade practices. For those societies, they found the following patterns related to the variables: (1) intensive couvade rituals in 70% of societies with both other variables; (2) intensive couvade rituals in 25% to 35% of societies with one variable; (3) intensive couvade rituals in 10% of societies with neither other variable. Half of such societies

which practiced neither mother-infant sleeping nor matri-residence also practiced no couvade ritual. Thus, a strong case is made for the impact of "low male salience" on a man's disposition toward later couvade practices as a function of both his culture and his individual history.

Munroe, Munroe and Whiting (1973), based on their study, argue that culture is assimilated by individual psychological processes, and provide thoughtful comment about the relationship between individuals, society, and the institutions of the society. Their thoughts are worth consideration in reflecting on the growing trend to include a role for fathers in the most dramatic part of the birth cycle.

> . . .the evidence upholds the. . .hypothesis that strong psychological dispositions will receive institutionalized expression in projective or secondary systems. . . . Although,. . .a high level of male cross-sex identity in a given society may not always result in adoption or independent invention of the couvade, some institutionalized expression of cross-sex identity should occur. This might make the form of various "expressive" (as opposed to "instrumental") institutions (e.g. social and domestic), which are most often associated with the female role cross-culturally. Alternatively, perhaps a form of institutionalized protest masculinity, a "defense against the couvade," might arise in some societies or subcultures (as in adolescent gangs. . .) (Munroe, Munroe and Whiting, 1973, pp. 66-67).

In another work, Munroe and Munroe (1977) suggest another cultural possibility for societies with early "low-male salience" for young boys.

> . . .he (the boy) enters a society in which maleness is emphasized, (and) any tendency to behave with feminine sex-typed behavior becomes highly inappropriate. Such societies, with low male salience in infancy followed by strong sex differentiation and male social dominance, practice male initiation ceremonies that include circumcision (p. 124). The rites can be interpreted as an attempt to expurge unacceptably feminine tendencies in young males. The interpretation is bolstered by the symbolic appropriateness of the genital operation (p. 125).

The authors note that societies which practice one rite, e.g. couvade, do not practice the other rite, e.g. initiation-circumcision rites, and vice versa. Data about the two rituals thus further support a hypothesis of cross-sex identity in societies exposing boys to early "low male salience."

Munroe and Munroe (1977) also summarize other studies on sex role identity. They agree with the general argument of Stoller (1975) that, even many cross-cultural studies, "indicate a generally greater difficulty in adjustment to sex role for men than for women . . ." (Munroe and Munroe, 1977, p. 129, citing D'Andrade, 1966). Munroe and Munroe suggest that men have more sex role problems because they experience "low salience of adult males in the formative years" (1977 p. 129). However, they recognize that such sex-role problems may also be triggered by "pancultural expectations that males must exceed females in power, dominance and superior status--expectations that are probably fulfilled at some psychic cost" (1977, p. 129). They conclude that both high

expectation for males, and low early contact with males may both affect a man's ability to fit his sex role.

Munroe and Munroe (1977) do not dismiss the problems faced by women as they become adults. They make an important distinction, however, between the general problems of men and women as reflected in a number of cross-cultural studies. They see the role of the male as having "world wide social superiority. . .associated with heavy psychic penalties" (p. 131) among which are problems with sexual role and identity. Women, on the other hand have fewer sex-role problems. The sex-typing problems they do have likely relate to their generally lower status in society. "It is perhaps a mark of women's basic sureness of sex that their displays of envy focus less on sex attributes and more on status attributes of the male role" (p. 131). Their ideas certainly contradict those of Freud, who agreed with his culture on its respect and admiration of the penis and his theory of a physical penis envy among all women.

Stoller (1975) suggests a view comparable to that of the Munroes (1977) in his refutation of part of Freud's theory. Based on his extensive work with sexual identity problems among both men and women (1973, 1975), Stoller suggests that a man may pass through a stage of rudimentary feminity when he is symbiotically tied to his mother, before the age of one year. Therefore, a man's

masculinity is an accomplishment of the boy's individuation process from his mother. It is not the basic "given" of Freudian theory (Stoller, 1975, p. 136-138). Stoller argues that a child's mother must encourage his masculinity for him to become masculine.

While such maternal encouragement may be quite important, the research of Munroe and Munroe, (1977) and others (Biller, 1976; Kaplan, 1978; Lamb and Lamb, 1976) suggest that a boy's early contact with adult men may be a more important factor. Kaplan, in her discussion of the separation-individuation process, also emphasizes the importance of the father as an aid to the child's ego processes in the work of separating himself or herself from the mother. She specifically notes the importance of the father for the small boy in her discussions (Kaplan, 1978, especially pp. 220-221).

In conclusion, several explanations for the couvade ritual have been proposed since its discovery. Based on the most recent anthropological studies and psychological research and theory, the couvade ritual is associated with cultures which also share two other practices, those of matri-residence and exclusive mother-infant sleeping for several months to two years. These factors combine to create "low male salience," that is, little emotional contact between infant or child and adult males. In cultures which also do not promote masculinity or male dominance

to help offset the early female dominance, a ritual couvade has often developed. The couvade ritual has also been linked to a disposition on the part of men to develop some cross-sex identity or feminine sex-role behavior as an outcome of the early association with women and lack of later competing male emphasis in the society (Munroe, Munroe and Whiting, 1973). Specific psychological reasons for a couvade ritual have also included more overt statements of male womb envy (Bettleheim, 1954), and ambivalence and latent hostility toward the woman in pseudo-maternal couvade rituals, and toward the child in dietary couvade practices (Reik, 1927).

Other theories, now discarded, have included Malinowski's idea (1927) that couvade practices function to bind the family unit by focusing the father's attention on his child. While discarded, this theory does correspond to evidence found in attachment studies (Klaus and Kennell, 1976) which point toward the importance of father-infant contact and proximity during the first hours and days after birth to facilitate bonding. This evidence suggests that further investigation of couvade practices which identify those separating father and infant from those which foster such proximity might identify more factors in how couvade practices contribute to other social institutions (e.g. indulgent fathers in non-aggressive societies vs. harsh, distant fathers in

warrior-based societies), especially in light of the findings of West and Konner (1976) discussed in the section on fathers and childbirth.

## E. The Couvade Syndrome

### Description and Practice

The term couvade refers to a syndrome of physical symptoms, called the couvade syndrome, which an expectant father displays during his mate's pregnancy and/or delivery. While several writers had observed and reported on male pregnancy symptoms, Trethowan and Conlon (1965) first used the term couvade syndrome. Trethowan and Conlon defined the term as follows:

> . . .a state in which physical symptoms of various kinds occur in the husbands of pregnant women, and are of psychogenic origin and connected in some way with pregnancy . . . They disappear when the child is born (p. 58).

They use the term couvade to emphasize the relationship of the syndrome to the couvade ritual and suggest that the syndrome is "psychiatrically analogous" to the ritual couvade in that they share several common factors. Trethowan and Conlon also suggest that almost any symptom which is functional and does not predate the pregnancy may be a syndrome symptom. All symptoms do not necessarily mimic those of pregnant women, although most do (Trethowan and Conlon, 1965; Trethowan, 1972). The present paper will use Trethowan's definition because it does

cover a broad list of symptoms, and because it emphasizes the relationship between the ritual and syndrome.

Unlike the couvade ritual, however, the syndrome is not usually viewed by the sufferer as connected to the pregnancy. The syndrome is unintentional, and most men see no connection between their symptoms and their wife's pregnancy (Trethowan and Conlon, 1965; Davis, 1977). Even men who practice a couvade ritual, or believe in superstitions connected with the birth and the father's behavior do not necessarily relate their own physical symptoms to the pregnancy. Munroe, Munroe and Whiting (1973b) quote a Black Carib man who "wonders" about a connection but does not go beyond that.

The couvade syndrome does not easily fit into a clinical diagnostic category. Moore (1975) suggested that the syndrome was most similar to conversion hysteria, and other conversion phenomena because the symptoms have a symbolic meaning of which the man is unaware. Because of the use of symbolic symptoms and because it does not result in bodily damage, the couvade syndrome was not viewed by Moore as a psychosomatic illness. In his study of sixty (60) men, however, Moore found no significant differences between expectant fathers with and without symptoms and non-expectant non-symptomatic married men in their tendencies to use conversion symptoms.

Various researchers have reported a large variety of symptoms. In fact, the investigators who limited their questions to a very narrow range of symptoms such as food cravings or aversions, or to broad, vaguely defined "illness" (Zussman, 1969) had a few responses, in contrast to the lowest general estimate of incidence in the U.S. of about one in ten (10%) (Trethowan and Conlon, 1965; Trethowan, 1968, 1972). The most common symptoms are similar to those of a pregnant woman. There is some cultural variation for syndrome symptoms, with similar variation in the pregnancy symptoms suffered by women in the culture. Munroe, Munroe and Whiting (1973) reported that Black Carib males reported "vomiting, lassitude, food cravings, headaches, giddiness-dizziness, toothache and 'fever.'" These are also the most common Carib pregnancy symptoms. "Fever" is not found in other cultures as a complaint, and may be related to local ideas about illness as well as the hot, sub-tropical climate (noted by the authors, p. 56).

Trethowan has listed the following nine symptoms as those most commonly reported throughout the literature: (1) indigestion or colic; (2) attacks of nausea or sickness; (3) increased appetite; (4) decreased appetite; (5) diarrhea; (6) constipation; (7) toothache; (8) backache; (9) other aches and pains. He also notes that anxiety is also usually included. He found that only

three symptoms significantly distinguished expectant fathers from a control group of married men whose wives were not pregnant. These were: (1) loss of appetite, (2) toothache, (3) nausea or sickness (Trethowan and Conlon, 1965).

In later work, Trethowan (1968, 1972) and others (Davis, 1977; Bittman and Zalk, 1978; Wapner, 1975) have found a wider range of symptoms than previously noted, which also fit the couvade syndrome pattern of occurrence only during a spouse's pregnancy. Wapner (1975), for example, found that his subjects reported feeling tired and having trouble sleeping more than any other symptom. He also found that the physical symptoms of his forty-six (46) subjects were diverse and did not relate in a significant way to a factor identified as "stomach upset" in his analysis of the variance of fathers' attitudes, feeling and behavior. In other words, stomach upset was not a major symptom, and many men listed a broad range of symptoms.

Among the symptoms reported to Trethowan in his later study were the following: "styes and tarsa cysts," boils and other skin conditions, one case of herpes labiales, dental abscesses and "Whitlows" styes, toothaches, nosebleeding, facial neuralgia, abdominal bloating, heartburn, stomach cramps and sympathy pains (1968, p. 108). One man reported the following symptoms over several pregnancies:

anorexia, toothache, morning sickness, various abdominal pains, chest pains, frequent urination, dermatitis, headaches, insomnia, poor concentration and "odd behavior" (snipping a row of wire during labor, incubating and hatching a "clutch of bantam's eggs," Trethowan, 1968, p. 109, citing Enoch, M.D., Trethowan, W.H., and Barker, J.C., 1961). Trethowan listed pica and other appetite disturbances among expectant fathers (1968). He also suggested that the incidence of some type of couvade syndrome may be far higher than his original report of 11% because men seem very likely to "under report" their symptoms and may also have a tendency to "suffer in silence" as part of the syndrome.

In their study of expectant fathers, (Bittman and Zalk, 1978) listed several items similar to those listed above, and included mood-related items. Of the physical symptoms, weight gain or loss was the only one reported in significant numbers. They found that 34.8% of the men reported weight gain, and 5.4% reported a loss.

Lipkin and Lamb (1982), reported one man who had upper leg pain. They noted his records indicated he had had a congenital displacement of the hips and wore casts on both legs as an infant, which causes upper leg pain.

The couvade syndrome apparently includes a wide range of physical symptoms, although the most common symptoms are those which tend to mimic pregnancy symptoms,

with the exception of the couvade toothache. But it is important to remember that almost any physical symptom may be evidence of the couvade syndrome.

There is also evidence that psychological symptoms may relate to the couvade. Clearly, psychological symptoms relate to more than the pregnancy as suggested by the man above with upper leg pain (Lipkin and Lamb, 1982), but may be triggered by the pregnancy (Curtis, 1955).

## Incidence

The couvade syndrome, as distinct from ritual couvade, has appeared in a number of different cultures and has been mentioned by several writers from the seventeenth century to the present. Trethowan's review of couvade references (1972) contains a very complete list of citations. Several will be noted here. The earliest mention of symptoms of a couvade syndrome date from the early seventeenth century. Trethowan (1972) listed its mention as a phenomenon by Sir Francis Bacon in 1627, by James Primrose, a physician of 1650, and by a chemistry professor in 1677. Trethowan also noted references to an expectant father's toothache, and other symptoms made by Restoration playwrights in England during the 1680's. The toothache was noted even earlier in Westward Ho, by Dekker and Webster in 1607. "Sympathy pains" were also noted by Beaumont and Fletcher, in 1647. Trethowan's use of a quote from Robert Heath, written in 1650, appears useful,

because it refers both to the syndrome, and a psychological (i.e. non-magical) explanation.

> We observe each loving husband, when the wife
> Is labouring by a strange reciproque strife
> Both sympathising sickens: and 't may be
> In Law they're one and in Divinity.
> (Trethowan, 1972, p. 70, citing R. Heath, 1904)

Trethowan also noted that there were neither references, nor interest in either the couvade, or the syndrome from the seventeenth century until the end of the nineteenth century. He found only two studies before his own of 1965, those of Curtis (1955) and Bardhan (1964). Both studies found that a variety of symptoms, both physical and psychological, occurred among men whose wives were pregnant. Curtis (1955) reported that twenty-two (22) of fifty-five (55) expectant fathers developed various physical symptoms. But, as Trethowan points out, neither study could answer what percentage of symptoms were due to couvade syndrome, and what percentage related to other factors.

Based on several studies and literature reviews, Trethowan suggests that couvade syndrome probably affects roughly 20% to 25% of all expectant fathers. Various studies have reported incidences between 11% and 50% (Trethowan, 1972). Another study found a 67% incidence of physical symptoms (Leibenberg, 1969).

Who are the men who tend to experience and report couvade syndrome symptoms? Several studies have been

done which make it possible to relate some demographic factors to a tendency to experience couvade syndrome. Trethowan (1968) reports on several such factors in a careful comparison of three hundred twenty-seven (327) expectant fathers. He found four groups of fathers: those who had clear couvade syndrome symptoms and three other groups who reported no symptoms, one symptom, or two symptoms respectively. The couvade syndrome group was not different in average age. First-time fathers and experienced fathers showed no differences. The wives of the couvade group had had slightly fewer miscarriages, and the men had missed slightly more work due to symptoms than the three other groups of fathers. As the number of reported symptoms rose between the groups, socio-economic status fell, but not significantly.

The couvade syndrome fathers, however, differed significantly when compared in the areas of psychological factor. The more anxiety each group reported, the more symptoms they reported (48% of the no symptoms group; 72% of couvade syndrome group). But Trethowan notes this is a complex relationship. Trethowan found a similar significant relationship between reported psychiatric symptoms and couvade, with the couvade group reporting the most symptoms.

In a careful study based in North Carolina, Davis (1977) found some differences among various groups in

their tendency to develop physical symptoms during their wives' pregnancies. She questioned ninety-one (91) men from a variety of backgrounds. Each expectant father was questioned during early, middle, and late pregnancy. She found, like Trethowan (1968), that first-time and more experienced fathers did not differ in symptom formation. Fathers of unplanned pregnancies reported more symptoms than fathers of planned pregnancies. Working-class fathers and blacks had more symptoms than whites. She also found that symptoms increased as pregnancy progressed, unlike Trethowan and Conlon (1965) who found that they peaked in the third month of the pregnancy then declined until the ninth month or at the onset of labor.

Like Trethowan (1968), Davis (1977), found that symptom frequency was significantly correlated with expectant fathers' reported anxiety and depression, and inversely with their level of satisfaction with their situation. However, symptoms were not correlated with the hostility scores of expectant fathers.

Lipkin and Lamb (1982) conducted an epidemiological study of the couvade syndrome among the users of a health maintenance organization in upstate New York. They found that 22.5% of expectant fathers of the two hundred sixty-seven (267) cases they studied had couvade syndrome symptoms. As in the Davis study (1977), Lipkin and Lamb found that couvade syndrome fathers were from lower

socio-economic groups than other fathers. Unlike Davis, however, they also found couvade fathers were less experienced fathers. They found no difference among the variables of age, color, race, complications in the wife's pregnancy, and attendance of childbirth education class. The differences between the Lipkin-Lamb study and the Davis study may be related both to the sampling techniques used, and the location of the study populations. Lipkin and Lamb used a very large potential population base and careful random sampling methods which were not available to Davis, which suggests their study reflects a more accurate picture of the demographic variables related to couvade syndrome.

Lipkin and Lamb found that men with couvade symptoms increased the number of visits to physicians 100% during their wives' pregnancy, compared to men without symptoms and compared to their visits before and after the pregnancy. In addition, in a careful review of the cases by the authors, other vague symptoms were found among higher socio-economic groups. These fathers reported "feeling rundown" and "weakness." Lipkin and Lamb suggested that men in higher socio-economic groups may suffer similar incidence of the syndrome in a "more psychologically hidden or 'defended' form."

In addition to fathers affected by the couvade syndrome, Trethowan reports that other relatives and friends

may be affected. Reports of a woman's father and of a woman's children have been noted, and one case of a nurse midwife (Trethowan, 1972, p. 73).

Explanations

If the phenomenon of the couvade syndrome has been well documented, and we can answer with increasing ease both what it is and who gets it--then the real question becomes why? No one has suggested a completely satisfactory answer, and like the explanations for the couvade ritual, the explanations have been many and varied.

Trethowan, who has studied the syndrome most closely, views it as a "neurotic" equivalent of the ritual. It is related, in Trethowan's mind, to "an anxiety state precipitated by concern over their wives' pregnancies" (1972, p. 81). Such anxiety is not based on reality (i.e. complications of the pregnancy), but on irrational and unconscious elements. The insignificance of pregnancy complications as a factor in a man's couvade symptoms in the Lipkin and Lamb study (1982) supports this much of Trethowan's view. Trethowan summarizes three "most likely hypotheses" for the derivation of such elements: (1) ambivalence, including a reaction formation against repressed sadistic impulses toward the wife; (2) identification and empathy; (3) jealousy of a woman's ability to bear a child. He suggests all three factors may operate in various cases, although he notes that the hypothesis

of ambivalence and that of empathy may seem somewhat contradictory (1972, p. 87). Trethowan thus summarizes the general views expressed in greater depth by other writers.

The hypothesis that a type of "pregnancy envy" or "womb envy" may be a factor was suggested by Van Leeuwen, (1966) in an essay on the topic. Van Leeuwan suggests that pregnancy envy brings hostile feelings (based on the envy) to the fore which in turn, prompts the father to identify with his wife in her pregnant state and with her physical suffering. The man thus takes on her symptoms as a way of turning his hostile feelings toward himself, rather than toward his wife. This hypothesis is similar to those of Reik and other analysts noted in the section on the ritual, who base their ideas on general theories of ambivalence and the role of hostility.

Other hypotheses included a father's early identification with his own mother, which becomes reactivated by experiencing his wife's pregnancy (Arnstein, 1972). Another approach to the idea of identification with the pregnant wife is proposed by Jessner, Weigert, and Foy, (1970), who suggest that the pregnancy may awaken a man's feminine traits, which in turn promote his further identification with his wife. These suggestions are similar to those described for the couvade ritual above by Stoller (1973, 1975) and others.

Cavenar and Butts (1977) suggest sibling rivalry as a major factor in the reactions of some expectant fathers. Based on four clinical cases of oldest sons who developed severe psychological symptoms, during their wives' pregnancies, the authors point toward sibling rivalry between an oldest child and a later born (e.g. ten years or more) sibling as a complicating factor for some men. In one of the cases, the man had severe anxiety attacks while other cases involved more severe psychological symptoms. These cases underscore the very individual dynamics which can contribute to a man's reaction to his wife's pregnancy.

The research by Munroe and Munroe (1971, 1977), Munroe, Munroe, and Nerlove (1973), and Munroe, Munroe, and Whiting (1973), all point toward a feminine or "cross-sex" identification pattern on the part of males experiencing the couvade syndrome, or male pregnancy symptoms as they term them. Seven separate cultures have been specifically studied by the authors, using several sex identity instruments. In all seven cultures, the researchers found evidence of male cross-sex identity among men who experienced pregnancy symptoms. The cultures included American (Boston), Black Carib of the West Indies, Logoli of Kenya, (Munroe and Munroe, 1971; Munroe, Munroe, and Whiting, 1973) and two other African cultures: the Luo and Gusii, both of western Kenya who come from different language groups (Munroe, Munroe, and Nerlove, 1973).

In their various studies, Munroe and Munroe argue that the development of a cross-sex identity in men disposes them toward male pregnancy symptoms. While the research has focused on couvade rituals, the authors found extensive evidence that the symptoms are related to the factors which also help promote the institutional expression of such symptoms--the couvade ritual. While they do not go beyond an explanation of "cross-sex" identity for male pregnancy symptoms, they do point out that the basis for such an identity derives from "low male salience" in a culture that practices couvade rituals. A "low male salient" culture may practice one of several different customs which promote a boy's early familiarity with the female role, and a lack of familiarity with the male role. Munroe and Munroe, in studying the couvade ritual, found that exclusive mother-infant sleeping arrangements, and matri-residences were often found in societies with a couvade, (Munroe, Munroe and Whiting, 1973) but other customs which promote early mother-infant exclusive contact and hinder father-infant, or adult male and child contact could also contribute to cross-sex identity and a psychological predisposition toward male pregnancy symptoms.

For example, father absence due to war with a resulting mother-centered home might create such a psychological disposition. The female households among U.S. blacks,

might be another example of a situation contributing to "low male salience" for a young boy in that situation, even in an American culture which emphasizes the masculine, and has male-dominance as part of its social and economic structure. The latter factors would tend to offset an individual boy's predisposition to develop the extent of cross-sex identity which develops in cultures with an institutional couvade ritual. However, it may be that boys with individual situations predisposing them to develop couvade try to compensate for an underlying cross-sex identity in the face of American culture's masculine emphasis, by using what the Munroes (1973b) call a "defensive" or "protest" masculine posture, with exaggerated, stereotyped male behavior, and with some covert feminine traits.

In summary, several major hypotheses have been proposed to explain the phenomenon of the couvade syndrome, or male pregnancy symptoms. They are all based on psychological processes because the syndrome appears to be functional. There is no evidence known to the author of any biologically-based explanation. Recent studies of apes suggest that both biological and psychological factors influence a male ape's sexual approach to female apes, including pregnant females. The male apes approached favorite pregnant or nursing females but less often than when they were not pregnant (Allen, 1981). If apes are influenced by both biological and psychological factors,

humans may be affected by biological factors. It is possible that some behavior of an expectant father is biologically linked to his wife's pregnant condition, although certainly it would be far more open to other influences than that of apes.

The psychological reasons cited for a couvade syndrome include (1) male "womb envy," or the envy of a woman's creative capacity, (2) male feminine or "cross-sex" identity, (3) a man's ambivalence and repressed hostility toward his spouse, (4) ambivalence and repressed hostility toward the child, as a fear or retaliation for early patricidal wishes (as in the explanation for the couvade ritual), and in some cases (5) extreme sibling rivalry as a component of ambivalence toward the child and/or wife. In addition, (6) general "immaturity" has also been cited as a component in men who develop the syndrome (Trethowan, 1972). Some writers view the symptoms as expressions of a man's (7) "involvement" in the pregnancy, or of (8) a man's identification with his wife.

A few recent writers, (Davis, 1977, Wapner, 1976) have suggested that the couvade syndrome may represent a means of participation for fathers in the birth cycle, through identification with their wives. Wapner's study (1976) found that the "physical reactions" men reported correlated well with their reported interest and involvement in the pregnancy. Wapner found that 56.2% of the

expectant fathers indicated they often felt "like we are both pregnant," which indicates the involvement level reported by such fathers. This view appears to emphasize a transitory process, rather than the idea of "cross-sex identity" suggested by Munroe and Munroe (1971, 1977).

A view from a slightly different angle is suggested by a study of pregnant women by Ballou (1978). She found that wives whose husbands could take on a maternal role themselves, and support their pregnant wives in a nurturant way, appeared to help facilitate an easier adjustment for their wives as they became mothers--both during the pregnancy, and after the birth.

Wapner (1976) also found that the expectant fathers agreed with statements indicating a high "overall nurturant quality" in their relationships with their wives. They wanted to care for and protect their wives. Wapner noted the nurturant quality was missing from fathers' interview statements about their future relationships with their children.

The above findings do not necessarily indicate a man identifies with his wife in the psychoanalytic sense of the word, but that husbands who can empathize with their wives and call on their own nurturant aspects can help their wives and families more than men who cannot do so.

The study by Grossman, Eichler, and Winickoff (1980) which found that a man's identification with a "nurturantly

perceived mother" was a major predictor for his ease of transition through pregnancy and his greater involvement with his child also suggests the importance of a man's identification with a nurturant figure. But any identification of a man with his wife is unclear in its meaning for a man. Such identification may lead to either nurturant behavior, or a lack of distance, and greater dependency on her or others, which would interfere with his ability to nurture his wife.

If, in fact, the ideal husband does play a major "maternal" role, during pregnancy, childbirth, and postpartum, men who can move into such a maternal role more easily may also fulfill this role more easily and quickly. It may be that men who experience the couvade syndrome may either move toward such a role more easily or, in light of the discoveries made by the Munroes about "protest" or "defensive" masculinity among men with couvade syndrome symptoms (1973b) such men may have a more difficult time assuming the maternal role which is useful to their wife and child, and may express this conflict in terms of the somatic symptoms of the couvade syndrome--the symptoms themselves may symbolize a confusion of their role--and suggest their inability to take on a caretaking role directly. Instead, they may be taking the role of helpless, suffering woman in competition with their wives.

Another consideration for fathers is how and from whom they get emotional and psychological support during pregnancy and early fatherhood. Wandersman (1980) found that first-time expectant fathers drew on a different support network than their wives did in the weeks after the birth. While women used the support of close friends, men drew on parenting support groups significantly more than other networks and more than did their wives. The couvade syndrome may be related to a father's need for greater emotional support.

None of the explanations of the couvade syndrome are satisfactory. The Munroes have done the most work in attempting to clarify the syndrome on the basis of data, rather than theory, and have given us the most useful clues as to its basis. But there remain too many factors which are unexplained and unqualified about the syndrome.

One question which has begun to intrigue the present writer is that of its effect, in various circumstances. Might such symptoms serve to facilitate the father-infant relationship, thus bearing out Malinowski's hypothesis (1927) about the function of the ritual for binding the family together? Or, does the syndrome provide a reduced way for fathers to participate, as a compensatory mechanism for their ambivalence and sexual identity confusion? Does it in some way signal a hindrance in a couples' capacity to deal with pregnancy and parenthood, which deserves

greater attention from medical professionals trying to help families have children? If the latter is true, it would provide a very simple signal system for such professionals and might help alert the medical system to families who may need extra support and help, if those medical people know of the signal. Trying to answer these questions would help us know more about how to help couples become good parents for their children, and are therefore important questions to answer.

## F. Summary and Conclusions

It is possible to summarize the general literature on fathers and their involvement in the birth cycle, based on the above literature review. A series of propositions can be generated to summarize the information most pertinent to the present study.

1. Fathers are involved in the birth cycle psychologically.
2. Their involvement affects their wives' experiences, and may thus indirectly have some effect on their child's experience and health.
3. Fathers are, in turn, affected by their wives' pregnancy, based on their own individual psychological history, and the cultural expectations for the role of father and expectant father.

4. Contrary to earlier hypotheses, the father's involvement in the childbirth process itself appears to be extremely beneficial to all family members--the father himself, the mother, and the baby.
5. The cultural expectations for the role of father and expectant father are currently undergoing change in the direction of increased paternal involvement in the birth cycle, and increased proximity with the baby at and after birth.
6. About one or two out of every nine to ten American fathers can be expected to develop some form of male pregnancy symptoms or couvade syndrome, as part of his experience of his wife's pregnancy.
7. The couvade syndrome is more likely to be found in men who have the following features:
   a. Men who report more anxiety and depression.
   b. Men who report less satisfaction with their situation.
   c. Men with unplanned pregnancies.
   d. Men who are black, and/or in lower socio-economic situations.
   e. Men who have more cross-sex identification, or covert "feminine identification."

f. Men who experienced "low male salience" during their early childhood--which could have involved either father absences, or another form of mother and/or feminine dominance during early childhood, especially during the first three to five years.

8. The couvade syndrome appears unrelated to fatherhood experience (i.e. first time versus experienced fathers. Experience has also been found to be unrelated to reported anxiety.)
9. The couvade syndrome is likely to form one of a variety of (incidence-frequency) patterns, based on man's background. A peak of symptoms may occur during the first, second, or third trimester.
10. The couvade syndrome can be manifested in a very wide range of physical, and probably psychological symptoms.
11. The most likely couvade syndrome symptoms include:
    a. gastro-intestinal complaints
    b. appetite and weight changes
    c. changes in sleep patterns and experienced energy
    d. body aches and backaches
    e. toothaches

It is possible for skin problems, eye problems, breathing problems, mood changes and emotional problems, and other symptoms to be manifestations of the syndrome.

## G. Statement of Hypotheses

Specific research hypotheses have been developed to guide part of the study, based on the general conclusions drawn from the literature, and the specific instruments proposed for the study. Hypotheses were confined to the couvade syndrome. They were not developed for other aspects of the study because other exploratory methods were used. Hypotheses will be listed following a discussion of the implications of both the study purposes and the literature review.

The purposes of the study include exploration of various aspects of expectant fatherhood, especially exploration of two ways the father may physically involve himself in participation in the pregnancy and birth event--(1) couvade syndrome symptoms (a man's reaction to his spouse's pregnancy) and (2) approaches to childbirth participation. These two aspects were explored both as separate phenomena and as potentially related to each other as possible manifestations of the couvade ritual.

The literature on both the ritual and the syndrome can lead one to view recent socio-medical trends

encouraging father participation at birth as a possible new birthing ritual--one in which fathers play a major, direct role, as they do in the couvade ritual itself. The opprobrium the symptomatic father generally receives in the couvade syndrome literature and the encouragement the attending father receives in the father childbirth participation literature may reflect current social sanctions that fathers are subject to directly (i.e., from family, peers, society). Such sanctions may encourage the replacement of the more discouraged symptoms of the couvade syndrome with a new "ritual"--father-attended childbirth.

Another possibility is that the sanctioning of one aspect (father-attended birth) will allow for the greater expression of the second less sanctioned aspect (couvade syndrome). The latter might occur especially if expectant fathers were expected to "participate" more fully on "both" sides of the birth event itself, by their wives and by their society. The shift in the position of writers discussing fathers at childbirth suggests that it is entirely possible for a similar shift to occur for "male pregnancy symptoms."

While the implications of the couvade syndrome may change, the hypotheses developed for the present study were derived from the predominant literature which views the syndrome as a problem. If hypotheses which suggest that the couvade syndrome is a pathological phenomenon are

supported, the predominant view of the literature is supported. If such hypotheses are not supported, it may be increasingly possible to clarify healthier aspects, or views of such physical reactions. It is not the purpose of the present study to define the couvade syndrome as desirable or undesirable, healthy or unhealthy, but simply to explore further some implications of the literature.

Clinical instruments were chosen to clarify indications of poorer personal adjustment among couvade syndrome fathers if there are any, and to compare such men with low symptom fathers.

The hypotheses relate specifically to the following items in the literature:

1. Men who have the couvade syndrome are likely to report more anxiety and depression compared with other men.
2. Men who have the syndrome are likely to report less general satisfaction with their situation.
3. Men who have the syndrome are more likely to have conflicts in the areas of sexual identity (cross-sex identity), and relationships with women (possibly hostility toward them). They are also more likely to be "generally immature," which may imply more impulsivity, more conflict with authority figures, more dependency on

parental figures, and possibly more ego-centric thinking.

4. Men who have the syndrome are more likely to report more early father absence or less father involvement (low male salience) compared with other men. They are more likely to report more feminine or more "hyper" masculine interests.

The hypotheses for the present study are as follows:

1. Fathers reporting couvade syndrome symptoms will have more elevated scores than fathers reporting few or no symptoms on selected MMPI scales. Couvade syndrome fathers will have either much higher or much lower scores on the 5 (Mf) scale than a-symptomatic fathers. Asymptomatic fathers will have middle range scores on the 5 (Mf) scale. Couvade fathers will have a lower score on the ES (ego strength scale).
2. Couvade syndrome fathers will report more pre-oedipal themes on the Early Memories Test compared with asymptomatic fathers.
3. Couvade syndrome fathers will report frightening (phobic), and/or hostile themes in their Early Memories Test, especially around female figures, compared with asymptomatic fathers.

4. Couvade syndrome fathers will report significantly more early father absence in terms of length of absence and incidences of family disruption and father absence compared with asymptomatic fathers.

# CHAPTER III

# METHODS AND PROCEDURES

## A. Design

Limitations necessarily delineate any research project. The research design for the present study involves retrospective self-report, plus data obtained from two psychological instruments, to clarify personality variables and symptom manifestation of the expectant fathers included in the study. The design involves a comparison of a generally homogeneous group of expectant fathers (except for the independent variables), based on information obtained during the third trimester of the pregnancy.

Fathers were compared for incidence of the couvade syndrome. Questionnaire data from a general questionnaire, and data from the Early Memories Test was compared for high and low symptom group fathers, on a number of variables relating to family background and personality variables. In addition, expectant fathers were compared for their approach to the decision to participate in the childbirth process. Interview data for twenty-one (21) fathers were analyzed to develop a qualitative description of the phenomena of "anticipating childbirth" for the expectant father.

Data were collected during the third trimester of pregnancy to obtain maximum data on symptom manifestation. Studies of the couvade syndrome suggest that some fathers do not develop symptoms until the third trimester (Davis, 1979; Trethowan, 1972). The third trimester is also a time of anticipation and preparation for the birth (Heinowitz, 1977). Fathers were expected to be most focused on the birth, and to have more intense feelings and images around it which could be elicited in the interview for a phenomenological analysis of "anticipating childbirth" for the father. Also couples have usually reached a decision about the father's involvement at the birth during the third trimester. Therefore, questions to fathers about the decision would be expected to elicit a recollection and attitudes about the decision, rather than influence the decision-making process itself.

## B. Procedures

The investigator contacted area obstetricians and LaMaze educators by telephone and in person. They were asked to give interested patients/clients a consent form/letter about the study. If the wife signed a consent form (Appendix A), she took a second consent form (Appendix B) to her husband. Husbands were contacted directly in LaMaze classes. The investigator collected the forms from subjects and from offices. She then

contacted potential subjects by telephone to screen subjects with general questions and arrange for later appointments.

The subjects were asked to provide informed consent after discussing the study with the investigator. They were given the Minnesota Multiphasic Personality Inventory (MMPI) and a questionnaire asking about family background, health history, and basic demographic data (General Information Form, Appendix E). After filling out the two forms, each father was asked to report three early memories, which were tape recorded and written in note form by the investigator. Fathers were interviewed at the same time by the investigator. The interview followed a semi-structured interview protocol (Appendix G) addressing the following areas: images of birth, decision about participation in the birth, current relationship with parents, general health, and "sympathy pains."

Because so many subjects were drawn from LaMaze classes, and were volunteers, the sample of fathers is representative only of fathers who are willing to participate and interested in talking about their experiences. For two LaMaze groups, the entire group volunteered and therefore men were included who appeared less interested in the classes than some of their peers. But the sample limitation is important to keep in mind.

## C. Sample

A total of forty-four (44) expectant fathers were recruited using the above procedures to serve as subjects. The fathers who volunteered were from a range of socio-economic classes and educational levels. These two factors have been identified as significant in symptom manifestation of the couvade syndrome (Davis, 1977; Lipkin and Lamb, 1982). Therefore, the three symptom groups were compared for such differences using the chi-square test (see Table 2, 17, Appendix H). The lack of significant difference among groups suggests they were not factors for the independent variables. Experience of fathering was noted, but not matched, because it has been found insignificant in studies on anxiety and/or symptom manifestation (Davis, 1977; Lipkin and Lamb, 1982; Trethowan, 1972).

The sample was recruited in the Knoxville area. LaMaze childbirth classes, and two private obstetrical practices were the sources for all subjects.

The sample included forty-four (44) expectant fathers living in Knoxville, Tennessee and surrounding counties. Five (5) fathers were recruited through private physicians and thirty-nine (39) fathers volunteered through LaMaze childbirth classes. All were married and living with their wives. Forty-three (43) fathers were white, one was black. Their ages ranged from 21 through 36, with a mean age of

27.8 years. Their educational level ranged from some high school completed through graduate degrees. A total of 51% (22) of the fathers held a college degree only, making the total of college graduates 71% (31) of sample fathers. Fathers' reported incomes ranged from below $8,000 per year to over $51,000 per year (for 1981-1982). Nine (9) fathers or 21% had incomes below $12,000 per year; eleven (11) fathers (25%) had incomes between $12,000 and $20,000 per year. Eighteen (18) fathers or 42% had incomes between $21,000 and $50,000 per year, while five (5) fathers or 12% had incomes over $51,000 per year. Questionnaire and MMPI data are missing for one subject, so a total of forty-three (43) subjects will be found for a number of descriptions. Fathers had all been married between five months and thirteen years, with the average length of marriage four and two-tenths (4.2) years. Thirty-two (32) fathers had no children or step-children, while eight (8) fathers had natural children only, and three (3) fathers had stepchildren only. Therefore, thirty-five (35) fathers were expecting their first child while eight (8) fathers were expecting their second or third child. Due dates for childbirth ranged from November through June. It is not known what effect time of the year had on the fathers, if any.

## D. Instruments

Data and information for the proposed study were gathered using three types of instruments: (1) self-report questionnaire (MMPI and General Information Form), (2) projective technique (Early Memories Test), and (3) semi-structured personal interview.

By using three different methods of data collection, the investigator expected to gain a richer and more reliable information basis for each father. Because there are so many unknown aspects of an expectant father's experience, and because of limitations for any one type of data collection technique, it was hoped that this approach would yield more meaningful information about expectant fathers, and the couvade syndrome.

Each instrument in itself is both fairly simple and straightforward in terms of administration, and each method has been thoroughly tested for its particular validity and reliability.

### Self-Report Instruments

MMPI. The MMPI is a clinical self-report instrument which has been used with a variety of populations for over twenty (20) years. The thirteen (13) standard validity and clinical scales and one well-tested experimental scale, the "ego strength" (ES) scale, were used in the

present study. See Appendix C for further information on the MMPI and its use among populations related to pregnancy.

In addition, the MMPI is a useful instrument for use in the investigation of the couvade syndrome because it contains numerous questions on a wide variety of physical symptoms, including nearly all of the most common symptoms of the syndrome. Forty-seven (47) items are related to the most common couvade symptoms while thirty-eight (38) items relate to other physical conditions (although, as the literature suggests, any physical symptom may be part of the syndrome). Because the questions are embedded within the instrument, they may elicit a higher response rate. At least one study of expectant fathers found that it was necessary to use health questions scattered among other questions to elicit more accurate responses on such questions (Wapner, 1975). Thus, the MMPI effectively combines a wide list of physical symptoms, and a clinical instrument of accepted validity and reliability for use as a rough measure of broad personality traits and general emotional health.

Socio-Demographic Questionnaire. The second self-report questionnaire is a four page typed form (see Appendix E). Fathers were asked to report general socio-demographic data (age, education, occupation, income level,

race, religious preference, ethnic background), number of siblings, birth order position, length of marriage, number of children, other known pregnancies, background information on the father's family (parent occupation information, any early separations from mother and/or father, estimate of the dominant parent, parent father felt closest to, feels closest to now, family pets and their relationship to father), and brief health history of the father (general health before pregnancy and during pregnancy, chronic health problems, number of visits to doctors, dentists, obstetricians before and during pregnancy). The data from the questionnaire provided background information and helped identify variables which might affect symptom manifestation. It also provided a measure of control for men with a physical condition prior to the pregnancy who might otherwise have been counted as having the syndrome.

## Projective Techniques

Early Memories Test. Early memories have been chosen for the present study for several reasons. They are easily administered, and appear less intrusive than other techniques, yet yield rich and valuable information about the way a person views himself and others in direct and expressive terms. Early memories, in Mayman's words, can provide "reconstructions of 'intrusive interpersonal themes which define that person's enduring expectations of

others,'" (1968, p. 304, 1974, p. 445) without the complications of time or intrusion of other techniques. Early memory productions were scored using Mayman's techniques (Mayman, 1968). See Appendix F for additional information on Early Memories as a projective technique.

Except in individual case studies, early memories have not been used to a large extent in studies centering on family relationships. Ballou's study of pregnant women (1978) is one major study which does use early memory data in looking at themes of reconciliation between pregnant women and their mothers. Her study of twelve (12) women in their first pregnancy used Mayman's analysis of early memories, with special attention to the object relations of the subjects. She found that early memory productions, along with other projective techniques, and extensive interviews, helped contribute to a rich picture of the sense the women in the study had of themselves, and of their important relationships with their mothers, husbands, and the growing relationships with their babies.

Procedure for eliciting early memories was as follows: Fathers were asked for memories at the beginning of the interviews. The investigator said: "Now, I would like you to think back to when you were very little and tell me about the first thing you remember." Fathers were asked to elaborate memories which were vague, after their response. They were asked to report three memories.

Early Memory responses were elicited at the beginning of the interview, and were usually five to ten minutes in length.

Semi-Structured Personal Interview

Fathers were asked a series of open ended questions during a personal interview with the investigator. The interviews were tape recorded, and transcribed for later analysis. The questions (see Appendix G) included the following specific topics: (1) images and feelings about the birth; (2) decision about participation at birth; (3) changes in relationship with parents during the pregnancy; (4) father's health during pregnancy; (5) father's understanding of "sympathy pains." The specific responses of each father determined the direction and content area of subsequent follow-up questions for that subject area. If some areas did not emerge in the father's response, such as any hesitations he had about participating in the birth, for example, he was asked about them specifically. Total interview times were a half-hour to an hour in length including Early Memory responses. The average length was about 40-45 minutes, with the above responses averaging about 30-35 minutes. The first two interview questions elicited the longest responses, usually about 20 minutes long.

## E. Analysis of the Data

### Statistical Analysis

For the purposes of the present study, the couvade syndrome was defined by two criteria, both based on self-report items. They were: (1) a score of 22% or above on a specific couvade syndrome scale on the Minnesota Multiphasic Personality Inventory (MMPI) and (2) the father's description of his health during and before the pregnancy.

The specific couvade syndrome scale was made up of forty-seven (47) standard MMPI items, plus two additional items (See Appendix D). This scale was devised by the investigator based on a compilation of couvade symptoms found in the literature. Of the items used for this scale, some items overlapped with other scales. The couvade (CVD) scale and the Ego Strength (ES) scale had eight (8) common items scored in the opposite directions: the number of common items is no greater than the items in common between ES and scales 2 (8 items), 3 (9 items) and 7 (9 items). Items common to CVD and other scales are as listed in Table 1.

Although some scales contained a large number of items in common with the CVD scale, an examination of individual scores, especially extreme scores on the clinical scales, did not indicate any direct or simple correlational relationship.

TABLE 1

NUMBER OF ITEMS COMMON TO CVD AND OTHER MMPI SCALES

| MMPI Scale | Common Items to CVD Scale |
|---|---|
| L | 0 |
| F | 2 |
| K | 1 |
| (1) Hs | 18 items scored the same |
| (2) D | 13 items scored the same, 1 item scored opposite |
| (3) Hy | 15 items scored the same, 1 item scored opposite |
| (4) Pd | 2 items scored the same |
| (5) Mf | 1 item scored the same |
| (6) Pd | 2 items scored the same |
| (7) Pt | 8 items scored the same |
| (8) Sc | 9 items scored the same |
| (9) Ma | 9 items scored the same |
| (10) Si | 3 items scored the same |

Another scale of thirty-eight (38) standard items on the MMPI was also devised which listed physical and emotional symptoms which are not generally associated with the couvade syndrome but which might be checked by subjects who were anxious and/or especially concerned with their health. The non-couvade items were intended for use as a parameter or basis for comparison with the couvade item list. Expectant fathers who scored higher on the couvade list also tended to score higher on the non-couvade list, but the couvade scores were always a higher percentage.

In addition, all fathers beyond the first thirteen were asked about their health during the interview, after completing the MMPI. This additional information often verified the presence of symptoms and, in some cases, provided useful information about the father's own understanding of his symptoms. Such cases also confirmed the identification of couvade syndrome, especially among the fathers who remembered similar symptoms during previous pregnancies.

Further information was obtained by questionnaire about the father's visits to doctors, dentists and other therapists before and since the pregnancy. These data were also used as data reflecting the couvade syndrome (especially in light of a recent study on inappropriate treatment and medication of expectant fathers, (Lipkin

and Lamb, 1982), and were compared to the visits an expectant father made to the obstetrician and/or nurse-midwife during the pregnancy.

Using the couvade syndrome item scale, two groups of expectant fathers were found who had high and low couvade syndrome scores. The additional data from interviews and questionnaires were used to verify and confirm this criteria. Subjects for the three groups were determined primarily on the basis of their CVD scale score. Subjects who had a chronic or acute physical problem were not included in the couvade group--although such men usually had scores in the middle range. There were three such cases, and they were not in the high symptom group. In two cases the father reported mild symptoms or a specific couvade-like symptom during the interview, but did not have high scores on the MMPI couvade scale. These two cases were included in the group into which their score placed them. Neither of them was in the high symptom group.

The data from the MMPI, General Information Form, some Early Memory data and categories derived from interview data were analyzed using analysis of variance for continuous variables (numbers), and chi-square for discrete variables (categories).

In addition, coding of MMPI scores was done by the investigator for individual profile configuration, using standard clinical procedure for creating individual

profiles. Analysis of such profiles was done by the investigator according to standard MMPI profile interpretation techniques.

## Descriptive Analysis

A descriptive analysis of father's reports about birth participation was done using data gathered from interviews. The entire set of transcript data was read carefully in an attempt to learn how various fathers described their decision. The actual interviews, and the investigator's sense of the fathers during the interviews, were kept in mind during the reading process. With careful reading, comparing, and close inspection of the interview material, the investigator discovered that the father's descriptions fell fairly neatly into three major groups. A fourth group was formed by the result of their decision not to participate. The four groups were given descriptive labels by the investigator and were included in the statistical analysis. The groups, according to their initial general approach to the decision of birth participation were: (1) eager, (2) willing, (3) reluctant, (4) non-attending.

## Phenomenological Analysis

Phenomenological analysis involves both an attitude and a procedure which differ from above analytical methods. Phenomenological analysis involves the investigator of the

study as a participant, who enters the world view of a person describing his experience, and attempts to understand the meaning of the described experience. In describing phenomenological methodology, it is important to describe the investigator's views of the phenomena being "looked at." Therefore, a description of the investigator's view will follow a description of the methodology used.

The phenomenological part of the study was initiated formally after several interviews and is based on twenty-two (22) interviews plus interview responses from earlier fathers as they were appropriate. Each father was asked an initial question, and then engaged in a dialogue with the interviewer to clarify and elaborate the ideas and feelings of his response. The question was: "What are your thoughts, feelings, images and ideas about the birth of the baby?" The specific experience of the expectant father's "anticipating childbirth" is the phenomenon chosen for attention in this study. As such it is only one aspect of a much larger phenomenological field. But its limited focus allows for a greater depth of understanding for the particular experience of anticipation of an expectant father in the last few weeks, or days before the birth of his child. Other studies have explored the expectant father's experience during pregnancy and childbirth (Heinowitz, 1977; Viesti, 1980), including one using

a phenomenological approach (Heinowitz, 1977). Therefore, exploration of specific aspects of an expectant father's experience may further illuminate the experience. The particular experience of anticipating during the third trimester of the pregnancy would seem to be of special interest. It is a time of "anticipation" and "preparation" (Heinowitz, 1977). It is a time when a man may develop physical symptoms related to the pregnancy (Davis, 1977; Gurwitt, 1976; Trethowan, 1972), in addition to emotional reactions (Curtis, 1955; Gurwitt, 1976). Gurwitt's account of an expectant father's analysis especially emphasizes the psychological "work" of the third trimester for his patient, who "mostly in the third trimester, . . . had the intense experience of powerful magic forces being at work" (1976, p. 267). The third trimester is a special time during the pregnancy, and an appropriate time to explore the themes that emerge and define the experience of the very expectant father.

Qualitative analysis of the data. Analysis of each man's protocol (interview transcript) was performed to expand and articulate the phenomena of "anticipating childbirth" for the father. A model described by Paul Coliazzi (1978) has been used as a guide for the present analysis.

1. Initial Reading. Each protocol was read and studied, with an attempt to remember qualities within the interview experience.

2. Extracting Significant Statements. Each protocol was divided into separate thought groups. They were culled for phrases and statements that pertained to "anticipating childbirth." A list of significant statements was created for each father.

3. Formulating Meanings. The meaning, beyond the statements, was clarified and elaborated for each significant statement for all protocols. Every attempt was made to fully articulate the richness of the ideas, without moving beyond the meaning of the original protocol. This process often involved full elaboration of connotations and nuances held within the original protocol, which itself was held within the rich dialogue between two people.

4. Clusters of Themes. All meaning statements were placed on index cards and organized into clusters of themes. The themes were referred back to the protocols for validation. All statements in the protocols were reread to ensure that the themes included all relevant statements, and that they did not include themes which were not part of the original protocols.

5. Exhaustive Description of the Phenomenon. After validation of the themes was completed, a full

description of the phenomenon of "anticipating childbirth" was written, to include all theme descriptions.

6. Statement of Identification of the Fundamental Structure. This process involves tightening the exhaustive description, without losing meaning and richness, into an unequivocal statement of descriptive identification of the fundamental structure of the phenomenon of "anticipating childbirth" for the father.

Description of the investigator's views. The idea of my studying expectant fathers began during coursework on family and the life-cycle. The transition to parenthood literature was especially interesting to me because my husband and I were considering having a baby. During the course, I learned that we were going to have a baby, and pregnancy became an object of both personal interest, and great emotional involvement. In reading literature about pregnancy and parenthood, I found that there was very little literature on fathers, in contrast to that on mothers, so it would be a useful topic to explore. I also discovered that I did not want to read about the woman's experience of pregnancy and motherhood because I did not want to compare myself and my experience with professional literature or someone's idea of motherhood. I also did not want to distance myself from my experience by looking at it with my "professional eye." So, I turned to the literature on fathers and pregnancy.

As I became aware of the literature on expectant fatherhood, I found various areas that interested me. I was interested in the couvade syndrome, in which a man's experience of expectant fatherhood appears to touch close to that of a woman's. I was also interested in the recent trend toward a father's participation at birth. My own father had aided at my birth, and had delivered my brother, so I grew up with stories of how exciting and wonderful childbirth was. Fathers at childbirth were not foreign to me, but part of my past. I had also become interested in how the "other" (i.e., male) experiences what I had experienced, that is, how a father experiences something that, from a woman's perspective is so totally bound up with one's body and biological processes that another view, is almost unimaginable. I was aware of my own experience, and also found myself wondering how a man experiences the birth of his children--surely differently, yet there would be similarities. I realized that as a psychologist I would have access to some of the ideas and thoughts of a range of expectant fathers. The phenomenological method is especially useful for my task because it creates a framework in which to work at the imaginative art of understanding another's experience, even experience that is beyond one's own capacities.

# CHAPTER IV

## RESULTS: ANALYSIS OF THE DATA

Data obtained from expectant fathers was analyzed in three ways: statistically, descriptively for approach to birth participation, and phenomenologically for themes. Statistical analysis was used for analysis of the data as they related to the couvade syndrome and to fathers' attitudes toward participation at childbirth. A descriptive analysis of father's statements and interview data yielded categories of the range of approaches fathers expressed about attending the birth. A phenomenological method was used inductively to elucidate themes related to expectant father's view of the upcoming birth and to expectations about childbirth itself.

The data and analysis relating to the couvade syndrome, which is primarily statistical, will be presented first.

### A. Statistical Analysis: The Couvade Syndrome

For purposes of the present study, the couvade syndrome was defined by two criteria, both based on self-report items. They were: (1) A score of 22% or above on a specific couvade syndrome scale on the Minnesota

Multiphasic Personality Inventory (MMPI) and (2) the father's description of his health during and before the pregnancy.

A total of fourteen (14) expectant fathers obtained scores above 22% (11 items). Sixteen (16) expectant fathers obtained scores of 10% (5 items) or below. Another group of thirteen (13) fathers had scores in a middle range of 12% to 20% (6 to 10 items). The number of items for each group was arbitrarily set at 25% and 10% before data were collected, and the upper item limit was moved one item lower after initial data were collected. No father had a score of 0.

Although two groups were originally planned, the data produced three groups so neatly that data from all three groups were analyzed for comparison. The range of scores also suggests that the couvade syndrome may include a broad range of manifestations and may be a far less discrete entity than earlier literature suggests. Lipkin and Lamb (1982) suggest similar possibilities (i.e., both a range of manifestations and a larger percentage of fathers affected than past studies would suggest).

Demographic Data

The three symptom groups are similar in their general background characteristics. Table 2 provides a summary of the data. Significant differences were not found in comparing the average age of fathers, their socio-economic

TABLE 2

DEMOGRAPHIC DATA FOR COUVADE SYMPTOM GROUPS

| Variable | High | Medium | Low | Total |
|---|---|---|---|---|
| No. of Fathers | 14 | 13 | 16 | 3 |
| Mean Age | 27.6 | 27.3 | 28.5 | 27.8 |
| Mean Years Married | 3.4 | 4.4 | 5.1 | 4.3 |
| **Education Level** | | | | |
| Some H.S. | 1 | 0 | 0 | 1 |
| Completed H.S. | 5 | 2 | 4 | 11 |
| Completed College | 6 | 9 | 7 | 22 |
| Grad/Prof. School | 2 | 2 | 5 | 9 |
| **Income Level** | | | | |
| Below $11,000 | 4 | 0 | 5 | 9 |
| 12 - 20,000 | 4 | 4 | 3 | 11 |
| 21 - 40,000 | 5 | 7 | 6 | 18 |
| 40 - 75,000 | 1 | 2 | 2 | 5 |
| **Religious Affiliation** | | | | |
| Baptist | 5 | 4 | 4 | 13 |
| Other Protestant | 5 | 8 | 5 | 18 |
| Roman Catholic | 2 | 0 | 2 | 4 |
| Jewish | 0 | 0 | 2 | 1 |
| Atheist/Agnostic | 1 | 0 | 2 | 3 |
| Other | 1 | 1 | 2 | 4 |
| **Religious Practice** | | | | |
| Active | 3 | 6 | 4 | 13 |
| Moderate | 6 | 6 | 4 | 16 |
| Little | 5 | 1 | 8 | 14 |
| **No. of Children** | | | | |
| 0 | 11 | 10 | 11 | 32 |
| 1 | 3 | 2 | 4 | 9 |
| 2 | 0 | 1 | 1 | 2 |

TABLE 2 (continued)

| Variable | High | Medium | Low | Total |
|---|---|---|---|---|
| Planned Pregnancy | | | | |
| Yes | 7 | 11 | 12 | 30 |
| No | 7 | 2 | 4 | 13 |
| Feelings Toward Pregnancy | | | | |
| Very Happy | 12 | 9 | 14 | 35 |
| Somewhat Happy | 1 | 4 | 1 | 6 |
| Other | 1 | 0 | 1 | 2 |

levels, or education levels on chi-square tests ($p > .05$, see Table 16, Appendix H). A wide range of income levels and educations levels was evident in all three groups. Symptom groups did not vary significantly in terms of religious affiliation or level of participation in it, in number of children, or in planning of the pregnancy and reported feelings about the pregnancy for the three groups, or for high and low symptom groups on chi-square tests ($p > .05$, see Table 17, Appendix H).

MMPI Data

In a comparison of scores on the MMPI, the group scores on several scales did show differences that supported the hypothesis.

Hypothesis 1. Fathers reporting couvade syndrome symptoms will have more elevated scores on selected MMPI scales than fathers reporting the most extreme range of scores (higher and lower) on the scale 5 (Mf) than nonsymptomatic fathers, whose scores will fall within the middle range. Couvade fathers will have lower ego strength (ES) scale score than low symptom fathers.

As can be seen on Table 3, the high symptom group had mean scores which were higher than low symptom fathers on all MMPI clinical scales except scale 9 (Ma). High symptom group means for validity scales L and K were lower than

TABLE 3

MEAN SCORES FOR SYMPTOM GROUPS ON THE MMPI

| MMPI Scale | High | Medium | Low | Total Group | F-Values |
|---|---|---|---|---|---|
| L | 2.9 | 2.3 | 4.7** | 3.4 | 5.040** |
| F | 7.6* | 5.2 | 4.8 | 5.8 | 3.708* |
| K | 12.3* | 14.8 | 17.4* | 15.0 | 4.282* |
| (1) | 14.9* | 11.5 | 11.3 | 12.6 | 5.798*** |
| (2) | 22.1** | 17.8 | 17.6 | 19.1 | 5.602 |
| (3) | 20.1 | 18.7 | 18.6 | 19.1 | 0.788 |
| (4) | 24.2 | 21.7 | 21.8 | 22.6 | 1.301 |
| (5) | 27.4 | 24.7 | 26.2 | 26.1 | 1.340 |
| (6) | 11.6 | 10.1 | 10.0 | 10.6 | 1.187 |
| (7) | 27.8* | 24.3 | 22.9* | 24.7 | 3.505* |
| (8) | 26.1 | 26.0 | 23.1 | 25.0 | 1.096 |
| (9) | 19.9 | 21.4 | 20.4 | 20.5 | 0.439 |
| (0) | 22.7 | 21.6 | 20.6 | 21.6 | 0.336 |
| (ES) | 44.8** | 48.5 | 50.3 | 58.0 | 9.490** |
| ES t scores | (54) | (59) | (62) | (59) | |
| (NCVD) | 8.1** | 4.8 | 4.3 | 5.7 | 10.382** |

All scores used were K-corrected raw scores.

*Significant at .05 level on a one-way analysis of variance (see Appendix H for ANOVA Tables); indicates score was significantly different from the other two scores as determined by the Duncan Multiple Range Test.

**Significant at .01 level on a one-way analysis of variance (see Appendix H for ANOVA Tables); indicates score was significantly different from the other two scores as determined by the Duncan Multiple Range Test.

***Significant level may be related to non-independence of variables.

low symptom group means. Mean scores for all three groups were compared using a one-way analysis of variance (See Table 3, and Table 10, Appendix H). Table 2 indicates the mean scores for high, medium, and low symptom groups, and for the total group on the MMPI (group profiles are presented in Figures 1, 2, 3, 4, and 5, Appendix C).

Significant differences were found in the hypothesized direction for three (3) clinical scales as well as for the ego strength (ES) scale. Clinical scales (1), (2), (7) were significant at the .05 level. (Scale (1): $F = 5.798$, df = 2, 40, $p = .0061$; Scale (2): $F = 5.602$, df = 2, 40, $p = .0072$; Scale (t): $F = 3.505$, df = 2, 40, $p = 0.396$, see Table 11, Appendix H for summaries of the analyses.) The ES scale was also significant ($F = 9.490$, df = 2, 40, $p = .0004$). In addition, a Duncan Multiple Range Test was performed on the significant scales. On the test, mean scores for high symptom fathers differed from the other two groups for Scale (1), (2), (7) and (ES). Differences were not significant for other scales, although mean score differences were in the direction of the hypothesis.

In addition, father's scores on a list of symptoms which were not related to the couvade syndrome were also examined. The mean scores for the non-couvade symptom list was significantly related to symptom groups as listed on Table 3 ($F = 10.38$, df = 2, 40, $p = .0002$).

There were no significant differences found between groups on the specific MMPI items, "child interest" (1 item) (chi-square = 3.627, df = 2, p = 0.16), or "doctor fear" (1 item) (chi-square = 0.095, df = 2, p = 0.95, see Table 16 and 17, Appendix H). Although not statistically significant, some score patterns are of interest. Scores for "child interest" (which is also an item for Scale 5), indicated on Table 4, showed a pattern which suggests that high symptom fathers and low symptom fathers may differ in some interests related to children.

TABLE 4

CHILD INTEREST SCORES FOR SYMPTOM GROUPS

| | Child Interest Item | |
|---|---|---|
| Group: | Number of Fathers with Item Left Blank | Number of Fathers with Item Checked |
| High symptom | 10 | 4 |
| Medium symptom | 6 | 7 |
| Low symptom | 6 | 10 |

It is also interesting to note that the "doctor fear" item was extremely evenly distributed throughout all groups, suggesting the absence of relationship between a fear of doctors and reluctance to attend the birth.

Early Memory Data

Hypotheses 2 and 3 related to early memory data.

Hypothesis 2. Couvade syndrome fathers will report more pre-oedipal themes on the Early Memories Test than asymptomatic fathers.

Hypothesis 3. Couvade syndrome fathers will report more passive, frightening (phobic), and/or hostile themes in their Early Memories Test, especially around female figures, than asymptomatic fathers.

There were no significant differences found among the three groups, for any of the hypotheses related to Early Memory data (see Tables 13 and 14, Appendix H for summary of data). Themes related to punishment and injury themes were evenly distributed among memories of all groups (Hostility in Memory A: $x^2 = 2.702$, df = 2, p = .25; B: $x^2 = 0.439$, df = 2, p = .80; C: $x^2 = 0.734$, df = 2, p = .69). There were no differences in number of males or females in memories (Memory A: males, $x^2 = 4.000$, df = 6, p = .67; females, $x^2 = 1.333$, df = 4, p = .85, see Table 14, Appendix H). In fact, only one pattern could be detected for memory scores: high and low symptom groups had an approximately equal number of active and passive themes scores, whereas the middle group had approximately three times more active than passive theme scores (15 active scores to 6 passive scores for middle group

compared with 14:12 active:passive for the high group and 13:13 for the low group).

Family Background Data

The three symptom groups were also compared on various questions related to their family background to explore possible factors which have been suggested by the literature on the couvade syndrome. Hypothesis 4 relates to such questions.

Hypothesis 4. Couvade syndrome fathers will report significantly more early father absence in terms of length of absence and incidences of family disruption and father absence than asymptomatic fathers.

There were no significant differences found among groups for any of the family background variables related to early father absence or family disruption ($x^2$ = 1.333, df = 4, p = .85) (see Tables 15 and 17, Appendix H for data on family background).

Four men reported early separation from fathers: these were distributed throughout the groups. There were no significant differences for mean ages at the time of separation (on one-way analysis of variance, $F$ = 42.250, df = 2, 1, p = 1.081) or for the mean lengths of separation from fathers ($F$ = 0.194, df = 2, 1, p = .8389); or the type of separation (military service, parental separation, or stay with relatives) ($x^2$ = 5.000, df = 4, p = .28).

One variable approached statistical significance. Men reported on major family disruptions (death of a parent, divorce, major illness of parent) which changed their family living situation. The mean age for the change varied for the groups, although not significantly. For seven reported family changes, the mean ages for each group were as follows:

| | |
|---|---|
| High symptom | 16.3 years (N = 3) |
| Medium symptom | 11.5 years (N = 2) |
| Low symptom | 20.5 years (N = 2) |

* $\underline{F}$ = 4.823, df = 2, 4, p = .0859, (see Appendix H).

There were no other differences of note for types of family disruptions, or for reported deaths of parents (Father's death: $\underline{F}$ = 0.037, df = 2, 4, p = .9643; Mother's death: had too few cases [N = 3] for analysis).

In addition to family situation data, fathers were asked to report on their perceptions of their parents. Ideas for the following items were first developed by Moore (1975). Moore explored the perceived closeness to parents that fathers and expectant fathers reported as a child and currently to each parent. He also asked his subjects how much energy each parent invested in the man's upbringing. Moore found no significant differences for couvade and non-couvade expectant fathers for the questions he asked, although the direction of his data supported a hypothesis of their relationship to the syndrome. His suggestions for further exploration of these areas was used as a guide in the present study. No

statistically significant findings were discovered in the present study for the closeness and energy items, but some patterns are of interest.

Most fathers reported feeling closer to their mothers as a child (72%, N = 31), although some felt closer to their fathers (19%, N = 8). One group, all low symptom fathers, could not choose between their parents and went beyond the two answers of the questionnaire to report equal closeness to parents (9%, N = 4). This last group's responses approached the level of statistical significance on a chi-square test ($X^2 = 8.82416$, df = 4, p = .0656, see Appendix H). In later analysis, the same four fathers also belonged to the second, or willing, category of fathers. Thus, they form an easily identifiable subgroup within two major variables of the study.

A careful inspection of individual responses and statistical analysis was done for reports of parent "closest to now" (see Table 15 and Table 17, Appendix H for summaries of this data). Most fathers, in all three groups, if they shifted, shifted to feeling closer to fathers "now," or equal closeness to both parents "now." There was no difference among the groups for "closer now." Men in all three groups tended to shift to feeling closer to father "now." Medium symptom group fathers reported feeling closer to their fathers slightly more as a child, and thus had slightly fewer scores in the closer

to mother "now" category. But these patterns were not statistically different (as "child": $X^2 = 8.824$, df = 4, p = .0656; "now": $X^2 = 4.054$, df = 4, p = .3987).

All groups reported more father-dominant childhood homes (67% or 29 subjects) than mother-dominant homes (33% or 14 men) (see Tables 15 and 17, Appendix H for data). They, as groups, also reported similar scores for the amount of energy invested by their fathers, and mothers in their own upbringing. Mothers were seen as contributing more energy than fathers for all groups. Thirty-three (33) fathers or 79% of the same reported mothers invested more energy than fathers.

In addition to these items, fathers were asked about family sibling patterns. No specific hypothesis was generated for this exploratory question, although Cavenar and Butts (1977) have suggested that, for an oldest boy, sibling rivalry may play a significant part in the development of the man's later emotional illness as a response to pregnancy. The question was included to explore the possibility of sibling rivalry in the couvade syndrome. Sibling pattern information has provided some of the most significant results in the entire study. Low and high symptom fathers generally come from very different family constellation patterns. Table 5 presents the relationship. It indicates that sisters are quite important, both their number and their birth order in relation to

TABLE 5

FAMILY SIBLING PATTERN RELATIONSHIPS
FOR SYMPTOM GROUPS

| Symptom Group | Two-Unit Families with Sisters: Older Sister | Two-Unit Families with Sisters: Younger Sister | Larger-Unit Families with Sisters | Families Without Sisters | Row Total |
|---|---|---|---|---|---|
| High | 5* | 0 | 5 | 4 | 14 |
| Medium | 2 | 3 | 4 | 4 | 13 |
| Low | 0 | 1 | 13 | 2 | 16 |
| Column Total | 7 | 4 | 22 | 10 | 43 |

Note: Chi-square = 15.05 with 6 degrees of freedom. Significance = .05.

*Numbers indicate the number of fathers whose birth order and sibling patterns fall within the categories.

the men in the study. Table 5 is a summary of a 3 x 4 chi-square test using sisters in relation to the three symptom groups. Family size is also indicated in the table with two-unit and larger families organized by number and birth order of sister.

About 35% (5) of fathers with high symptoms were the younger brother of an older sister in a two sibling family. The high symptom group tended to consist of men who were either the youngest child (8), or the oldest child in a family of several children, mostly boys (2 all boys, 2 both sexes). One man had two younger half-siblings and one was a middle child whose two older brothers either died or had a chronic disease. Table 6 lists family constellation patterns for all fathers in the study.

Among the low symptom group, fathers were generally the oldest child (7), usually with a sister (5), or a middle child (6), (half with oldest sisters, half with oldest brothers), usually the second child (5). There was one youngest child who had an oldest brother and a sister.

The moderate symptom group had two (2) only children, seven (7) oldest children, and two (2) middle and two (2) youngest children. (The two youngest were also younger brothers of older sisters and were the only other two men from that pattern outside of the high symptom group.)

TABLE 6

INDIVIDUAL FAMILY CONSTELLATION PATTERNS FOR ALL SUBJECTS LISTED BY SYMPTOM GROUPS

| | High Symptom | Medium Symptom | Low Symptom |
|---|---|---|---|
| 1. | F-(M) | F-(M) | M-F-(M) |
| 2. | F-(M) | F-(M) | M-(M)-F |
| 3. | F-(M) | F-(M)-F | M-(M)-M |
| 4. | F-(M) | M-F-(M)-M-M | M-(M)-F-M |
| 5. | F-(M) | (M)-F | F-(M)-M |
| 6. | F-M-(M) | (M)-F | F-(M)-F-F-M-(+3) |
| 7. | M-M-(M) | (M)-F | F-M-(M)-F-F |
| 8. | M*-M**-(M)-F | (M)-M | M-F-(M)-F- [M-F] |
| 9. | M-M-M-(M) | (M)-M | (M)-F |
| 10. | (M)-M-M | (M)-F-F | (M)-M |
| 11. | (M)-M-M-M | (M)-F-M | (M)-F-F |
| 12. | (M)-M-M-F | (M) | (M)-F-F |
| 13. | (M)-M-M-F | (M) | (M)-F-M-F |
| 14. | (M) (F-M) | | (M)-F-M-M |
| 15. | | | (M)-M-F-M |
| 16. | | | (M)-M-F-M |

Circled letter indicates the subject's birth position

F = female; M = male

*Died when subject was 12 years

**Major health problems

[ ] Niece and nephew raised as siblings

( ) Half-siblings raised in same home

In addition to family constellation information, fathers were also asked to give some information about any major and/or chronic illnesses or deaths of siblings. Illness and death of siblings was examined to explore nonparental family illness and death as a variable in symptom manifestation of fathers. There were too few reported cases of sibling death for statistical analysis. The total number of cases was two, reported by men in the high and middle symptoms groups. Six (6) sibling health problems were reported by high (N = 2) and low (N = 4) symptom group fathers. The high symptom group reported one sibling death and two sibling health problems. The medium group reported only one sibling death. The low group reported sibling health problems and no deaths. It may be that health and physical symptoms have played a slightly more central role in the awareness of low symptom fathers, and they may be more inclined to keep from developing symptoms as a reaction. No variable related to age of sibling, age of subject, or type of health problem was statistically significant. In addition, one man from the low symptom group reported two separate sibling health problems (see Tables 15 and 17, Appendix H).

Relationships with pets was also explored for fathers. There were no differences found among symptom groups in the type of pet or the relationship (close, distant) with pets. A total of forty (40) fathers, 93%

of the sample, reported having one or more pets as a child. Of that group, twenty-eight (28) fathers, or 70%, reported a close relationship with pets.

## B. Descriptive Analysis: Fathers' Views on Participation in Childbirth

Forty-two (42) of the total sample of forty-four (44) fathers discussed above were asked about their decision to attend the childbirth. Their answers were analyzed by noting who was involved in the decision for the father to attend (or not to attend) the birth and for the specific words used to describe the process. Fathers' answers were also analyzed by listing the reasons they gave for wanting to be present, hesitating to be present, or not wanting to be present. In addition, an attempt was made to judge the degree of willingness or reluctance to be present expressed by the fathers. Judgement was based on data available to the interviewer alone (i.e., voice tone and gestures). Both what the fathers said and the expression, including phrasing and tone of voice, was considered, as was a comparison among fathers.

### Reported Reasons for Fathers' Approach to Participation

Fathers gave a variety of reasons (or influences) for wanting to be present at the birth of their child. The influences most encouraged participation were:

1. Their own personal experience of participating in a birth--(second fathers; medical corpsmen).
2. Hearing the personal experiences of friends, relatives, peers at work, neighbors (even as little as "I wouldn't miss it for the world," with all its accompanying gestures and facial expressions from a peer or relative had an impact on an expectant father).
3. Interest in the mystery of life, birth, parenthood--"being there to see my child born."
4. Curiosity at what happens at birth.
5. Curiosity about medical procedures that go on behind hospital walls.
6. Support for the wife, for closeness; in sharing the experience.
7. Support for the wife so she won't be alone, especially facing the unknown and alien, often personified by doctors, nurses, and anonymous and/or non-supportive hospital staffs (especially true of "willing" and "reluctant" fathers).

Fathers also reported several other ideas about their participation. Several were related to the question fathers had about their role in childbirth; that is, that they might be:

1. A hindrance. "I might be in the way."
2. An intruder--"I don't really belong in there."

3. A spectator--without a real role, only a made-up one, or as a non-helpful onlooker. (Some fathers felt that role is okay--they really just want to watch. Others wanted to have something to do, and would feel helpless and insignificant as a spectator).

Other images related to the fathers' sense of being able to "handle" the experience. Specifically they wondered about "handling":

1. Seeing their wife in pain--feeling helpless in their ability to help or comfort her. (This sense may be like those expressed by new parents: their feelings of helplessness in caring for their baby, especially a colicky baby.)
2. The work--"It's long, hard work"--"Will I get exhausted?" "Do I really need to go through it, too?" Also, fathers wonder how they will cope with unknown expectations and pressures.

Categories of Fathers

Fathers reported a wide range of attitudes toward their participation in childbirth, from very eager, even insistent, to very reluctant. Of the few fathers interviewed who did not plan to attend the birth, only one appeared to insist on not attending. The fathers' responses fell into four broad categories describing their

desire or reluctance to be present at the birth: (1) eager, (2) willing, (3) reluctant, (4) non-attending.

Numerically, the four groups broke down as follows:

| | | |
|---|---|---|
| 1. | Eager | 15 |
| 2. | Willing | 18 |
| 3. | Reluctant | 6 |
| 4. | Non-attending. | 3 |
| | | 42 fathers |

The categories came from the following descriptions:

(1) Eager Fathers. Eager fathers (N = 15) reported they had thought about and planned to attend their child's birth before any specific decision related to the hospital was made. These men often decided this before their wives were pregnant and for some, before marriage, upon first hearing it was possible. Such fathers talked about the mystery of birth (or life) and also curiosity about hospitals, and/or women. They also tended to see themselves as important participants, able to support their wives in an alien, unknown situation (hospital birth) among strangers (medical staff). They also often had positive images about childbirth after hearing from male peers as well as some expectations of gaining something emotional for themselves from "being there." They also often reported that they felt close to their wives and wanted to share the experience as much as possible with her.

(2) Willing Fathers. These fathers usually had not thought about participation in childbirth before their

wives talked to them about it. At their wives' initiative they agreed to participate. They were the largest group (N = 18) and some were quite interested in participating. Others reported "going along" with what seemed to be "a good idea." They were distinguished from the eager group in that their wives initiated the decision, not they themselves. The men who "went along" were distinguished from the reluctant group by their lack of comments like being "not crazy about it" or other more hesitant statements. But their statements were less direct and active than eager fathers; for example, "I kind of thought it would be better" to go.

Willing fathers generally focused on providing support for their wives. They saw themselves primarily in a role as husband, rather than in a role of expectant father, excited about the baby, which was suggested by the eager fathers. This difference was subtle, and does not imply less excitement, but rather a slight difference in their focus, and sense of themselves, especially around the process of childbirth.

They tended to express more fears of or concerns about hospitals and complications for wife and child at delivery compared with eager fathers. They felt they should be there as husbands to support their wives, especially if problems developed. They often reported that they had become more involved with their work during

the pregnancy. They also expressed curiosity in wanting to see the birth, but it was less clear whether this was curiosity about the medical procedures and the birth or about the more mysterious life processes and birth.

Some fathers in this group reported the greatest sense of change in themselves during the third trimester while attending childbirth preparation classes. They reported initial uncertainty, and struggles to change their image of the birth (and therefore their role in it) from being in the waiting room to being in the delivery room. A couple of fathers said they had to struggle through their "old image" and replace it with a new one. In their struggles they wondered about what was the masculine thing to do and whether they belonged in what seemed to be a "woman's place" and/or a medical procedure. They reported major changes toward excited anticipation of the birth and their "being there." In some ways, both medical personnel and women may underestimate the changes in role and image for a man to participate in childbirth. It may seem to be like asking the rest of us to be present and in some way contribute in a surgical procedure for a loved one or some other procedure which has heretofore seemed well beyond the remote possibility for most people. Willing fathers appear to be more tentative in sorting out this new role and place for them, and may have been

more strongly confirmed in a traditional image of waiting in a waiting room, than fathers who are eager.

Willing fathers also differed from reluctant and non-attending fathers in their protective images and sense of duty toward their wives. They were concerned about the complications and pain their wives might face, but felt they should "be there" to face them together or because "she's doing the work--the least I can do is be there." They also tended to express more ideas about the hard work and drudgery that might be involved in labor whereas eager fathers did not remark on that aspect. Willing fathers found themselves getting more excited as the birth date grew close. They also expressed relief to learn as much as they did in classes for their role and about the whole, mostly unknown, procedures of the childbirth process. Perhaps this was a difference from eager fathers--they learned more before the classes and willing fathers learned more during classes about their potential role at childbirth, and thus became comfortable only after they felt more confident about their ability to fit into an important, new, unknown, and potentially demanding role.

(3) Reluctant Fathers. These fathers (N = 6) reported some reluctance even after attending a few classes. The decision for their participation was initiated by their wives. There was a sense that the wives had been

insistent in the face of some opposition on the husband's part rather than the more mutual decision sensed among eager and/or the "going along with a good idea" sense among some of the somewhat uncertain but willing husbands. Men in the study did not appear comfortable reporting their hesitation to be present or their desire to wait in a waiting room or elsewhere and therefore often said less than others; for this reason a summary of their ideas is more vague. Some fathers reported a very serious struggle over giving up the traditional image of being in a waiting room and having someone bring out the baby "all cleaned up" and of not seeing the pain or problems or "mess" of delivery. While this struggle seemed more internal and resolved for willing fathers, it seemed more interpersonal (i.e., with wife) and overlaid with concerns about control for reluctant fathers. It also did not seem related, except tangentially, to their desire for the baby but was more narrowly focused on the childbirth process itself. Some men who were willing, in fact, expressed more ambivalence about the pregnancy itself than the childbirth process and this colored their generally subdued mood and may have appeared to their LaMaze teachers as disinterest in the classes or process.

Unfortunately, more information is needed for a better picture of reluctant fathers than the data available in the present study. Because they talked less, it

is impossible to extricate such information, and speculation is more likely to stereotype such fathers than to be of use to them or to those working with them.

(4) Non-Attending Fathers. This group comprised three men who planned not to participate in the birth. Their reasons were varied, and seemed related to factors other than their own unwillingness. In fact, one such father said he probably would be there if his wife wanted him to go. This was not their first child and they saw no reason to "change things" for this baby. Another father's work schedule and dislike of any type of school or class situation and a very long drive made it very difficult for him to attempt to go to the classes required although his wife was interested in him being there. Another father related his fear at seeing his wife in pain and his sense of helplessness during a previous labor which made him quite reluctant to be with her during labor and delivery, although she wanted him to be there.

Some of these fathers reported that they did not want to see, visually, any of the problems that might occur during delivery, especially if there was a problem with their wife or child. They also said that if the "hospital atmosphere" was something they would like to avoid.

One father reported that he had wanted to "go in" when their first child was born, but was not allowed to do so. His sense of remoteness from the event, which he can

still remember vividly several years later, was summed up with, "There I was, filling out forms while he was born." One got the sense that he survived that, and he was unwilling to find out what other complicated and perhaps disheartening experiences hospitals might have in store for him if he did not stay beyond their confines. Perhaps his anger at his earlier treatment contributed to his reluctance to try again to "handle" hospitals and medical personnel.

As a group, the non-attending fathers were no different in their interest and anticipation of their child's birth than other fathers who planned to attend. While such fathers have been stereotyped as uncaring or disinterested, this is clearly not the case. They were articulate, and two of them were fathers for the second or third time. They were clearly involved and loving husbands and fathers. If anything, factors such as distance from hospitals and classes, very demanding work schedules, and fear and some lack of distance from the possible pain of their wives and the possibility of being overwhelmed with their own feelings were more likely factors than any lack of care or concern.

Analysis of Data by Type of Father

After generating the categories for different types of fathers, men in the various categories were compared on the same variables used to analyze symptom groups.

Data for two men were not included in the analysis. The sample total was forty-two (42) men. The following results were obtained from the analysis.

Table 7 summarizes the general background for each group. No significant differences were found for education level, length of marriage, parents' ages, early separation from parents, major family changes, religious affiliation, planning of the pregnancy, feelings about the pregnancy, or illness or death of a sibling (see Table 7 and Tables 19, 20, and 21, Appendix H for data). As expected from the preceding descriptions, fathers' age was a significant variable for types of fathers, with the eager fathers producing a mean age of 27.1 years, the willing fathers 26.7 years, the reluctant fathers 30.8 years, and the non-attending fathers 32.3 years. In a Duncan Multiple-Range Test, the reluctant and non-attending groups were significantly different from the other two groups.

Income level was also a significant variable for types of fathers. Based on a chi-square distribution of income categories, the reluctant group had more fathers with higher incomes than did the other groups ($X^2$ = 16.67488, df = 9, p = .054 (see Table 9 and 10, Appendix H). This may be explained in terms of age differences reported above. Older men are more likely to be established, with higher incomes.

TABLE 7

DEMOGRAPHIC DATA FOR FATHER TYPES

| Variable | Eager | Willing | Reluctant | Non-Attending | Total |
|---|---|---|---|---|---|
| No. of Fathers | 17 | 15 | 6 | 3 | 41 |
| Mean Age | 27.1 | 26.7 | 30.8* | 32.3* | 27.9 |
| Mean Years Married | 3.9 | 3.3 | 6.3 | 6.3 | 4.3 |
| Educational Level | | | | | |
| Some H.S. | 1 | 0 | 0 | 0 | 1 |
| Completed H.S. | 4 | 2 | 2 | 2 | 10 |
| Completed College | 8 | 9 | 3 | 1 | 21 |
| Grad/Prof. School | 4 | 4 | 1 | 0 | 9 |
| Income Level | | | | | |
| Below $11,000 | 2 | 5 | 0 | 1 | 8 |
| 12 - 20,000 | 8 | 3 | 0 | 0 | 11 |
| 21 - 40,000 | 6 | 7 | 4 | 1 | 18 |
| 40 - 75,000 | 1 | 0 | 2 | 1 | 4 |
| Religious Affiliation | | | | | |
| Baptist | 4 | 4 | 3 | 1 | 12 |
| Other Protestant | 5 | 7 | 3 | 2 | 17 |
| Roman Catholic | 3 | 1 | 0 | 0 | 4 |
| Jewish | 1 | 0 | 0 | 0 | 1 |
| Atheist/ Agnostic | 1 | 2 | 0 | 0 | 3 |
| Other | 3 | 1 | 0 | 0 | 4 |
| Religious Practice | | | | | |
| Active | 4 | 6 | 2 | 1 | 13 |
| Moderate | 7 | 5 | 3 | 0 | 15 |
| Little | 6 | 4 | 1 | 2 | 13 |
| Planned Pregnancy | | | | | |
| Yes | 13 | 11 | 3 | 2 | 29 |
| No | 4 | 4 | 3 | 1 | 12 |

TABLE 7 (Continued)

| Variable | Eager | Willing | Reluctant | Non-Attending | Total |
|---|---|---|---|---|---|
| Feelings Toward Pregnancy | | | | | |
| Very Happy | 15 | 13 | 4 | 2 | 34 |
| Somewhat Happy | 1 | 2 | 2 | 1 | 6 |
| Other | 1 | 0 | 0 | 0 | 1 |
| No. of Children | | | | | |
| 0 | 14 | 13 | 3 | 1 | 31 |
| 1 | 3 | 2 | 2 | 1 | 8 |
| 2 | 0 | 0 | 1 | 1 | 2 |

*Significant at .05 level; indicates subgroup which differs significantly from other two groups on Duncan Multiple Range Test.

Number of children was a third variable which was not significant, but appeared important in light of the variables of age and income. The reluctant group contained fewer men with no children and a higher number of children than did the other groups, at a significance level above .05 (chi-square = 11.029, df = 6, p = .0875, see Table 21, Appendix H). It is likely that all three variables, age, income, and number of children help describe fathers in the reluctant group.

In addition to the above findings, MMPI data revealed some interesting patterns and one significant difference. It is summarized in Table 8 (see Table 18 for ANOVA summaries; group profiles are presented in figures 6, 7, and 8, Appendix C). The mean scores for the groups tended to be higher for fathers in descending group order. That is, eager fathers tended to have the lowest mean scores, while non-attending fathers tended to have the highest for all mean scales, except for Scales (5), (6), and (9), on which the trend was reversed. Scores for Scale (0) also showed a different but non-significant pattern. The means for Scale 0 (Si) were: eager, 20.8; willing, 22.7; reluctant, 19.5; non-attending, 24.7. However, the mean scores for Scale (8) (Sc) showed a significant difference ($F$ = 2.96, df = 3, 37, p = .04). On the Duncan Multiple-Range test, the willing group was significantly different from other groups.

TABLE 8

MEAN SCORES FOR FATHER TYPES ON THE MMPI

| MMPI Scale | Eager | Willing | Reluctant | Non-Attending | Total Group | F-Values |
|---|---|---|---|---|---|---|
| L | 3.2 | 3.6 | 1.8 | 5.7 | 3.3 | 2.150 |
| F | 5.7 | 5.7 | 5.8 | 6.7 | 5.8 | 0.085 |
| K | 14.1 | 14.9 | 17.0 | 16.7 | 15.0 | 0.550 |
| (2) | 18.4 | 19.8 | 19.2 | 21.0 | 19.2 | 0.387 |
| (3) | 18.2 | 19.7 | 19.8 | 20.0 | 19.1 | 0.580 |
| (4) | 21.1 | 23.1 | 24.2 | 25.7 | 22.6 | 1.343 |
| (5) | 26.5 | 26.3 | 25.3 | 23.3 | 26.0 | 0.580 |
| (6) | 10.0 | 11.3 | 9.5 | 8.7 | 10.4 | 0.776 |
| (7) | 22.8 | 25.9 | 26.8 | 26.0 | 24.8 | 1.711 |
| (8) | 21.8* | 27.9* | 26.8 | 24.0 | 24.9 | 2.956* |
| (9) | 20.6 | 20.9 | 19.5 | 19.7 | 20.5 | 0.190 |
| (0) | 20.8 | 22.7 | 19.5 | 24.7 | 21.6 | 0.514 |
| (ES) | 47.8 | 47.1 | 48.7 | 52.0 | 47.9 | 1.199 |
| ES t Scores | (58) | (58) | (64) | (59) | (58) | |
| NCVD | 5.1 | 6.6 | 5.5 | 5.0 | 5.7 | 0.779 |

*Significant at the .05 level on a one-way analysis of variance (see Appendix H for ANOVA Table); indicates score was significantly different from other scores as determined by the Duncan Multiple Range Test.

There was only one significant difference found for the four groups on family background data (see Tables 19, 20, and 21, Appendix H). In addition, some non-significant data patterns are of interest. In a comparison of visits to the obstetrician during the pregnancy, fathers in the reluctant and non-attending groups had comparable visits to those in the eager group and all fathers in the reluctant group visited the obstetrician at least once, while two willing fathers did not.

A comparison of the type of major family change indicated a total of eight (8) fathers reported death of a parent, divorce, or prolonged illness of a parent during their childhood. Fathers in the eager and willing groups reported deaths and divorces only, while one non-attending father reported a severe chronic illness of a parent as indicated in Table 9. (see also Tables 19-21, Appendix H).

Some patterns emerged in an analysis of data reported on relationships with parents. For the total group, most men (30 or 73%) reported they were closer to their mothers as children. As a whole, only eighteen (18 or 45%) of the fathers reported being closer to mothers now. The shift in closeness was never in the direction of father to mother, but in the opposite direction, or to include both father and mother, even though fathers were asked to choose one parent. In studying which men reported being "closer now," eager, reluctant, and non-attending fathers

TABLE 9

TYPE OF FAMILY DISRUPTION COMPARISON
FOR FATHER CATEGORY TYPES

| Type of Father | Death of Parent | Divorce | Chronic Illness of Parent | Row Total |
|---|---|---|---|---|
| (1) Eager | 3 | 2 | 0 | 5 |
| (2) Willing | 0 | 2 | 0 | 2 |
| (3) Non-attending | 0 | 0 | 1 | 1 |
| Column Total | 3 | 4 | 1 | 8 |

Note: chi-square = 10.4 with 4 degrees of freedom.
Significance = 0.0342

appeared to shift to greater closeness with their father, or with both parents. Most men in the willing group, however, reported being closer to their mothers now. This group reported less "shift" toward closeness with fathers. The comparison was not significant statistically, when tested by a chi-square test ($X^2 = 6.481$, df = 6, p = .3715; see Tables 20 and 21, Appendix H).

Willing fathers also reported a higher ratio of father-dominant homes than eager fathers, although this ratio (approximately 3:1 or 4:1) was similar to those of reluctant and non-attending fathers. Willing fathers also reported the highest number of their own fathers who contributed "very little" to their own upbringing. That is, the willing group contained men who saw their fathers as very uninvolved in their own upbringing. This finding also was not statistically significant, but the various patterns appear related, and important for an understanding of some fathers in the willing group ($X^2 = 13.944$, df = 12, p = .3043; see Tables 20 and 21, Appendix H).

Men in the willing group also answered "both" on a question asking the man to decide which parent spent more energy on his upbringing. The question attempted to force subjects to choose, so a man had to go beyond the form by supplying his own answer, or otherwise bring the question to the interviewer's attention. The willing group contained the only men who did this, and their responses

were included. Usually, these men reported verbally that both parents had spent equal amounts of energy, and they could not choose between them (see Tables 20 and 21, Appendix H).

### C. Phenomenological Analysis: Themes of "Anticipating Childbirth" for Fathers

In addition to these data, several (22) fathers were asked to describe their thoughts, feelings, ideas or images about the birth of the baby. The answers to this specific question, and any clarifying questions related to their answer, provided data for a phenomenological analysis of a father's views of the birth of his child.

Describing the experience and viewpoint of the expectant father involves describing the father's view of things--a description of his own "inner experiences." The focus is on the father's experience, in the last few weeks, perhaps days, before his child is born. There has been no attempt to describe his total experience of pregnancy; just what is going on at the particular time before the birth of his child.

The description is not of the father as he fits into a series of categories--his age, or occupation, etc.--but as he experiences his life. Rather than explain the descriptive process, it may be easier to use a visual metaphor to clarify what this analysis is attempting to do.

If one imagines a landscape with a man in it, from the point of view of the observer, it is possible to describe the man in objective terms--his height, coloring, physique, etc.--and the landscape around him--the terrain, its colors, the heights and breadths of its features. If one wishes, however, to describe the landscape from the man's point of view, one must change perspectives. One might ask the man to move aside, and stand in the spot he stood on. Or one might stand very close to him and try to figure out and extrapolate what he sees (saw). One might stand close to him and ask him to describe the landscape. Perhaps a combination of all three procedures will help describe how the landscape appears to the man. By standing in his previous spot, one enters the same landscape. By standing very close, one stays within the landscape and views it at the same time the man does so any temporal changes it undergoes can be noted. By asking him to describe the landscape he sees, one can learn the order of his various focal points, and what colors and shapes and sizes he sees in the terrain. Thus, one can try to "see" as the man sees.

It is this latter attempt which was made with expectant fathers. The investigator has attempted to stand close to individual expectant fathers as they described their thoughts, images, ideas and feelings about the birth.

She has tried to see this extraordinary landscape as they do, and to articulate that viewpoint.

What is the experience of the expectant father in the few weeks before the birth of his child? What is he thinking and feeling? How do his thoughts and feelings organize themselves around the anticipated birth? What aspects of his individual viewpoint are shaped by his special situation, that of expectant father? How is it shaped by that situation? These are the questions which have been asked of the data gathered from expectant fathers in interview format.

Each father was asked to describe his thoughts, feelings, ideas and images about the impending birth of his child in a recorded personal interview. After an initial response, he was asked questions based on his response to clarify and expand his responses so the interviewer could get as complete a picture as possible. Each father's responses formed the basis for a series of statements about his experience. Such statements were restatements of the responses which remained as true as possible to the original experience and also clarified that experience.

An example of a response and the "meanings" it contains is given here. During the interview, several fathers answered with the phrase, "I'm looking forward to it," or "We're really looking forward to it," as their first

response to a question about the birth. The phrase points to the structure of assumptions beyond it. It conveys the anticipation, the sitting-on-the-edge-of-the-chair, forward looking thrust of the father. He is "looking forwad," into the future, focusing on his child's birth. The phrase also conveys happiness, excited anticipation. All these meanings are being conveyed by the phrase. It carries the structure along to the listener, as do the father's tilt of his head--his half-smile or broad grin, and the brightness in his eyes, the serious, excited quality in his voice. A similar analysis was done for each statement. The statements became the basis for the themes of expectant fatherhood which describe and delineate the background, or organization, or structure, on which an expectant father bases his viewpoint.

The following is a description of the main focal issues and a list of the themes which emerged from an analysis of the protocols of the expectant fathers. Examples of each focus is given. A complete list of descriptive statements can be found in Appendix I. The specific statements which make up the descriptions are fully articulated thoughts which were developed by the methodological process described in Chapter III.

## Description of Initial Theme Clusters

Five themes pervaded the father's statements about

the above topics. They can be summarized with the following lables:

1. "Handling"/"Floating"/"Being Overwhelmed" (the self and powerful focus).

2. Reflecting/Experiencing (the self and lived experience, involving some choice of degree of participation.

3. Relaxing/Attending (the self experienced as "we," involving a sense of almost involuntary maintenance of focus and attention on the wife/fetus).

4. "Waiting"/"Anticipating" or "Looking Forward" (the self in time).

5. "Missing Out"/"Being There" (the self as separate, involving a sense of potential exclusion).

The first major theme relates to a father's sense of "looking forward." It illuminates the sense of the self in time and suggests a "waiting/anticipating" continuum. All themes will not be exemplified, but examples of the first theme will indicate how each theme is found in statements of several different foci including self, wife, baby and birth event.

1. One anticipates the birth with an intense, shifting mixture of feeling, predominated by excitement and apprehension.

2. A long wait of several months, possibly longer in

attempts to conceive, is finally ending in the climactic event of birth.

3. One wonders what changes the baby will bring into one's life.
4. One wonders about the child's characteristics (health, sex, appearance, personality) in anticipation of seeing "that little feller (person) who's been kicking around in there."
5. One considers and feels the permanence and weight of responsibility of providing for, teaching, and raising the child.
6. One considers the specific tasks of preparation, transportation, and management involved in bringing one's wife and helping professionals together at the appropriate time.
7. One wonders about the parental and fatherly requirements that the particular baby may need and their presence, absence, or capacity to develop in oneself.
8. One wonders what new things will be learned, what new experiences will be lived through. Newness and change prevade the atmosphere of one's thoughts and world view.

The various themes are embedded within the statements below, which relate specifically to various foci. For the

examples given below, descriptive statements are organized by focus rather than by theme, as in the above examples.

Six separate foci emerged from analysis of father's views. They are: (A) self as father, (B) the physical body, (C) emotions and reactions of the self, (D) the wife/fetus, (E) the baby, and (F) the birth event. The six foci are outlined below, with descriptive statements which relate to each focus. The birth event was an especially rich, complex cluster involving some overlap with other foci.

(A) Self as Father. The first focus is that of the father's sense of self as the father, especially as the father of this particular child. It includes reflection on his position as son, husband, and father of other children, as well as on his sense of "self." The following statements exemplify the "self as father" focus.

1. One wonders what exactly is the role of the husband/father to one's wife/family for this pregnancy.
2. One feels the weight of the responsibility to provide for one's family. One feels one to be more serious and concerned about making money to give one's family a good home.
3. One finds oneself thinking about one's parents and one's childhood--one's relationship to them in the past, and now.

(B) The Physical Body. The second focus is that of the father's physical body. It includes awareness of the role as biological father, the differences between a father's body and his wife's, and the physical changes, accommodations, and reactions to the pregnancy.

1. One is sometimes surprised to learn how much one's wife's pregnancy and the anticipation of the birth have affected oneself, including one's physical reactions.
2. One realizes one may be pushed to the limits of one's physical and emotional resources by being at the birth.
3. If one has fears or concerns about blood, hospitals, doctors, or one's wife's pain, one expects to be able to handle such concerns and make it through all right.

(C) The Emotions/Reactions of the Self. The third focus involves a father's awareness of his emotional responses to the changes in his life and his expression of those emotions in reactions.

1. One wonders how and what the rolling mixture of feelings will come up with, especially at the birth--feelings like resentment, indifference, unreality, overwhelmed, calm, curious, joy, euphoria, happiness, excitement, etc.

2. One hopes everything will be fine, and one sets one's mind to be generally optimistic rather than focus on the ever present fears and anxieties.
3. One seeks reassurance from past resources, especially private feelings--wisdom or stories of other men, wife's health and condition, birth as a common human experience, religious beliefs, philosophical beliefs, fatalism, etc.

(D) The Wife/Fetus. The wife/fetus, almost as a single entity, is a fourth focus for the father. His wife remains wife, but the changes in her and of her change a father's way of seeing her. The wife's physical body is especially important to the father.

1. One tries to predict how one's wife will handle this childbirth, physically, emotionally, and in terms of when the baby might come.
2. One is more aware of one's wife in nearly all ways--and especially physically--than when she is not pregnant.
3. One does not want to see one's wife suffer or undergo pain.

(E) The Baby. A fifth focus for the father is the baby itself. A father focuses on what the baby will be

like and how he is related and will relate to this new person.

1. One has some sense of knowing and relating to the baby now as "that little feller who's been kicking around in there."
2. One feels the baby as an amazing, transcendent, but also routine, common human offspring/creation--a gift from God--an extension of the love of the couple for each other.
3. One is awed by the fact that the baby is both a part of oneself and also a unique, separate individual human being.
4. One feels a sense of having to wait to meet the baby before really building a relationship with the child--with a sense that one's wife may already have more of a relationship started with the baby because of her biological connection to the child.

(F) The Birth Event. The birth event itself is a very important focus for the expectant father. It touches on other foci, but remains the important future event around which other clusters organize. It is the anticipated event which will move the man from expectant to actual father, with the baby born. It is a clear, rich focus for fathers. The majority of statements reflect

views of fathers expecting to be physically present at the birth.

1. One feels growing excitement as the birth time approaches. One is an exciting time--a time like the anticipation and build-up of emotion one felt as a child before Christmas or birthdays.
2. One thinks about where one will be when the baby is born. One has some specific images related to how one knows the baby is born, is okay, and it's here.
3. One senses one can share the experience of pregnancy and birth as fully as possible, in an almost physical way, and one must choose whether to open oneself completely to such total sharing/expreiencing, or to keep one's distance and maintain one's own perspective clearly.

Table 10 on anticipating childbirth presents a grid of the six foci and five themes, plus one or two examples for each cell.

## D. Other Findings

Other findings, including the investigator's observations and data from interview material are briefly reported because they shed light on various phenomena and will be discussed in Chapter V.

TABLE 10

ANTICIPATING CHILDBIRTH FOR THE FATHER

| FOCI OF EXPERIENCE: | A. Self/Father | B. Physical Body | C. Emotions/Reactions | D. Wife/Fetus | E. Baby | F. Birth Event |
|---|---|---|---|---|---|---|
| **THEMES OF THE SELF AS EXPERIENCED:** | | | | | | |
| 1. Handling/Floating/ Being Overwhelmed (Self and Parental Focus) | One must handle new responsibility as protector and provider. One must handle the changes in one's life-patterns, routines, oneself. | One may handle one's reactions physically with physical symptoms. One expects to handle the birth without "passing out." | One feels one must handle the intense, shifting feelings one has. One maintains an optimistic outlook to handle one's reactions. | One helps one's wife handle the pregnancy. One must handle the accommodation of one's wife, with the changes in her. | One wonders how he will handle this baby - how he will deal with any problems. | One hopes to handle the birth event - one expects one will be overwhelmed. |
| 2. Reflecting/Experiencing (Self and Lived Experience) | One reflects on one's relationship with one's parents. One evaluates oneself as a father. | One may want to share the experience of pregnancy, or to emphasize the separate experience of one's own body. | One's emotions allow one to experience the pregnancy and involvement in it. One feels excited, proud, happy, anxious, resentment, etc., around the pregnancy. | One observes one's wife, evaluating her current and future capacities. One enjoys sharing with her as the baby kicks. | One knows the baby is "there", but it is not quite "real" and believable. | One wants to experience the birth - not just "see" it. |

TABLE 10 (Continued)

| FOCI OF EXPERIENCE: | A. Self/Father | B. Physical Body | C. Emotions/Reactions | D. Wife/Fetus | E. Baby | F. Birth Event |
|---|---|---|---|---|---|---|
| **THEMES OF THE SELF AS EXPERIENCED:** | | | | | | |
| 3. Relating/Attending (Self as We) | One thinks about oneself as oneself less. One focuses on one's work, other projects, or one's new role. | One is aware that one receives less attention, and one's physical activities may change to accommodate pregnancy. | One attends to oneself and one's reactions less than to one's wife's reactions. One tries to be tolerant and accommodating of her reactions, but not of one's own. | One attends to, monitors and evaluates one's wife fairly constantly and seriously. | One tries to get to know the baby through one's wife. | One expects to be completely, intensely focused on the birth. |
| 4. Waiting/Anticipating (Self in Time) | One must wait to become a father, fully. One anticipates the future, wondering how it will be. | One can feel impatient in physical ways as the birth becomes closer. | One's feelings build as the birth grows closer. One becomes more excited, or anxious. | One sees one's wife get larger and more tired. One stays close to her, to be ready for the hospital trip. | One wonders what the baby will look like, be like. One develops pictures of it. | One has specific/vague images of the birth event itself. |

TABLE 10 (Continued)

| FOCI OF EXPERIENCE: | A. Self/Father | B. Physical Body | C. Emotions/Reactions | D. Wife/Fetus | E. Baby | F. Birth Event |
|---|---|---|---|---|---|---|
| **THEMES OF THE SELF AS EXPERIENCED:** | | | | | | |
| 5. Missing Out/Being There (Self as Separate) | One wonders if he will have to make an effort not to "miss out" on being close to his child and plans to make sure the child will not "miss out" on things one missed. | One wonders about "missing out" on the physical pregnancy. One is usually comfortable to "miss out" on it. | One's is aware of "missing out" on some social attention. One may remind oneself that the baby is "mine as much as hers." | One senses one's wife's experience is different, potentially closer to the child. One wants to share it or not be excluded. | One wants to "be there" in relation to the baby. | One hopes to "be there", not "miss out" or feel excluded at and during the birth. |

Description of Symptoms. In the present study, one father described a serious skin condition in which he lost all his outer layer of skin a few days after his wife delivered their first child. He was bedridden by the condition at the time she brought the baby home and was dependent on her help, and she therefore relied on help from other family members. The condition cleared up quickly, and did not recur for several years, until, during the second pregnancy, he developed a mild rash. The rash and skin loss may be similar to the loss of the very top layers of skin by an infant in the several days after birth. This father's early history included being the younger son of an older sister, who contracted a very serious illness when he was about two. Thus, he might fit into the pattern described above, with a disruption for the family occurring with his sister's illness.

Observations of the Investigator. The present investigator has also been struck by informal stories from wives who are not in the current study about husbands becoming sick, or having other difficulties, when the women have returned home from the hospital with a baby. A sick husband certainly may need the same sort of attention that a new baby demands, and if there is little help from outside, the husbands may inadvertently compete with his child for care for a few days.

In talking to high symptom men, the investigator also noted some sense of the man's early disappointment in the mother and of his turning away from her toward pursuits outside her realm, perhaps to the father or others. One father described a supportive grandfather who helped reassure him of his own competence.

## E. Summary of Results

In summary, the present study yielded several findings about male pregnancy symptoms (couvade syndrome), fathers' views on childbirth participation, and a phenomenological analysis of "anticipating childbirth" for the father.

Couvade Syndrome. The findings in the present study supported one (1) of four (4) hypotheses proposed. Fathers in the high symptom group had higher average scores on the MMPI for all but one of the clinical scales. The scores were significantly higher than the other two groups for scales (1) Hs, (2) D, and 4 (Pd) and the Ego Strength (ES) experimental scale. Hypotheses related to early memories and early separation from fathers or traumatic family disruptions were not supported.

Other significant findings related to family sibling patterns and birth order, especially the position of the sisters of the expectant fathers. Nearly two-thirds (9 of 14) of high symptom group fathers either were

younger brothers of older sisters in a family of two children or belonged to a family without girls. Among the low symptom group, four-fifths (13 of 16) of the fathers were from larger than two-sibling families and had sisters. Other birth order and family patterns were also summarized.

Childbirth Participation. Analysis of interview data yielded four approaches to childbirth participation for fathers in the study. They were (1) eager, (2) willing, (3) reluctant, and (4) non-attending. Eager fathers had decided to attend the birth before any discussion of it with their wives. They used active "I" statements in describing their decision and wanted to be there for their own reasons. Willing fathers agreed to attend after their wives initiated discussion of the subject. They often became quite interested in attending, but described their decision in more passive, or complex statements than those used by eager fathers. Reluctant fathers planned to attend because their wives, or someone else wanted them to go. They used active, negative "I" statements, usually "I'm not crazy about it" to express their views. This group had a significantly higher income level than other groups and contained older men than either the eager or willing groups. Non-attending fathers chose not to attend the birth or classes. Their reasons included difficult work schedules, no interest on their wife's

part to have a "prepared natural birth," and strong reluctance to see their wife in great pain. They were significantly older than other groups.

Fathers' views on participation were affected by a number of influences which were summarized from those reported by fathers. The major positive (i.e., pro-birth attendance) items were (1) knowledge of their own or others' personal experience of participating in a birth, (2) curiosity about the mystery of life, birth, and/or medical procedures, and (3) the opportunity to help and support their wife and share the experience. The major negative (i.e., anti-birth attendance) items were (1) fear of being a hindrance or intruder at birth, and (2) fear of the emotional pain of seeing their wife in severe physical pain or dealing with serious complications and feeling helpless.

Anticipating Childbirth. Several foci and major themes emerged in the phenomenological analysis of the interview data. Six major foci were (1) the self as father, which included reflection on being a son, (2) the body, (3) the emotions and reactions, (4) the wife-fetus, (5) the baby, and (6) the birth event itself. Five themes pervaded the father's statements about the above topics. They can be summarized with the following labels:

1. "Handling"/"Floating"/"Being Overwhelmed" (the self and powerful focus).

2. Reflecting/Experiencing (the self and lived experience, involving some choice of degree of participation.

3. Relaxing/Attending (the self experienced as "we," involving a sense of almost invlontary maintenance of focus and attention on the wife/fetus).

4. "Waiting"/"Anticipating" or "Looking Forward" (the self in time).

5. "Missing Out"/"Being There" (the self as separate, involving a sense of potential exclusion).

# CHAPTER V

## DISCUSSION OF THE RESULTS

The three aspects of the present investigation--the couvade syndrome, paternal approaches to the childbirth process, and a phenomenological description of an expectant father's world view--all illuminate different levels of experience of expectant fatherhood, the physical, the emotional-psychological, and the intellectual-psychological.

In the consideration of the couvade syndrome, what is crucial are differences in the physical reactions of individual expectant fathers to pregnancy, with such differences ranging from clear and marked physical reactions to little or no physical reactions. As a woman undergoes the bodily changes characteristic of pregnancy and childbirth, the issue of the physical body moves into focus. Another person's body, and a body within that one, reminds the man of his own body and its own particular capabilities and limits. The investigation of the couvade syndrome clarifies the profound importance of the body for an expectant father.

A father's approach to the childbirth process involves his emotional response to an emerging sense of fatherhood. Beyond a father's individual reactions to the

birth event itself, his general emotional reactivity and his sense of his own psychological involvement are at issue for the expectant father as he moves closer to childbirth. His own approach to birth will reflect his individual answer to how much involvement he will have in the process. They are his individual responses to what for him is a unique event, but for which all fathers must have answers, within the limits and rituals of their society. Distance and closeness, reflection and involvement delineate major aspects of a man's sense of himself as an expectant father. A man, in his ancient roles of progenitor, provider, and protector, must decide where, within those categories, he can be.

The phenomenological data help illuminate the man's experience and help clarify and place the other two foci of study (i.e., couvade and birth participation) in the context of the thoughts and feelings of the expectant father. The reflective process of the method and data bring to the fore the issues of reflection, observation, and perspective in the seemingly unreflective, primarily body-oriented process of pregnancy and childbirth. The description of the expectant father's experiences illuminates the degree to which reflection and observation are a part of the expectant father's world. He is a little less "close" to the situation than his wife and it is he who focuses on how they will continue to "fit" into the

physical material world beyond them. If a woman's domain is the specific physical and emotional environment with the fetus and later the baby, the man's domain is how that smaller, focused, specific environment fits into, is affected by, and deals with the larger environment of people and places, of material needs outside home and family. If the woman is mainly concerned with nurturance, the man is concerned with protection and provision and with interpreting the larger environment for the family. While individual couples work out the "who" and "how much" of any particular role, the themes for an expectant father point to the father's concern with how an "outside world" and his own domain will fit together and will negotiate exchanges.

## A. The Couvade Syndrome

In the literature on the couvade syndrome, several explanations for the syndrome have been proposed. In summary, they are (1) male "womb envy," the envy of a woman's biological creative capacity (2) male/female or "cross-sex" identity (3) a man's ambivalence and repressed hostility toward his spouse (4) ambivalence and repressed hostility toward the child (5) extreme sibling rivalry (6) general "immaturity" (7) involvement with and participation in the birth cycle.

In a previous study (Davis, 1977), the couvade syndrome has been linked to higher reported levels of anxiety and depression but not hostility among expectant fathers. In the present study, the significantly higher mean score for high symptom group fathers on scales 2 (D) and 7 (Pt), which relate to depression and anxiety, respectively, coincide with Davis' findings (1977). These findings were part of the findings for the first hypothesis which dealt with MMPI scores.

Other aspects of the first hypothesis related to MMPI scores as reflective of personality tendencies such as "general immaturity" and "feminine" identification. The results of the MMPI data suggest slight support for the explanations of immaturity. High symptom fathers had a significantly lower Ego Strength (ES) score, suggesting they may be less "mature" than the other groups of fathers. The mean scores for high symptom fathers on scale 5 (Mf) were higher than for other groups, but not significantly, and so there is little support for a "feminine identification" in any straightforward way.

The higher mean scores for high symptom fathers lends support to suggestions that the syndrome is related to such terms as "general immaturity" although mean scores for all groups were well within a normal range. It is interesting to note that mean scores for scales 4, 5, 6, and 9 were all generally high. These scales were also the

highest points, or among the highest scores on a majority of individual profiles and may be related to expectant fatherhood. Scale 5 (Mf) scores might indicate greater interest and appreciation for the feminine aspects of life (including nurturance, and awareness of feminine biological creativity). Scale 9 (Ma) scores might indicate a general sense of well-being and high energy level. Elevations of both scales may be temporary reactions to the situation of a third-trimester expectant father and would certainly coincide with both the optimism and excitement and with the growing awareness and appreciation of a "woman's job" reported by many fathers in their interviews. Scales 4 (Pd) and 6 (Pa) may indicate the great mixture of ambivalent feelings expressed by fathers as well as a sense of their own limits and lack of power in a situation that is so important in their lives.

The second and third hypotheses related to Early Memory data were not supported by present results. Methodological considerations may be responsible for the lack of support. The fact that themes of hostility and punishment were evenly distributed among symptom groups suggests either that memory themes are not different for couvade syndrome fathers, or that a far more complex analysis of memory data must be done to uncover differences. The latter is certainly most likely. The general themes may have to be considered very carefully within the context of each

memory and in the sequence of memories to clarify differences among groups.

The fourth hypothesis related to early father absences and family disruption. Data from family backgrounds did not support this hypothesis. In view of both the relatively high incidence of couvade-like symptoms among this sample population (14 of 43 subjects), the premise of early father absence may deserve more investigation. Moore (1975) found a similar lack of father absence in his study of couvade syndrome, unlike the studies reported by Munroe and Munroe (1971, 1977; Munroe, Munroe, and Nerlove, 1973; and Munroe, Munroe, and Whiting, 1973). As suggested by Moore, father absence may involve emotional as well as physical absence (1975).

Other findings which were significant in the backgrounds of men in the three groups relate to sibling patterns. As discussed in Chapter IV, the sibling patterns, especially those relating to sisters, were quite significant in that younger brothers of older sisters in two-unit sibling patterns tended to be in the high symptom group. None were in the low symptom group with more members of the low symptom group coming from larger than two-unit families with sisters.

This finding is neither reported nor suggested in the previous literature on the couvade syndrome, although a few case histories which list sibling patterns can be related

to this finding. For example, the expectant father who developed couvade symptoms in Gurwitt's discussion (1976) was a middle brother of two sisters, which is not a pattern found in the present study. In this case, the father described his older sister as "consuming." His mother's pregnancy with the younger sister deprived the boy of her attention, in a family with a withdrawn father. The combination of an older sister and withdrawn father may have contributed to the boy's early involvement with his mother which emphasized his "loss" of her during her third pregnancy.

In view of the couvade syndrome literature and the results of the present study (including the investigator's observations of men in the study), a tentative explanation for some of the mechanisms at work in the formation of the couvade syndrome is suggested and would seem to be as follows: The couvade syndrome appears to develop as a specific, pregnancy-related, psychosomatic condition in men who have been the recipients of both perceived early indulgence or some type of "closeness" with their mothers (like that of a youngest boy as in the family pattern data) and subsequent perceived "deprivation" or loss of that closeness before the onset of the oedipal struggles (as happened to the man who developed a rash). The particular mother-boy relationship would probably be characterized by some infantilization and enjoyment of the boy as the

"baby" of the family or "mama's boy"; that is, the boy as an object for the mother's gratification and entertainment rather than in terms of emphasis on his mastery or on his sense of being a "big boy." This type of relationship might be more likely to occur in a situation of a passive or absent father, for an only or an oldest boy, or in a situation of being the youngest in the family, especially the younger brother of a sister (Toman, 1976; Wilson and Edington, 1981). In all the above situations, there would be a "low male salience," as described by the Munroes (1973b), in the life of that particular boy.

A second condition--that of perceived "loss" of the mother's attention and apparent indulgence--would occur quickly and somewhat traumatically, so as to be explained as a "loss" rather than something either rejected or otherwise "given up" and mastered (usually with a father's help). The idea of a sense of "turning away" and "loss" of the mother was developed based on the investigator's observations of the tone and mood men in the study used when describing their mothers, and their families. The timing of such a sense of "loss" would also appear to fit with Mahler's theories (1979) on the rapprochement subphase of the separation-individuation process at about age 2. Conditions which might create such a sense of deprivation would include the return of an absent father, the mother's involvement with a new father figure such as in remarriage,

other major family disruptions which involve only the emotional and not the physical loss of the mother, or, as in the case of Gurwitt's patient (1976), the birth of another sibling and the withdrawal and depression of the mother during pregnancy, including more serious post-partum depression. The situation of an oldest boy who is "replaced" in his mother's eyes by a series of little baby brothers would also appear to play a role in the syndrome.

The boy who later develops couvade syndrome would appear to identify himself as "the needy baby," at levels below his conscious awareness. His sense of himself as baby would have derived from his mother's definition of him and relationship to him. While aspects of such self-identity would appear to be linked with qualities defined as feminine such as passivity and dependency, it can more properly be seen as an "infantile" identification. Such self-identification would appear to be set within a larger context of mastery and competence for the man. In fact, a disruption of a "baby" role may help push the boy to explore other roles and lead him to become more competent than he would otherwise. Presumably the early "indulgence" or infantilization loss is not so traumatic that it undermines later development and/or mastery of later issues. In reading about cases or in talking to high symptom men, one does gain a sense of the boy's disappointment in the mother and his turning away from her toward pursuits

outside her realm, perhaps to that of the father. One father described a supportive grandfather who helped reassure him of his own competence. It is important to note that this is not an oedipal situation, but one which involves real disruption of a relationship with the mother. The men in this pattern are generally competent, normal men. Their subsequent marriage and pregnancy creates again the setting for "indulgence" in their one-to-one relationship with their wives. They re-experience "loss" as their wives focus on the mysteries of pregnancy. The emergence of the "baby" as a potential replacement for them may continue the disruption of the relationship with their wife. After a child comes, and the family adjusts to it, a man may re-establish his former relationship with his wife, so the syndrome does not recur until there is another pregnancy. The pattern of loss of the wife while she is pregnant was discussed by Millet, Karkous, Jorda, and Cabal (1978).

The symptoms of the couvade syndrome, or at least some manifestations of, it may, therefore, be more related to an unconscious, physical sense of being the "baby," rather than strictly to being like the pregnant mother. It may be important to remember that, for the expectant father, the child-to-be and his wife share the same general body space. Their separation is an intellectual and emotional fact more than a directly observed one for the man

who sees his wife's body changing. Thus, his symptoms may involve both a sense of being a "baby" in need and an awareness of "pregnancy symptoms" which are outward signs of both the woman and of the baby within.

Symptoms described by two couvade fathers also suggest recapitulation of events during or related to infancy, rather than symptoms common to pregnant women. Lipkin and Lamb (1982) reported a father who had upper leg aches and who, as an infant, had been in leg casts which made his upper legs ache. Lipkin and Lamb had access to medical histories for many of their subjects, which could bring to light such indicents. Other studies have lacked such detailed histories and, therefore, may have overlooked sources of the symptoms. In the present study, one father described a serious skin condition in which he lost all his outer layer of skin a few days after his wife delivered their first child. He was bedridden by the condition at the time she brought the baby home and was dependent on her for help. For this reason, she had to rely on help from other family members. The condition cleared up quickly and did not recur for several years, until, during a second pregnancy, he developed a mild rash. The rash and skin loss may be similar to the loss of the very top layers of skin by an infant in the several days after birth. This father's early history included being the younger brother of an older sister, who contracted a very serious illness

when he was about two. Thus, he might fit into the pattern described above, with a disruption for the family occurring with his sister's illness.

The present investigator has also been struck by informal stories from wives about husbands becoming sick (or having other difficulties) when the women returned home from the hospital with a baby. A sick husband certainly may need the same sort of attention that a new baby demands and, if there is little help from outside, the husbands may inadvertently compete with his child for care for a few days. While such an occurrence (i.e., illness) would often be beyond a man's control, it is interesting that such emergencies do arise not uncommonly. Perhaps there is a psychological contribution in a man's becoming ill around his child's birth which relates to a man's sense of deprivation.

An aspect of some men who develop the couvade syndrome is their nurturant qualities. There is no clear evidence that men who have mild versions of the syndrome are different in their fathering abilities compared with other fathers. Many of the high symptom fathers appeared to the investigator to possess nurturant, caring, fatherly qualities in quantities similar to other fathers. Apart from the situations noted above in which fathers competed with babies, many fathers seemed well able to care for and nurture their wives and children. Thus, any conflicts

involving their own (or others') nurturant aspects do not appear to interfere completely with the emergence of such qualities in them. It may be that the conflicts over nurturance promote the emergence of nurturant qualities to overcome them, as in a reaction formation or a compensatory mechanism. Nor is it suggested that the syndrome is associated with such qualities in the present study, although Munroe and Munroe (1971) found evidence of greater interest in children and caretaking in part of the group of high symptom fathers they studied. It is possible that such fathers had more experience with nurturant or fatherly males later in their lives than did the men in the Munroe study who had a "hyper-masculine" identification.

If a man's sense of "fatherliness" and identification as a father develop in part from his identification with his father's position in the family rather than his personal qualities, as suggested by Richards (1982), and in part with his identification with a nurturant mother, as suggested by Grossman, Eichler, and Winickoff (1980), then it is precisely this identification process which would be disrupted in the model suggested above for the origin of the couvade syndrome. The main characteristics of the father's position and of a generally nurturing (though somewhat infantilizing) mother are present. Their presence would help explain the nurturant capacities found among many high symptom fathers. The father's position may be

filled by a passive father or a step-father and therefore may be a source of additional conflict.

Because of the particular family organization and the particular type of relationship with the mother (i.e., excluding the father), a disruption of the boy's relationship with his mother may leave him especially sensitive to issues of nurturance and parenting. While such a disruption may not be major or traumatic, it might involve a disruption of the boy's sense of himself as a baby or "mama's boy" (as defined by the mother and to which he accommodates himself). Such a disruption would seem to be the ground work for the later symptoms. The boy would go on to other relationships and roles but he would have lost aspects of an earlier one, rather than rejecting it or moving beyond it himself.

Images of the female as both very exciting and powerful (i.e., engulfing) as well as depriving may remain with the boy (Gurwitt, 1976; Miller, Karkous, Jorda, Cabal, 1981). He may have a sense of having been involved, and then excluded and "left out." When a man marries, there may be aspects of this earlier, disrupted relationship with his mother in his relationship with his wife. After a man impregnates his wife, and she becomes "mother-to-be," his early sense of being the "baby" and his desires for involvement coincide with fears of being excluded and with a sense of being shut out. The symptoms may be a way

to relieve the issues on a physical plane. The man again may have a sense of being involved, and then helplessly excluded from the experience of his wife. He may have a sense of being "replaced." By developing symptoms, he may be able unconsciously to appeal to the emerging "motherliness" of those around him, and also to share in an experience from which he feels and has been excluded (i.e., pregnancy).

Men who develop couvade symptoms may now have a clear tendency to somaticize in reaction to stresses and conflicts in their lives. But it would be of interest to know if they tended to "get sick" as a young boy, which might have temporarily revived earlier aspects of their relationship with their mothers.

The finding in the present study that a man's relationship with a sister or sisters may affect his tendency to develop couvade syndrome may relate to the influence of females, both mothers and sisters, in his life, or his identification with them. The finding that men with few symptoms also had sisters in larger families suggests that familiarity with females who are of equal or lower status (in terms of age rank), in a situation not conducive to the couvade syndrome. It may also be that such men are far less affected by the relationship with their mothers because there are other children, especially other females in the family. In a larger family, or with more

sisters, a boy has a less exclusive relationship with his mother, or, he has other sources for ideas about females. A younger brother of an older sister or a brother of all brothers will have a very different view of the power and qualities of females than boys with younger (or several) sisters.

In addition to these explanations, it is important to keep in mind that men identified as having a couvade syndrome reaction may be reacting to stress in their lives, rather than to deeper, "unconscious" processes. The usual couvade symptoms are also symptoms of anxious reactions to stress (nausea, G.-I. tract problems, skin problems, lack of sleep, weight gain or loss). Certainly, pregnancy is a time of readjustment and anxiety as well as anticipation, and reactions to stress may be a major part of the syndrome for some men without reference to unconscious motivation other than a tendency to somatize reactions to stress.

Another possible explanation for the syndrome is that it is based on a man's empathic responses to his wife's pregnancy. He may identify with her, and physically empathize with her. The investigator's observations that some high symptom fathers were nurturant and apparently empathetic to their wives suggests the support for this explanation.

In summary, the couvade syndrome appears to be related to several aspects of a man's background. These include a quality of "low male salience" (Munroe, Munroe, and Whiting, 1973) which may include either early physical father absence or an emotionally withdrawn father. Other family pattern factors, such as number of siblings and number and relationship of sisters, also appear to affect a man's tendency to develop couvade syndrome. A model is suggested of a boy's early infantilized involvement with the mother which is disrupted by the birth of newer siblings or his abandonment which leaves the boy feeling excluded, "left out" or replaced.

In future investigations of the couvade syndrome, it may be useful to consider the syndrome as distinct from labor-like "sympathy pains" experienced near the time of delivery in some fathers. The only fathers in the present study who reported such pains had some of the lowest symptom scores in the sample suggesting that such pains may have a somewhat different significance.

## B. Approaches to Birth Participation: Types of Fathers

Four categories of fathers were developed from interview data related to father's decisions to attend the birth: (1) eager (N=17), (2) willing (N=15), (3) reluctant (N=6), (4) non-attending (N=3).

Men in the reluctant and non-attending groups tended to be older, with more children, than eager and willing fathers. Reluctant fathers also tended to have higher incomes compared with those in other groups. These findings suggest that the changes in childbirth practices since older men have had their children may have affected their reluctance to participate. The trend toward non-medicated and father-coached childbirth practices may involve more men who are older and have had children in a different way. Their initial reluctance may be related to their comfort with previous childbirth experiences, which they are now being asked to change. Such men were not among early groups of fathers who attended the birth, and therefore are probably more conservative in the face of social trends than earlier "attending" fathers. It also may be difficult to change one's customary way of having children. If the previous procedures worked, why risk new procedures?

Among fathers who did not have children, individual interview data suggested that some fathers had already begun to imagine themselves in a waiting room and were reluctant to give up their image of where and how they would pass the final stage from expectant to actual father. Such images had sometimes been created during conversations with other fathers, including their own. These images, therefore, served as links to their identification

with being and becoming a father. For other men, being in a place designated for fathers, or a place associated with men and male aspects of birth customs seemed important. A reluctance to be at the birth itself did not necessarily relate to lower interest or involvement in the pregnancy, as demonstrated by the pattern of obstetrical visits. A larger percentage of reluctant and non-attending fathers visited the obstetrician than willing fathers.

Thus, men had a variety of reasons for their reluctance to attend the birth, many of which were only tangentially related to the birth process itself. In some situations, their reactions appeared related to their relationship to their wives, and only one or two men seemed to feel trapped into the situation.

The consideration of reluctant and non-attending fathers discussed above helps clarify the complex issues involved in a father's birth attendance. Some men, like some women, have their own good reasons for trying to reduce their participation at the birth of a child. If a man feels trapped into being there, he may comply although, under such conditions, he is less likely to be a supportive coach for his wife. Many men who are initially reluctant gain information in classes and are later glad to go. For men who remain reluctant, and continue to seek alternatives, it may be far better to let them remain

outside the process where they will not be called upon to perform an important role they feel themselves unwilling to handle or unable to prepare for by attending classes. Such respect for individual wishes may help prevent couples from becoming angry and defensively hostile during the labor and delivery process.

The issue of father participation during pregnancy, birth, and early parenthood is a difficult one to assess. It may be that fathers, in the roles of husband-father and father, may require an individually chosen balance of involvement and reflection. An individual father's desire and capacity to step back, reflect, observe, judge and predict may be at odds with his wife's desire for greater support, involvement, sharing, or with the desire of professionals involved in childbirth to see the father excitedly overwhelmed. Some fathers appear to need this reflective, observing capacity for themselves and for decisions concerning their families. It is also likely that in an adequate husband-wife relationship, a husband's reflective capacities fit for the couple. It is, in fact, a father's capacity for calm, accurate, but vitally interested observation and judgement which will enable him to be a good childbirth "coach."

Additional data distinguishing among the various categories of fathers on the MMPI yielded only one statistically significant finding. The mean scale 8 (Sc) scores

for willing fathers and for reluctant fathers was higher than the scores for other groups. It is unclear why this difference is significant.

In looking at other, non-significant mean scores, it was interesting to note that in only one group--eager fathers--were the mean scores for scales 5 (Mf) and 9 (Ma) elevated. These two scales suggest both the excitement, and the interest and appreciation for feminine aspects of life which one might expect to find among expectant fathers interested in participating in the childbirth process. Mean scores on other scales for willing fathers were slightly more elevated than those of eager fathers, perhaps indicating slightly greater overall ambivalence in their general outlook. The significantly higher scale 8 (Sc) mean score for willing fathers may also be reflective of greater ambivalence and may relate to some of the more unusual thinking an expectant father may normally experience during the few weeks before birth. Gurwitt (1976) described his analytic patient as having many magical fantasies involving good and evil forces in the third trimester of pregnancy. The Sc scale can indicate unusual, imaginative thinking, especially for higher scores which are still within the normal range. The higher Sc scale means may also be related to two other findings for a subset of this group of fathers. Four fathers in the willing group who all experienced few symptoms (low group) reported

that both of their parents spent equal amounts of energy in their upbringing. It may be that fathers who do not somatize engage in more free, abstract, or unusual thinking and fantasy as the delivery date approaches. This finding also may be related to the Sc scale which may indicate unusual thinking. The lack of symptoms for these fathers may relate to their having two nurturant parents with whom they have identified, especially their father. This finding may support the suggestion that the couvade syndrome is related to problems encountered in an identification with a nurturant figure.

Fathers in the willing group also had less "shift" toward current reported closeness with their fathers compared with other groups. They also reported the largest number of uninvolved fathers (i.e., their own fathers) for any group. These two patterns indicate that willing fathers had more conflict related to fathers, and fatherhood, which might, perhaps also account for their higher mean score elevations on the MMPI.

### C. The Fundamental Structure of "Anticipating Childbirth"

The world view of an expectant father during the few weeks before birth is a shifting and changing one as it constantly refocuses on the impending birth event. Reflection, anticipation, anxiety, and excitement all coalesce around the birth event. In order to recover the

structure of this world, an analysis of the themes and statements offered by expectant fathers were analyzed in an attempt to clarify the fundamental structure of an expectant father's world view. The complete descriptions can be found in Appendix I. The assumption was that behind each specific statement was a "ground" of general assumptions and that careful analysis of specific statements would lead to a description of this "ground."

If one thinks again of the man and landscape used in describing what this analysis is attempting to do, then the image of the "ground" becomes clearer. The "ground" for the phenomena "anticipating childbirth" can begin to be articulated. Several broad themes (e.g., Anticipating; Handling; Being There) attempt to capture the essential "ground" of anticipating childbirth. The themes are experienced as the vague shifts that an expectant father encounters which help him become excited and uneasy. A man's "ground" does seem to "shift" and become less certain when his wife becomes pregnant. Various new foci (e.g. Baby, Birth Event) or transformed "old" ones (e.g. Body, Wife as Wife/Fetus) now emerge with the "shifts" in the man's experience, or "ground" of assumptions. These foci are specific points of meaning like points of light around which the father organizes the new meaning (new constellations) of his life. He especially grapples with the meaning of the birth, and of his own fatherhood.

Thus, he forms (new father) or reforms (experienced father) the emerging constellation of fatherhood, from the shifting "ground" (themes) and the newly meaningful points of "light" (foci). The themes and foci which have emerged from father's responses to the interview questions about birth are discussed below.

Theme #1: Handling/Floating/Being Overwhelmed: Self and Powerful Forces

The father feels a strong and growing weight of responsibility coupled with a sense of his own limited power and control, sometimes verging on helplessness. He is unable to "make sure everything turns out right."

Focus A: Self as Father. A father feels the weight of his responsibility as "father." He must handle the events, complications, and changes which have and will continue to follow the fact of conception. He has a sense of having helped set things into motion that can threaten to overwhelm him, and his family. Ideas about being a father, especially for first-time fathers, "float around inside," like the hormones that "float around inside" his wife. The father finds himself feeling more serious. He feels the weight of his role as provider and protector for his family, to provide a "good home" financially, and to provide his time and energies as "good" husband now and "good" father in the future. He must "handle" the

responsibility rather than let his fears and anxieties overwhelm him and thus affect his family. He draws on various sources to handle and clarify his growing sense of father to this child. These include male friends, childbirth classes, past experience with his own children, or the children of others, reading, and reflection.

Focus B: Physical Body. The father has moved beyond the mixed feelings of pride and apprehension that followed his biological paternity. As impregnator and progenitor, he feels responsible for the pregnancy: "She didn't get that way by herself." Unlike his wife's body, his own body does not help him move toward becoming a father with a set of biological mechanisms. As responsibilities and apprehensions build, a father may experience physical reactions to the pregnancy. He may handle the anxieties in physical ways through loss of sleep, weight loss, stomach upset, etc.

Focus C. Emotions/Reactions. An intense mixture of feelings surround and well up within the father. Excitement, euphoria, dread, ambivalence, fear, resentment, happiness, joy, pride, embarrassment, etc., come and go. The intensity and shifting nature of the father's feelings and reactions leave him with a sense of having to "handle" them. He may let them flow freely through him or he may try to stop those which seem too intense for his personal

comfort. He focuses on maintaining an optimistic outlook and on managing any fears and ambivalence. He has a sense of his own ability to manage his feelings, and is determined to do so, even in the face of great fears and anxieties.

Focus D: Wife/Fetus. The father focuses on his role as provider and protector for his wife and the child within her. As she moves through the phases of pregnancy and toward childbirth, the father feels especially responsible to support her, tolerate her differences, protect her from his own negative feelings and reactions, and carefully to monitor her "handling" of the pregnancy and her ability to "handle" the birth and the child. He feels he is to handle himself, and help her to handle and to manage herself and the pregnancy according to how they "work" and share tasks as a couple.

Focus E: Baby. A father wishes he could "make everything turn out right" for his child. He hopes (or expects) to learn to handle the baby--to take care of it, teach it, raise it. The father evaluates his skills, capacities, and abilities to take care of his child, be around a child and enjoy the child. He recognizes that the child will have a unique set of individual needs and characteristics which he, the father, must take into account. The father wonders how he will react to the child,

and especially about handling any problems the child may have. He cannot assure a healthy child but feels he can handle "whatever happens." The father also estimates how he and his wife will handle the changes the baby brings.

Focus F: Birth Event. Themes of "handling" and/or "being overwhelmed" particularly pervade a father's thinking and imagining concerning the birth event itself, especially if he plans to be present. He feels responsible for getting his wife to the hospital and for minimizing her discomfort. During the event he expects to handle "whatever happens": the waiting, the hard work, any complications, his wife's pain and difficulties, and then the happiness, joy, and intensity of seeing the baby born. Many fathers expect to "be overwhelmed" while seeing their baby being born. A father expects to have some control of the powerful feelings he expects, or hopes for at birth. He expects to manage negative reactions. These include fears related to blood or hospitals, distress at seeing his wife in severe pain, and his wife's irritability, fear, or panic. A father also expects to allow happier feelings to flow through him. He wants to feel happiness and joy at seeing the baby "being born." He hopes to enjoy "closeness" and sharing the experience with his wife, as they look at and hold the baby.

Some fathers who have taken childbirth classes think the information helps them have a greater sense of control because they have an idea "of what to expect." Such knowledge helps them manage their anxieties and contribute to their confidence in their ability to "handle" the birth event.

Theme #2: Reflecting/Experiencing: Self and Lived Experience

The experience of the expectant father moves between reflecting on and experiencing the pregnancy and childbirth. The father is drawn to greater and richer involvement in the experience as he watches the powerful dramatic changes in his wife and especially of her body. Her experiences are not his, and he is most often an observer of her experience by virtue of his proximity. He is also drawn toward involvement by his own curiosity, his intimate connectedness, and his wife's embeddedness in the pregnancy.

(A) Self as Father. As a man becomes a father, especially for the first time, he reflects on his role as a son and re-evaluates his view of his parents. He gains insight and understanding for "why they did some of the things they did." People around him, including his family and friends, treat him differently. If he is a first-time father, he and others identify him more as a father. He evaluates himself as a father, or as a future father,

reflecting on his experience as a son, and on his experience or ideas about children, and how he wants to father. He senses his life is changing and has mixed feelings about what freedoms, routines, patterns, and shapes of relationships he may be giving up in exchange for being a father to a child or another child. He may feel very satisfied to move to a new position or he may feel very ambivalent.

(B) Physical Body. A father may feel ambivalence about the capacities and limits of his own body as he shares the pregnancy experience with his wife. He may be greatly relieved that her body undergoes the seemingly impossible transformation he observes. Or, he may feel envious of her capacities to carry and bear a child. She may seem to have an "unfair advantage" for becoming closer to and more involved with the baby--both as a pregnant and later as a nursing mother.

Men who want to share the experience may develop "sympathy pains," which are pregnancy-like discomforts, often like brief labor pains. They want close, intimate, shared involvement in all aspects of the pregnancy, including physical involvement. Other men have difficulty with the sense of sharing and empathizing with the pain their wives will undergo during labor and delivery. It will be hard to watch their wives suffer. They want to share it in the sense of supporting her through it with their psychological sharing, not physical shared involvement.

(C) Emotions/Reactions. The emotional intensity and shifting of feelings provide an expectant father's greatest experential involvement in the pregnancy. His own personality and comfort help determine his reflective staying calm or his excited involvement. Rich feelings of satisfaction, confidence, pride, excitement and happiness allow a man emotional involvement in pregnancy, especially as he and his wife share these feelings. A man's feelings of fear, ambivalence, resentment, anxiety, dread lead him to feel too involved and force him to move back and reflect in order to manage such feelings.

(D) Wife/Fetus. The father observes and evaluates his wife's experience. He monitors her to see "how she's doing" and "how it's going." He considers her abilities to go through the birth and to be an effective mother. He also experiences her withdrawal of attention from him and his needs. As he and she accommodate the changes, he gains a close feeling of mutual sharing and working together toward the birth of the baby. As the father feels the baby kick inside his wife, he works toward developing a relationship with the baby as separate from the one of his wife. He remains very aware of his wife's experience and tends to be less reflective about how her experience influences him.

(E) Baby. As the father works toward a relationship with his growing, yet-to-be-seen baby, he may name and/or imagine it. It becomes "that little feller kicking around in there." Despite this, the baby, and the man's sense of being its father, remain "unreal," not "tangible," not quite "believable." The baby is, in fact, more a part of his wife's body, and an image in his own imagination than is directly experienced.

A father finds himself noticing other children more, especially interactions between children and their parents. If he has children of his own, he concentrates more on those relationships because he knows they are going to change.

(F) Birth Event. The birth event, like the father's emotions, is another focus that allows the father great involvement, if he and his wife choose to have it. The birth event allows choices, ranging from distant observation or imagining beyond the event, to very active coaching and supporting of the wife during the entire childbirth process, as well as opportunity to be involved with the child immediately after birth.

Men who plan to attend the birth expect the birth itself to be the event worth "going through" to see. They expect their wives to suffer pain and for themselves to undergo hard work during labor. At birth, they expect to be intensely focused on the birth, watching and feeling,

totally experiencing "being there at the exact moment of birth," "seeing life born." It is the richness of the lived experience they want to "be there" for. They anticipate that it will involve feelings of happiness and closeness to their wife and baby.

Theme #3: Relaxing/Attending: Self as We

An expectant father's attention, focus, and concern move beyond himself during pregnancy in a clear way. He is more aware of and wants to be more accommodating of his wife and growing child than before the pregnancy. He feels her own focus shift inward and away from him. As the wife's attention moves inward, the husband's moves toward her. He focuses less on himself as a separate person and more on his role of husband and father, paying attention to things with which his wife does not or cannot now deal.

(A) Self as Father. A man considers himself in light of his new role--father to the unborn baby. This may involve his first experience as a father; or it may involve his first pregnancy with this woman, or it may involve his experience of becoming a father for the second, third, or "nth" time. His reflection on himself involves a rethinking and a re-focusing, rather than relaxing in the present situation, because the father experiences himself as in change. He may also pay more attention to his

work, or school, as a reflection of his idea of being a provider.

An expectant father is especially focused on his wife/fetus and family (including other children). He may be aware of some loss of her attention to him, or simply observe she doesn't do things the same way, and he tries to be tolerant. This is not the time to involve her with "his" problems unless they concern her. It is as though the point of summed focused attention between a couple or within a family has shifted, from a point closer to the father to a point inside or very close to the mother. All people in the family share in their average focus on the "new" spot. The father especially expresses that he is putting his own personal needs and wishes "on the back burner," to help his wife, just as his wife does to some degree to accommodate the growing child.

(B) Physical Body. A father's body does not receive attention. Sexual activity, especially, changes and declines for the couple, as the wife grows larger. Her body as containing the fetus receive primary consideration. While some fathers accommodate their wive's discomfort in stopping sexual activity, for others, it is the father who decides to stop activity which might endanger the baby, even as he feels very ambivalent about such a stop. This "stopping" can also be true in other physical activities. A man may curtail his and his wife's activities.

(C) Wife/Fetus. An expectant father is sensitive to and attends to his wife's emotional reactions, often more than his own. He gauges her reactions to see how well "it's going." He also interprets her reactions. Sometimes he "can tell" when something "means a lot to her" and tries to accommodate her. His loss of some of her attention with accompanying ambivalence is rationalized.

An expectant father also learns about pregnancy and childbirth, through watching his wife and often attending classes. He reacts with respect, fascination, and sometimes awe at the biological processes involved; especially what his wife experiences and undergoes. He often "didn't realize what a woman goes through" before and is glad to learn about it. He takes some pride in his wife's "job" and her ability to do it.

(D) Baby. While the man focuses far more on his wife, he attends to the growing child through his wife. He is building a relationship with "that little feller," but its unreality limits his ability to do so. The baby is known less as a person and more as an amazing, transcendent, hunan offspring/product. The baby, as a part of himself and his wife, fascinates the father. It is as his own, a part of himself, that the baby is especially meaningful and special to the father.

(E) Birth Event. The father feels called upon to attend to his wife, especially around the birth event itself. He must be ready to get her to the hospital and, if he does not attend, will wait "to make sure everything's all right." If he is a coach, he anticipates trying to be especially sensitive to her needs and wishes and to refrain from doing anything that might interfere with her/their work. He expects to support her through "whatever happens" and expects little or no attention to be paid to his needs by his wife or by the medical staff. He hopes not to feel like an intruder to the professional staff or to his wife.

At the birth event, the father expects to focus on his wife first. As the baby is actually being born, he expects to focus on the birth and then on the baby with his wife. He has little thoughts of focusing on himself.

Theme #4: Waiting/Anticipating: Self in Time

For expectant fathers in the last few weeks or days before birth, time is a palpable presence. The time of pregnancy., in retrospect, has moved more quickly to its climax than he/they thought it would, although it now seems to have slowed interminably. There is a suspension of the present--a waiting and waiting for the future to arrive. All meaningful activity has been projected into

the future, where a father is now "really" living, except for the big event that has not yet occurred.

(A) Self as Father. It is himself as the father of this child, that must await the event which makes him the father of the child. For first-time fathers, excitement and anticipation are especially acute. A father wonders and anticipates how the child will change his life, his relationships, his routines and patterns, his work and ability to work. "How will my dog react?" He also wonders how being a father to this child, especially for first-time fathers, will change his sense of himself. He is looking forward and can't wait. He has been waiting for a long time and wishes it were over.

(B) Physical Body. Waiting and anticipating can be hard for some fathers, who feel "trapped" by being forced to suspend plans and activities, especially shared physical activities or sexual activity, until after the birth. They feel "antsy." Others feel growing excitement, almost physical anticipation.

(C) Emotions/Reactions. Emotions are intense and building as the birth gets closer. Some fathers are getting really excited for the first time--and get "more excited the closer it gets." Ambivalence and fears are unwelcome by fathers. They want to feel good and are

disappointed with themselves if they cannot generally succeed in "adjusting" to the birth by now. If they have felt ambivalence, it is time to "put that behind us" and make the "adjustments" necessary to feel good about the baby.

(D) Wife/Fetus. A father is waiting for the baby to come. He wonders when it will come, how soon. He sees his wife become more tired, restless, impatient and feels the strain of waiting in himself. He stays fairly close to his wife and keeps his wife fairly close to the hospital or doctor. He has plans about where to go and what to do when it comes and how to manage getting his wife there. Some first-time fathers wish they knew exactly what to do at every step.

(E) Baby. A father wonders what the baby will look like, what sex it is, what abilities it will have. He wonders and hopes it will be healthy and tends not to describe specific problems, preferring to keep specific images to himself, or to keep them vague, because dwelling on them might just create worry over nothing. He wants to see the baby, hold it, see his wife hold it, see that it is "all right."

(F) Birth Event. A father has ideas about the birth itself, from vague images to detailed pictures involving

seeing the baby held by the doctor, or emerging at birth. He expects to feel intensely and to see painful events, such as his wife in pain. Despite this he is generally confident and optimistic or determined to do the best he can. He hopes and expects to be helpful and supportive and to be needed by his wife. He anticipates that helping his wife and/or experiencing the birth itself will make all the work and effort and waiting worthwhile, apart from having the baby. Fathers who do not expect to be present expect a birth event to be overwhelming, especially if there are problems, or to be fairly routine for their wives and therefore not a situation where they are needed or wanted.

Theme #5: Missing Out/Being There: Self as Separate

An expectant father is aware of being excluded, or included, in various ways throughout pregnancy and childbirth. His physical separateness and lack of body changes are in sharp, if reassuring, contrast to his wife's body changes and to her union with the growing baby inside. This theme of "missing out" or "being there"-- of exclusion, inclusion, or intrusion--emerges many times in a father's description of his situation.

(A) Self as Father. A father wonders how close to the child he will be after it is born. He wonders if the

apparent biological ties between mother and child will tend to exclude him, and if he will need to put forth an effort so as not to "miss out" on taking care of and becoming close to the child. He wonders how the child will react and respond to him. Will he easily be included as one of the important people by his child? When will the child know and recognize him?

Fathers do not experience a sense that they are "missing out." By having a child, they are "fulfilled," "satisfied" and would not be if they did not have children. The child, especially for first-time fathers, means they become fathers, and have taken on one of life's good, important, satisfying roles. A father also plans to make sure his child does not "miss out" on things he missed with his own father.

(B) Physical Body. A man does "miss out" on the physical pregnancy and childbirth experience. His body does not and cannot do what a woman's can and is doing before his eyes. A father must make an effort if he wants to share his wife's experience. He must also make some effort not to share her experience, especially her discomfort and pain if he does not want to. He takes a stand, physically, where he is comfortable--either trying to share, or trying to stay clearly separate. He may envy a woman's capacity to be "so close" to the child, to bear

life, but he also feels some relief at avoiding the "sacrifice," "strain and pain," and ordeal he sees her undergo.

(C) Emotions/Reactions. A father is aware of the increased attention his wife receives from others and can feel that he is "missing out" on such attention, although the baby is "as much mine as it is hers." Pregnancy and childbirth are viewed by society as "women-centered" rather than "family events." Fathers remind themselves of their importance and of their right to be "included."

For some fathers, the opportunity to "be there" is exciting. It allows them to see beyond a sexual mystery. For others, it will satisfy their curiosity about birth, women, and/or hospitals.

(D) Wife/Fetus. A father becomes aware of the emotional difference in his relationship with his wife. If he is able to move toward an emotional closeness on her new terms, he can share a new close relationship with her. If not, he feels deprived and excluded from her attention and involvement. He finds himself focusing on the baby as an intruder in his relationship with his wife and must "adjust" to "feel good" about the baby.

The father feels the baby kick within his wife, but "not like she does." He "misses out" on "knowing" the baby and feeling close to the baby in the way he perceives and imagines his wife does.

(E) Baby. The father must work harder than the mother to feel a direct relationship to the baby. The baby mainly remains "not quite real" until birth, even when the father tries to relate to it directly.

The baby is a presence in a man's relationship with his wife and other children. The baby can be an intruder. It can also be a welcome expression and "extension of our love for each other" for him and his wife, physical evidence of their "being there" for one another. The baby also can be a way for the father to treat his child better than he was treated--to become a good father. He hopes and plans that his child will not "miss out" on things he did as a child.

(F) Birth Event. For fathers who plan to attend the birth, the birth event itself is the main thing not to "miss out on." Seeing the baby born, "being there" to experience it are very important to many fathers. For others "being there" for their wives is the important aspect of attendance. They would not want her "to go through that all by herself." They would not want her to "miss" them and they feel needed by and important to their wives.

"Being there" will mean they have their own "memories" of the event in their own "memory banks," not from "what someone else tells you." Fathers who "missed out" during a prior birth remember feeling "cheated out of

something" and feeling like they were "far away," from the real, meaningful event in their lives.

Some fathers do not have a clear picture or sense of what it is they would "miss out" on if they are not "there," but they know they would miss something that could be very important--to them and to their feelings of closeness to their wife and child. "Being there" will help "start things out right" for the baby and its parents.

They hope they will not feel like intruders into the medical world, and fear this somewhat. Some men also wonder if their wives will feel "embarrassed" at having their husbands at an event that involves the personal parts of her body and strangers.

## Some Implications of the Themes and Foci of Anticipating Childbirth

Anticipating childbirth for fathers is an exciting and anxious time. Fathers' experience a complex constellation of physical, emotional, and intellectual reactions while their wives are pregnant. Their experience of anticipating childbirth appears as rich and complex as that of a woman's, yet we know far less about it. The themes and foci described in this study suggest the complexity, range, and intensity of fathers' experience.

The themes described in the previous section suggest ways of relating to the specific foci. Individual fathers find their own positions of comfort along each theme

dimension. They may try to control their situation rigidly, in an attempt to "handle" it. Such men might try to dictate to their wives, for example. Other fathers may be more comfortable with the experience of "being overwhelmed" in specific instances. A father may expect to "be overwhelmed" at the birth event which allows him a specific place and time to "be overwhelmed." A father who is especially excited by the image of "experiencing the birth" differs from the father who experiences pain himself when he sees his wife grimace with "false labor" pains. Both men, however, are "experiencing" at those times rather than reflecting. The themes describe dimensions, but the foci allow a father to act. What a father does (including what he says and thinks) illuminates his particular place on the theme dimension. He acts in relation to a specific focus.

The themes also relate to discussion in the literature review of fathers' reactions to pregnancy and childbirth. The theme of "handling/being overwhelmed" and with it the sense of "powerful forces" may relate to the literature on fathers' extreme pathological reactions to pregnancy (e.g. Curtis, 1955; LaCoursiere, 1976). Fathers who have severe reactions may represent the extremes of "being overwhelmed." The same theme can also be related to the literature on the couvade ritual with the fathers' battles against "powerful forces" described in

ancient and widespread ceremonies. There is the same fear of "being overwhelmed" and of "handling" "powerful forces." Modern fathers as "coaches" may be sharing a kinship with ancient couvade ritual fathers in a new "ritual" of father-attended birth.

The "crisis" literature--which describes pregnancy as a "crisis" period for the family--also can be seen in terms of "handling/being overwhelmed." Such literature supports the idea that fathers (parents) may experience a range of reactions between extreme pathology and excited, happy anticipation.

Other dimensions, and their implied range, relate to newer literature. The sharing of the experience at birth and the "engrossment" of fathers in their new baby (Greenberg and Morris, 1974) are suggestive of both the "experiencing" and the "being there" themes. The lower use of medication and greater ease of labor and delivery for wives of birth-attending husbands (Henneborn and Cogan, 1975) may be the result of husbands who work with their wives well because they have been so focused on them (relaxing/attending).

In general, the themes and foci discussed in the present study help bridge a large rift in the literature on expectant fathers. The literature implies that expectant fatherhood is either a time of potential "crisis" (e.g., LeMasters, 1957) and pathology, (e.g., Curtis,

1955; Gerzi and Berman, 1981), or a time of general satisfaction (e.g., Dodendorf, 1979). Clearly it is both a time of change and potential crisis and a time of excitement and joy. It is, above all, a meaningful time. As such, it contains elements and potential for both tragedy and joy.

The theme of "waiting/anticipating" captures the element of time in the expectant father's experience. Pregnancy is a meaningful time. It is an event that spreads out in time, and brings time into focus. The following discussion suggests some further implications both of the themes generally, and of the specific importance of time for the expectant father.

Anticipating childbirth is done in two ways--male and female. Women anticipate birth by being pregnant. Men are expectant. The words themselves clarify the fundamental difference. "Body," with its suggestion of the physical dimension of weight and biological changes, is the primary dimension for the pregnant woman. "Time," with its suggestion of the temporal dimension of past and future, change and continuity, choices and limits, and reflection, is the primary focus for the expectant father. If a pregnant woman in her ninth month is focused on "Body," an expectant father is focused on "Time." He is waiting for something to begin ("anticipating"), as his wife is waiting for something to end (waiting). If, in

fact, a man does focus on "Body" in terms of his own body, as in the couvade syndrome, he can be seen by society as not quite fulfilling his role. On the other hand, if he stays "too" removed from "Body" by refraining from participation at childbirth, he can also receive opprobrium.

"Body" is a focus for expectant fathers, but too much focus may create problems for him if he neglects the dimension of "Time." The expectant father, in clarifying "roles" during pregnancy, may seek inclusion in the "Body" preoccupation characteristic of a pregnant woman. "Time," however, may be a more natural dimension for the father. It involves awareness of both changes and continuity, of reflection, of the necessity to make decisions and choices, to observe and evaluate. These aspects of time are also fundamental to the "job" of expectant father. As his wife becomes preoccupied with the pregnancy (ranging from little to great preoccupation), the father must attend to the things she does not. In fact, the image of "coach" at childbirth captures the essence of the expectant father's role--evaluator, decision-maker, accurate observer, supporter. The same qualities are also implied by more traditional images like "provider" and "protector."

The "coaching" metaphor is appropriate as are "protector" and "provider" images. An expectant father constantly monitors and assesses. He provides support and manages his wife and family and their dealings, on

many levels, with the world beyond the immediate family. He also deals with the swirl of feeling and reactions, both in himself, and in his wife. It is an exciting and anxious time and he must help his wife and children manage things at many levels if they are to navigate their common voyage successfully.

The "powerful forces" for the modern American expectant father are not easily translated into the evil spirits and demons fought off through various couvade rituals in other societies. But there are "powerful forces" at work--together they are described as "hormones," or "internal conflicts," or "intensive emotions," or "financial worries." Expectant fathers do their job. Like any job, they may do it well or poorly. Their performance, like any other, is affected by their personal approaches, their families, and circumstances that are beyond their control.

Another metaphor can be used to describe the expectant father's position, and his role. One can think of pregnancy and birth in terms of a series of passages, which surround one another, like a series of tunnels within other tunnels. They all have "beginnings" and "endings," and "movement through", clarifying the significance of time in the phenomena of pregnancy and birth. At the center is the tunnel, or passage of the baby from the womb to the outside world. The infant must usually negotiate this

passage alone, and with great work. Everyone at birth tries to help him or her. The mother's body pushes as other people monitor and "deliver" the child. Only the baby can negotiate the passage itself, but he or she must have the help and firm support provided by the mother and sometimes others.

Beyond the baby is the mother. She moves through the "passage" of pregnancy and childbirth. It is a physical passage involving accommodation, weight, reflection, preoccupation. Her body becomes a "passage" for her child. She must negotiate the physical "passage" or "tunnel" of pregnancy, and then a passage of "strain and pain" to deliver the baby. In order to negotiate her own passage through pregnancy, and to accommodate the baby's passage, she must have help.

While the mother may need and receive help from a number of sources in negotiating her passage, the father's help is extremely important. As the mother negotiates her passage, the father must provide the strong walls and floor for her to move through. If he is verbally or physically affectionate or supportive, she may notice his support. If he is not, and worries silently about money, or about her, and "keeps his eyes on things" in other ways, she may be far less aware of his "support." His monitoring ("attending") and assessing ("reflecting") on their situation, his grappling to "handle" "powerful

forces" in the situation, his "being there" as husband, father, provider and protector form the "passageway" that helps the mother negotiate the physical pregnancy, just as her body forms the strong walls that allow the baby to grow safely, and then move through to enter the world.

The strength and accommodation of such personal "walls" created by fathers (and mothers) may or may not fit the expectations that various professionals, or family members have for them. The "walls" may or may not fit such expectations mothers and fathers have themselves. Such "walls" may fit easily, or poorly around the people they accommodate. Their presence, however, is part of the nature of the human passage of pregnancy. Some sort of "tunnel walls" are also a major part of the "construction" job that expectant fathers do, whether they are noticed doing it or not. All the fathers in the present study worked at this important job in various ways and under various pressures. Expectant fathers do not need to be told what their job is, because they are already doing their best to do it. They, like all of us, may be helped to do it better and need recognition for what they do.

## Recommendations

Based on findings and problems in the present study, the following recommendations are offered for future research in this area. A continued effort should be made to include fathers who do not attend special childbirth

preparation classes. A review of studies on the couvade syndrome which have sibling pattern data would be useful to clarify the finding in the present study. Such data may also help clarify or reflect the model for the origin of couvade syndrome formation suggested in the study. At this point, more detailed information is needed about the medical background and childhood patterns of men who develop the syndrome, from case studies, interview and projective technique data. The lack of significant findings related to the Early Memory data is surprising and may be due to the methodology used in scoring and comparing the data.

For studies of expectant fathers using descriptive or phenomenological methodology, a study of the couple's experience, examined individually and together, and compared with other couples would be useful. The phenomenological method, interestingly, is very powerful for uncovering themes. The findings of the present study, based on questions to fathers during the last few weeks before birth were very similar to a detailed study using fewer subjects and spanning the pregnancy and post-partum periods (Heinowitz, 1977).

The general study of fathers' "fatherliness" remains a useful, and still very unknown area of research. Studies of "normal" fathers which effectively clarify aspects of a father's experience before and after birth that relate to

his capacities for "good enough" fathering would be very helpful. It may take 15-20 years to assess effectively a father's fathering abilities and capacities, because we now only assume that fathers who are good fathers for babies and toddlers are also good fathers to children and adolescents. Short of 20 year studies, much more attention is needed for later relationships between fathers and children who are beyond toddlerhood.

# CHAPTER VI

## SUMMARY AND CONCLUSIONS

The present study explored the following aspects of the expectant father's experience which illuminate the complexity of this experience: (1) fathers' physical reactions to pregnancy (couvade syndrome); (2) fathers' views on childbirth participation (father-attended childbirth); (3) fathers' reflections on the experience of "anticipating childbirth." These aspects will be discussed in conjunction with the general purposes of this study. The purposes as summarized are:

### Purposes of the Study

Specifically, the purposes of the study are these:

1. To explore personality variables and personal adjustment of expectant fathers, related to couvade syndrome.
2. To discover and explore the relationship between birth involvement and couvade syndrome manifestation in expectant fathers.
3. To record incidence of the couvade syndrome among expectant fathers.
4. To explore the following factors affecting the couvade syndrome. These include:

(a) family position (related to sibling rivalry as a component of couvade syndrome)

(b) attitudes toward the father's own parenting

(c) identification (related to sexual identity conflicts as reason for symptoms)

(d) cross-sex identification problems

5. To provide information about fathers' choices on their birth attendance and its relationship to fathers' personality variables.
6. To describe the structure of the world view of the expectant father.

The Couvade Syndrome. For the whole sample of fathers and for high symptom fathers, MMPI scores for high, medium, and low symptom groups were within the normal range. The specific scales which appear to be related to couvade syndrome were: 1 (Hs), 2 (D), 7 (Pt), and (ES) Ego Strength. Also, significant differences among groups were not found in analysis of Early Memories or family background data. The relatively even distribution of scores for Early Memory data and of family disruptions among the three groups may indicate the syndrome is less related to pathology than prior literature suggested. There was no control group of non-expectant fathers or of married men, and the sample was too small for generalization. The generally elevated scores on the MMPI for

scales 5 (Mf) and 9 (Ma) may suggest that expectant fathers, especially first-time fathers planning to attend the birth, are more interested in feminine interests and may be very optimistic and feel more energetic than would a normal sample of men. The higher scale 2 (D) and 7 (Pt) scores for couvade fathers may be in contrast to other, more optimistic, expectant fathers.

The second purpose of the present study was to explore the possibility of a relationship between the couvade syndrome and attitudes toward participation at birth. No clear relationship was found.

A third purpose was to record the incidence of the couvade syndrome. In the present study, 32.6% of forty-three (43) subjects reported a high frequency symptom. The incidence is higher than other studies. It also suggests that the syndrome affects a large number of expectant fathers and has been under reported in the past.

The fourth purpose was to explore some possible factors affecting the couvade syndrome. Family constellation patterns and identification issues appeared related to the syndrome. Family constellation data and birth order patterns provided surprisingly significant findings. High and low symptom fathers came from families with significantly different patterns among sisters. High symptom fathers were likely to be a younger brother of an older sister, or the oldest boy of several brothers. Low

symptom fathers predominantly came from families with girls which were larger than two children. If a man had younger brothers in such families, he also had a younger sister within the two next born siblings. The family pattern data lends support to the suggestion that the syndrome is related to sexual identity issues but emphasizes the very complex nature of this relationship. It also suggests that exclusive focus on the parent-child relationships of men with the syndrome is probably too narrow, although much of the literature on the couvade syndrome has taken this focus.

A model for the origin of the couvade syndrome was suggested. This model involved an intense, infantilizing mother-boy relationship which either excluded a passive father or grew in the absence of a father. The relationship was disrupted by the mother's attention elsewhere (another man, depression around birth of a sibling, etc.), and by an enduring sense on the part of the boy of "being a baby." The nurturant qualities found in many couvade men were developed in one or both of two ways in the model: (1) identification with at least one nurturant figure (mother or father, or other), (2) accommodation to the mother's demands that nurturance be directed toward herself. As an adult, the man's later experience of his wife's pregnancy was a re-experience of the loss of his own mother. He wanted to regain the "motherliness" of

his wife and to accommodate her increased demands for support from him. The symptoms allowed him to share the experience with her (provide sympathy) rather than to be excluded (again). The father's attempt to accomplish both desires and resulting internal struggle produces the tendency toward the couvade syndrome.

It is easy to see a man's physical reaction to pregnancy if he has one. The present study also allows one to see a range of physical reactions to pregnancy, from several symptoms to virtually none. Some men may react by developing physical symptoms like those of pregnant women (high symptom group) and others may react by developing "healthiness" in clear contrast to the changes in their wives (low symptom group). Both high and low symptom groups may focus on "Body" in opposite ways as part of their general experience of "anticipating childbirth."

Childbirth Preparation. As suggested by the fifth purpose of the study, fathers' views and approaches to childbirth were explored. They were analyzed and divided into four categories of childbirth participation: (1) eager (2) willing (3) reluctant (4) non-attending. Eager fathers wanted to attend as much for their own experience as to help their wives. Willing fathers were more focused on their wives. Reluctant fathers were struggling with giving up their more traditional image of childbirth.

They were also significantly older and had more income compared with other groups. Non-attending fathers did not attend because of their strong reluctance to see their wives in pain and/or difficult work and transportation schedules. There were no major differences among background or personality variables beyond those of age and income noted above for the four types of fathers.

Fathers' reasons for attending the birth and their hesitations in doing so can be seen in terms of some of the themes found in the "anticipating childbirth" analysis. Some men wanted to share the birth experience very fully ("experiencing") with their wives, to "be there" and not "miss out" or feel excluded. Several men hoped they would not be made to feel like an "intruder" by the hospital staff, suggesting the theme of "missing out" versus "being there" with the possibility of exclusion.

Other men expressed their desire to stay away, as a way of "handling" their own reactions, to seeing their wives in pain, for example. Their desire might be to move toward the "reflecting" rather than the "experiencing" end of that dimension. Men who do not share the strong desire to "experience" with their fellow expectant fathers are also less likely to be included in studies of fatherhood. It is therefore important to remember the continuum of "reflecting" and "experiencing" rather than assume that "experiencing" fully is the

desire of all expectant fathers. Such a desire while important will probably tend to be over-represented in father studies.

Anticipating Childbirth. The last purpose of the study was to explore the phenomena of "anticipating childbirth" for fathers. Physical symptoms and childbirth participation are ways to anticipate childbirth for fathers. They bring the dimensions of "Body" into focus for the father. They, along with other aspects of expectant fatherhood, provide him with a range for the expression of his own constellation of fatherhood. The father's unique reactions emerge from the "ground" of expectant fatherhood. This ground has been analyzed and has yielded the five themes and six foci of the study.

The five themes create the vague shifts and uncertainties of expectant fatherhood: (1) handling/being overwhelmed as the father deals with "powerful forces"; (2) reflecting/experiencing as the father chooses his degree of involvement in the pregnancy/childbirth process; (3) relaxing/attending as the father shifts his focus toward his new wife/fetus; (4) waiting/anticipating as the father looks forward to the birth and after; (5) missing out/being there as the father pushes to avoid his exclusion from important processes.

The six foci capture the father's attention as he organizes and reorganizes his individual constellation

of fatherhood. The foci serve as organizing points. They are: (1) the self as father, (2) the physical body, (3) emotions/reactions of the father, (4) the wife/fetus as one, (5) the baby as a newly emerging focus, and (6) the birth event itself. Fatherhood emerges as a powerful constellation of old and new images, feelings, and meanings. It appears to help move men toward the hopeful confidence and optimism most expectant fathers expressed in their interviews in the face of their anxiety and their sense of the "powerful forces" involved in pregnancy and birth. As men navigate the time of expectant fatherhood successfully, their confidence and optimism prepare them for the new person who is being born into their family.

# REFERENCES

REFERENCES

Abelin, E. L. Triangulation, the role of the father and the origins of core gender identity during the re-approchement subphase. In R. Lax, S. Bach, and A. Burland (Eds.), Rapprochement. New York: Jason Aronson, 1980.

Allen, M. Individual copulatory preference and the "strange female effect" in a captive group-living male chimpanzee (Pan troglodytes), Primates, 1981, 22, 221-236.

Ansbacher, H. L. Adler's interpretation of early recollections: Historical account. Journal of Individual Psychology, 1973, 29, 135-145.

Anonymous. Aucassin et Nicolette. Twelfth century. First printed in Paris, 1752, translated 1875, no publisher, no date.

Arbeit, S. A. A study of women during their first pregnancy. Unpublished doctoral dissertation, Yale University, 1975.

Arnstein, H. S. The crisis of becoming a father. Sexual Behavior, 1972, 2, 42-47.

Attarian, P. J. Early recollections: Predictors of vocational choice. Journal of Individual Psychology, 1978, 34, 56-62.

Bachofen, J. J. Das Mutterrecht, Stuttgart, 1861.

Ballou, J. The psychology of pregnancy: reconciliation and resolution. Lexington, Mass.: Lexington Books, 1978.

Ballou, J. The significance of reconsiliative themes in the psychology of pregnancy. Bullitin of the Menninger Clinic, 1978, 42, 383-413.

Barash, D. P. Ecology of parental behavior in the hoary marmat (marmota caligata): An evolutionary interpretation. Journal of Mammology, 1975, 56, 613-618.

Bardhan, P. N. The fathering syndrome. Armed Forces Medical Journal, 1964, 20, 200.

Beaumont and Fletcher. The custom of the country. 1647.

Benedek, T. Parenthood as a developmental phase: A contribution to the libido theory. Journal of the American Psychoanalytic Association, 1959, 7, 389-417.

Bettelheim, B. Symbolic wounds. New York: Free Press, 1954.

Bibring, G. Some considerations of the psychological process in pregnancy. The Psychoanalytic Study of the Child, 1959, 14, 113-121.

Bibring, G., Thomas C., and Dwyer, M. Study of the psychological processes in pregnancy and of the earliest mother child relationship. Psychoanalytic Study of the Child, 1961, 16, 9-24.

Bieber, I. and Bieber, T. B. Post-partum reactions in men and women. Journal of the American Academy of Psychoanalysis, 1978, 6, 511-519.

Biller, H. The father and personality development: paternal deprivation and sex-role development. In M. Lamb (Ed.), The role of the father in child development. New York: John Wiley & Sons, 1976, pp. 89-156.

Bittman, S. and Zalk, S. Expectant fathers. New York: Ballantine Books, 1978.

Bowen, S. Father's attachment behavior as related to preparenthood classes, presence at delivery and infant state. Unpublished Master's thesis, University of Tennessee, 1978.

Brown, S. B. The effects of natural childbirth classes on the early father-child relationship. Unpublished doctoral dissertation, University of Washington, 1978.

Butcher, J. N. & Tellegen, A. Common methodological problems in MMPI research. Journal of Consulting and Clinical Psychology, 1978, 46: 620-628.

Cavenar, J. O. and Butts, N. T. Fatherhood and emotional illness. American Journal of Psychiatry, 1977, 134, 429-431.

Chertok, L. Psychosomatic methods in painless childbirth: history, theory and practice. New York: Macmillan Co., 1959.

Colaizzi, Paul F. Psychological research as the phenomenologist views. In R. Valle and M. King, (Eds.), Existential phenomenological alternatives for psychology. New York: Oxford University Press, 1978, 48-71.

Coley, S. B. and James, B.E. Delivery: A trauma for fathers? The Family Coordinator, 1976, 25, 359-363.

Colman, A. and Colman, L. Pregnancy: The psychological experience. New York: Herder and Herder, 1971.

Colvin, C. H. Men's motivations for fatherhood. Unpublished doctoral dissertation, California School of Professional Psychology, 1980.

Cronenwett, L. R., and Newmark, L. L. Fathers' responses to childbirth. Nursing Research, 1974, 23, 210-217.

Curtis, J. L. A psychiatric study of 55 expectant fathers. United States Armed Forces Medical Journal, 1955, 6, 937-950.

D'Anarade, R. G. Sex differences and cultural institutions. In E. E. Maccoby (Ed.), The development of sex differences. Palo Alto, Calif.: Stanford University Press, 1966, 174-204.

Dekker, T. and Webster. Westward Ho, 1607. In F. Bowers, (Ed.), The dramatic works of Thomas Dekker. Cambridge: Cambridge University Press, 1955, p. 329.

Dawson, W. R. The custom of couvade. Manchester: Manchester University Press, 1929.

Davis, O. S. Mood and symptoms of expectant fathers during the course of pregnancy: A study of the crisis perspective of expectant fatherhood. Unpublished doctoral dissertation, University of North Carolina, 1977.

Deutsch, H. The psychology of women: A psychoanalytic interpretation. New York: Grune & Stratton, 1944.

Deveraux, G. Institutionalized homosexuality of the Mohave Indians. Human Biology, 1937, 9; 498-527.

d'Evreux, Yves: In A. Metraux. The couvade. In J. Steward (Ed.), Handbook of South American Indians, Vol. 5. Bureau of American Ethnology, Bulletin 143, 1949, pp. 369-374.

Dickens, G. and Trethowan, W. H. Cravings and aversions during pregnancy. Journal of Psychosomatic Research, 1971, 15, 259-268.

Dodendorf, D. M. A developmental framework for the analysis of expectant fatherhood. Unpublished doctoral dissertation, University of Nebraska, 1979.

Driver, H. Couvade. Encyclopaedia Britannica, Vol. 6 London: Encyclopaedia Britannica, 1964, p. 674.

Dyer, E. D. Parenthood as crisis: A re-study. Marriage and Family Living, 1963, 25: 196-201.

Earls, F. The fathers (not the mothers): Their importance and influence with infants and young children. Annual Progress in Child Psychiatry and Development, 1976, 19, 81-107.

Eckstein, D. G. Early recollection changes after counseling: A case study. Journal of Individual Psychology, 1976, 32, 212-223.

Eisenstein, V. W. and Ryerson, R. Psychodynamic significance of the first conscious memory. Bulletin of the Menninger Clinic, 1951, 15, 213-220.

Enoch, M. D., Trethowan, W. H., and Barker, J. C. Some uncommon psychiatric syndromes. Bristol: John Wright & Sons, 1967, p. 56.

Fein, R. A. Men's entrance to parenthood. The Family Coordinator, 1976, 25, 341-348.

_____. The first weeks of fathering: The importance of choices and supports for new parents. Birth and Family Journal, 1976, 3, 53-58.

Fielding, W. L. and Benjamin, L. The childbirth challenge: Common sense versus "natural" methods. New York: Viking Press, 1962.

Fodor, H. E. The transition to parenthood: Life change and continuity in two phases of the famil life cycle. Unpublished doctoral dissertation, University of Michigan, 1981.

Ford, C. V., Castelnuovo-Tedesco, P., and Long, K. Women who seek therapeutic abortion: A comparision with women who complete their pregnancies. American Journal of Psychiatry, 1972, 129, 546-552.

Fraiberg, S. Clinical studies in infant mental health: The first year of life. New York: Basic Books, 1980.

Frazer, J. G. Totemism and exogamy. London: Macmillan & Co., Ltd., 1910.

Freeman, T. Pregnancy as a percipitant of mental illness in men. British Journal of Medical Psychology, 1951, 24, 49-54.

Freidberg, R. L. Early recollections of homosexuals as indicators of their life styles. Journal of Individual Psychology, 1975, 31, 196-204.

Gay, J. T. Behaviors of first-time fathers at the time of their initial acquaintance with their infants. Unpublished doctoral dissertation, University of Alabama, 1980.

Gayton, R. R. A comparison of natural and non-natural-childbirth fathers on state-trait anxiety, attitude and self-concept. Unpublished doctoral dissertation, United States International University, 1975.

Gerzi, S. and Berman, E. Emotional reactions of expectant fathers to their wives' first pregnancy. British Journal of Medical Psychology, 1981, 54, 259-265.

Gittleson, N. The case against natural childbirth. Harper's Bazaar, 1961, 95, 136-137, 178-179.

Greenberg, M. and Morris, N. Engrossment: A newborn's impact on the father. American Journal of Orthopsychiatry, 1974, 44, 520-531.

Grossman, F. K., Eichler, L. S. and Winickoff, S. A. Pregnancy, birth and parenthood: Adaptations of mothers, fathers, and infants. San Francisco: Jossey-Bass, 1980.

Hafner, J. L., Fakouri, M. E., Ollendick, T. H., and Corotto, L. V. First memories of "normal" and of schizophrenic, paranoid-type individuals. Journal of Clinical Psychology, 1979, 35, 731-733.

Harrison, R. H. and Kass, E. H. Differences between Negro and white pregnant women on the MMPI. Journal of Consulting Psychology, 1967, 31, 454-463.

Hartman, A. A., and Nicolay, R. C. Sexually deviant behavior in expectant fathers. Journal of Abnormal Psychology, 1966, 71, 232-234.

Hathaway, S. R. and McKinley, J. C. The minnesota multiphasic personality inventory. New York: The Psychological Corporation, The University of Minnesota, 1943, 1948.

Heath, R. 1650. In Lean, V. S. (Ed.), Collectanea. Bristol, England: Simpkin, Marshall & Co., 1904.

Heinowitz, J. R. Becoming a father for the first time: A phenomenological study. Unpublished doctoral dissertation, California School of Professional Psychology, 1977.

Henneborn, W. J., and Cogan, R. The effects of husband participation on reported pain and probability of medication during labor and birth. Journal of Psychosomatic Research, 1975, 19, 215-222.

Hertzog, J. The father's role in the modulation of aggressive drive and fantasy. Paper presented at the American Psychoanalytic Association, New York City, December, 1979. Cited by Machtlinger, V. J., The father in psychoanalytic theory In M. Lamb, The role of the father in child development (2nd Edition). New York: John Wiley & Sons, 1981, pp. 113-154.

Hobbs, D. F., Jr. Parenthood as crisis: A third study. Journal of Marriage and the Family, 1965, 27, 367-372.

_____. Transition to parenthood: A replication and an extension. Journal of Marriage and the Family, 1968, 30, 413-417.

_____, and Cole, S. P. Transition to parenthood: A decade replication. Journal of Marriage and the Family, 1976, 38, 723-731.

Hogenboom, P. Man in crisis: The father. Journal of Psychiatric Nursing, 1967, 5 , 457-464.

Hooke, J. F., and Marks, P. A. MMPI characteristics of pregnancy. Journal of Clinical Psychology, 1962, 18, 316-317.

Jacobson, E. The male wish for a baby: Development of wish for a child in boys. Psychoanalytic Study of the Child, 1950, 5, 139-152.

Jacoby, A. P. Transition to parenthood: A reassessment. Journal of Marriage and the Family, 1969, 31, 720-727.

Jarvis, W. Some effects of pregnancy and childbirth on men. Journal of the American Psychoanalytic Association, 1962, 10, 689-699.

Jessner, L., Weigert, E., and Foy, J. L. The development of parental attitudes during pregnancy. In E. J., Anthony, and T. Benedek (Eds.), Parenthood: Its psychology and psychopathology. Boston: Little, Brown and Co., 1970.

Jones, L. F. A study of the Thlingets of Alaska. New York: Fleming H. Revella, 1914.

Josselyn, I. M. Cultural forces, Motherliness and fatherliness. American Journal of Orthopsychiatry, 1956, 26, 264-271.

Kaplan, L. J. Oneness and separateness: From infant to individual. New York: Simon & Schuster, 1978.

Keniston, K. The uncommitted: Alienated youth in American society. New York: Harcourt, Brace & World, 1960,

Klaus, M., Jerauld, R., Kreger, N., McAlpine, W. Steffa, M., and Kennell, J. H. Maternal attachment: Importance of the first postpartum days. New England Journal of Medicine, 1972, 286, 400-463.

Klaus, H. M., and Kennell, J. H. Human maternal and paternal behavior." In M. H. Klaus and J. H. Kennel (Eds.), Maternal-infant bonding. Saint Louis: C. V. Mosby Co., 1976, pp. 38-98.

Krohn, A., and Mayman, M. Object representations in dreams and projective tests. Bulletin of the Menninger Clinic, 1974, 38, 445-566.

LaCoursiere, R. The mental health of the prospective father: A new indication for therapeutic abortion? Bulletin of the Menninger Clinic, 1972, 36, 645-650.

Lamb, M. E., and Lamb, J. E. The nature and importance of the father-infant relationship. The Family Coordinator, 1976, 25, 379-385.

Langs, R. J. Earliest memories and personality: A predictive study. Archives of General Psychiatry, 1965, 12, 379-390.

LaRossa, R. Marriage close up: A study of couples expecting their first child. Unpublished doctoral dissertation, University of New Hampshire, 1975.

Larson, V. L. Stresses of the childbearing year. American Journal of Public Health, 1966, 56, 32-36.

LeMasters, E. E. Parenthood as crisis. Marriage and Family Living. 1957, 19, 352-355.

Lienbenberg, B. Expectant fathers. Child and Family, 1969, 8: 265-277.

Lipkin, M., and Lamb, G. S. The couvade syndrome: An Epidemiologic study. Annals of Internal Medicine, 1982, 96, 509-511.

Machtlinger, V. J. Psychoanalytic theory: Preoedipal and oedipal phases with special reference to the father. In M. Lamb (Ed.), The role of the father in child development (1st Edition). New York: John Wiley & Sons, 1976, pp. 277-306.

_____. The father in psychoanalytic theory. In M. Lamb (Ed.), The role of the father in child development (2nd Edition). New York: John Wiley & Sons, 1981, pp. 113-154.

Mahler, M. Rapprochement: Subphase of the separation-individuation process (1972). In The selected papers of Margaret S. Mahler, Vol. 2. New York: Jason Aronson, 1979.

Malinowski, B. Sex and Repression in Savage Society. New York: Harcourt, Brace, 1927.

Manaster, G. J., and King, M. Early recollections of male homosexuals. Journal of Individual Psychology, 1973, 29, 26-33.

Manaster, C. J., and Perryman, T. B. Early recollections and occupational choice. Journal of Individual Psychology, 1974, 30, 232-237.

May, K. A. Management of detachment and involvement in pregnancy by first-time fathers. Unpublished doctoral dissertation, University of California, San Francisco, 1980.

Mayman, M. Early memories and character structure. Journal of Projective Techniques and Personality Assessment. 1968, 32, 303-316.

Mayman, M., and Faris, M. Early memories as expressions of relationship paradigms. American Journal of Orthopsychiatry, 1960, 30, 507-520.

Mead, M. Male and Female. New York: William Morrow and Co., 1949.

Meikle, S., and Gerritse, R. A comparison of husband-wife responses to pregnancy. Journal of Psychology, 1973, 83, 17-23.

Metraux, A. The couvade. In J. Steward (Ed.), Handbook of South American Indians, Bureau of American Ethnology Bulletin, 1949, 5, 369-374.

Meyerowitz, J. H. Satisfaction during pregnancy. Journal of Marriage and Family, 1970, 32, 38-42.

Millet, E., Karkous, E., Jorda, P. et Cabal, P. Les psychonevroses de la paternite: Psychonevroses pverperales chez l'homme. Annales Medico-Psychologues, 1978, 136, 417-449.

Moore, J. V. The couvade syndrome: A study of personality variables and family relationships. Unpublished doctoral dissertation, California School of Professional Psychology, 1975.

Munroe, R. L., and Munroe, R. H. Male pregnancy symptoms and cross-sex identity in three societies. Journal of Social Psychology, 1971, 84, 11-25.

_____, and Munroe, R. H. Cross-Cultural Human Development. New York: Jason Aronson, 1977.

_____, Munroe, R. H., and Nerlove, S. B. Male pregnancy symptoms and cross-sex identity: Two replications. Journal of Social Psychology, 1973a, 89, 147-148.

_____, Munroe, R. H., and Whiting, J. W. M. The couvade: A psychological analysis. Ethos, 1973b, 1: 30-74.

Osborne, D. MMPI characteristics of multigravidas and primigravidas in the third trimester of pregnancy. Psychological Reports, 1977a, 40, 81-82.

_____. Comparison of MMPI scores of pregnant women and female medical patients. Journal of Clinical Psychology, 1977b, 33, 448-450.

_____. MMPI changes between the first and third trimester of pregnancy. Journal of Clinical Psychology, 1978, 34, 92-93.

Papanek, H. The use of early recollections in psychotherapy. Journal of Individual Psychology, 1972, 28, 169-176.

Parke, R. D., and Sawin, D. B. The father's role in infancy: A re-evaluation. The Family Coordinator, 1976, 25, 365-371.

Peterson, G. H., Lewis, E. M., and Leiderman, P. H. The role of some birth-related variables in father attachment. American Journal of Orthopsychiatry, 1979, 49, 330-338.

Polo, Marco. The description of the world. London: G. Routledge and sons, Ltd., 1938.

Reik, T. Couvade and the psychogenesis of the fear of relation. Ritual. London: Hogarth Press, 1927, pp. 27-89.

Richards, M. P. M. How should we approach the study of fathers? In McKee, L. and O'Brien, M. (Eds.), The father image. London: Tavistock Publications, 1982, pp. 57-71.

Rising, S. S. The fourth stage of labor: Family integration. American Journal of Nursing, 1974, 74, 870-874.

Robbins, P. R., and Tanck, R. H. Early memories and dream recall. Journal of Clinical Psychology, 1978, 34, 729-731.

Roberts, F. B. Infant behavior and the transition to parenthood. Unpublished doctoral dissertation, University of Tennessee, 1980.

Rogers, G. W. Early recollections and college achievement. Journal of Individual Psychology, 1977, 33, 233-239.

Ross, J. M. Fathering: A review of some psychoanalytic contributions on paternity. International Journal of Psychoanalysis, 1979a, 60, 317.

_____. Paternal identity: The equation of fatherhood and manhood. In T. B. Karasu, and C. W. Socarides (Eds.), On Sexuality: Psychoanalytic observations. New York: International Universities Press, 1979b.

Rotmann, M. Der Vater der fruhen kindheit-ein struktur-bildendes drittes objekt. Unpublished manuscript of a lecture presented at a meeting of the German Psychoanalytic Association in Stuttgart, November, 1979. Cited by Machtlinger, V. J., M. Lamb (Eds.), The role of the father in child development (2nd Edition). New York: John Wiley & Sons, 1981, pp. 113-154.

Russell, C. S. Transition to parenthood: Problems and gratitifications. Journal of Marriage and the Family, 1974, 36, 294-302.

Shaefer, G. The expectant father. Nursing Outlook, 1966, 14, 46-48.

Shapiro, E. R. Transition to parenthood in adult and family development. Unpublished doctoral dissertation, University of Massachusetts, 1979.

Shapiro, M. P. Fathers' experiences of childbirth. Unpublished doctoral dissertation, Boston University Graduate School, 1980.

Simmons, L. W. Statistical correlations in the science of society. In G. P. Murdock (Ed.), Studies in the Science of Society. New Haven: Yale University Press, 1937, pp. 495-517.

Soule, B., Standley, K., and Copans, S. A. Father identity. Psychiatry, 1979, 42, 255-263.

Stewart, R. H. Natural childbirth, father participation, rooming-in or what-have-you. Medical Times, 91, 1065-1068, 1963.

Stoller, R. J. Splitting: A case of female masculinity. New York: Quadrangle Books, 1973.

_____. Perversion: The erotic form of hatred. New York: Delta Books, Dell Publishing Co., 1975.

Strabo. In H. C. Hamilton and W. Falconer, (trans.), The geography of Strabo, Vol. 1. New York: George Bell and Sons, 1903.

Sumner, W. G., and Keller, A. G. The science of society. New Haven: Yale University Press, 1927.

Taylor, J. A. Early recollections as a projective technique: A review of some recent validation studies. Journal of Individual Psychology, 1975, 31, 213-218.

Toman, W. Family constellations (3rd Edition). New York: Springer, 1976.

Towne, R. D., and Afterman, J. Psychosis in males related to parenthood. Bulletin of the Menninger Clinic, 1955, 19: 19-26.

Trethowan, W. H., and Conlon, M. F. The couvade syndrome. British Journal of Psychiatry, 1965, 111: 57-66.

Trethowan, W. H. The couvade syndrome: Some further observations. Journal of Psychosomatic Research, 1968, 12: 107-115.

Trethowan, W. H. The couvade syndrome. In J. G. Howell (Ed.), Modern Perspectives in Psycho-obstetrics. New York: Bruner Mazel Publishers, 1972, pp. 66-93.

Tylor, E. B. Researches into the early history of mankind and the Development of Civilization. London: John Murry, 1878 (1st Edition), 1889.

Van House, C. L. An investigation of expectant parents' emotional stability, perceptions of locus of control, and parental role identification. Unpublished doctoral dissertation, Ball State University, 1977.

Viesti, C. R. An exploration of the psychological experience of expectant fatherhood. Unpublished doctoral dissertation, 1980.

Wainwright, W. H. Fatherhood as a percipant of mental illness. American Journal of Psychiatry, 1966, 123, 40-44.

Wandersman, L. P., and Wandersman, A., and Kalen, S. Social support in the transition to parenthood. Journal of Community Psychology, 1980, 8, 332-342.

Wapner, J. H. An empirical approach to the attitudes, feelings, and behaviors of expectant fathers. Unpublished doctoral dissertation, Northwestern University, 1975.

_____. The attitudes, feelings, and behaviors of expectant fathers attending LaMaze classes. Birth and the Family Journal, 1976, 3, 5-13.

West, M., and Konner, M. The role of the father: An anthropological perspective. In Lamb, M. E. (Ed.), The role of the father in child development. New York: John Wiley and Sons, 1976, pp. 185-218.

Wilson, B., and Edington, G. First child, second child. New York: McGraw-Hill, 1981.

Zilboorg, G. Depressive reactions related to parenthood. American Journal of Psychiatry, 1931, 87, 927-962.

Zussman, S. A study of certain social, psychological, and cultural factors influencing husbands' participation in their wives' labor. Unpublished doctoral dissertation, Columbia University, 19691

# APPENDIXES

# APPENDIX A

## MOTHER'S CONSENT FORM

Investigation of Expectant Fatherhood

University of Tennessee

Dear Expectant Mother:

This is a very special time in your life and for your husband. Because pregnancy and childbirth is such an important time for families, we would like to know more about its influence upon family members so that we can help doctors, nurses, and other family specialists provide even better services in the future. We are learning a lot about mothers and their needs during this period, but we know far less about the experience of expectant fathers. The present study is designed to learn more about the experience of prospective fathers. The study is being conducted through the University of Tennessee Department of Psychology.

Expectant fathers will be asked to fill out two questionnaires, and answer a few questions about their background in a short personal interview. All information received for the study is confidential and no identifying information will be disclosed. Your cooperation and your husband's help will be greatly appreciated. It is only with the help of families like yourself, who are in the midst of this special time, that we can learn the facts we need to help families in the future.

Although you might not be able to say whether or not your husband will participate in the study, we would like your permission to contact him. If we have your consent, please fill in the information below. Thank you very much for your consideration.

Carol M. Walton

Carol M. Walton
Clinical Psychology Graduate Student
University of Tennessee

---

Your name: _____

Your expected date of delivery: _____

Your husband's name: _____

Address: _____

_____
City State Zip Code

Telephone number: _____

Do you and your husband plan for him to attend the birth? Yes___

Thank you. No ___

# APPENDIX B

## FATHER'S CONSENT FORM

Investigation of Expectant Fatherhood:
Human Subject Consent Form

Dear Prospective Father:

Although we are learning quite a bit about pregnancy as it affects expectant mothers, we know far less about the experience, concerns, and needs of expectant fathers. The present study is designed to learn more about the experience of expectant fathers, especially as the experience relates to a father's health, his background, and his general outlook on life. This research will help doctors, nurses, psychologists, and other family specialists better understand the experiences of prospective fathers. The information will help them meet the needs of both fathers and their families. It is only with the cooperation of men like you who are in the midst of experiencing expectant fatherhood, that we can better understand this very special time in a man's life.

You will be asked to participate in two ways during this study. First, you will need to answer two written questionnaires. One questionnaire asks for general information about you, your family, and your background. The other questionnaire lists a number of statements on a wide range of issues relating to interests, health, and feelings, to which you will answer true or false as they relate to you specifically. Second, you will be asked to tell a little more about your background in a fifteen to twenty (15-20) minute personal interview. The interview will be recorded on tape. Both questionnaires and the interview will take about one to one and one-half (1-1½) hours of your time.

Your replies to both the written and oral questions will be completely confidential. There will be no record of names, and names and other identifying information will not be used in the reporting of this research. The responses from all the participants will be combined to give an overall picture of expectant fatherhood rather than used for a description of any particular expectant father.

Your cooperation in helping us learn more about expectant fatherhood will be greatly appreciated. It is only through your help that we can get the facts we need. I will be very glad to answer any questions you have about the study at any time. If you should decide against further participation, you are free to withdraw your consent and discontinue your participation at any time during the study without penalty.

Thank you for your consideration and your help.

Carol M. Walton

Carol M. Walton 588-3748
Clinical Psychology Graduate Student
University of Tennessee

I have been informed as to the nature of the research project, and I agree to participate.

Signature _____ Date _____

## APPENDIX C

## MMPI INFORMATION

The MMPI is a clinical instrument consisting of 566 separate items to which the subject responds either true or false as the item relates to himself. Three validity scales and ten clinical scales have been developed and used for over twenty years with a variety of clinical and normal populations. There are also a number of more experimental scales measuring such factors as "ego strength," etc., which can also be drawn from MMPI answers. Thus, it provides a potentially very rich source of data from each individual, when his responses are compared to other subjects who have taken the test.

While some clinical scales are subject to mood changes, the general "stability" of the MMPI, as measured by retesting subjects, is about 87% in several studies (Butcher and Tellegen, 1978).

In addition, the MMPI has, as of 1979, been used on only one group of normal expectant fathers (Moore, 1975). Four studies are available on the profiles of normal expectant mothers (Ford, Castelnuovo-Tedesco, and Long, 1972; Harrison and Kass, 1967; Hooke and Marks, 1962; Osborn, 1977a, 1977b, 1978), and there are two studies of pregnant women planning abortions (Ford, et al, 1972;

Meikle and Gerritse, 1973). In one of the latter studies, the husbands were also given the MMPI, and a comparison of men and women planning to abort a pregnancy were compared (Meikle and Gerritse, 1973). Interestingly enough, the MMPI data on pregnant women suggest that the pregnant subjects of the studies had better emotional health and had greater ego strength and more maturity than the normative population originally used in the MMPI scales (Hooke and Marks, 1965) and had fewer physical complaints, more ego strength, and a greater general adjustment than a comparative group of female medical patients in their twenties (Osborne, 1977b).

These studies contradict some of the general literature on pregnant women which views them as in greater emotional turmoil than non-pregnant women (Ballou, 1978, Bibring, 1959; Bibring, Thomas, and Dwyer, 1961). Perhaps the normal upheaval of pregnancy is not as pathological, nor as obvious on a test like the MMPI, as it appears to be to both observers, and to those involved with the pregnancy (i.e., expectant parents). If the same findings are true for fathers, this would be useful information, and would lend perspective to the pathological slant of most previous studies on clinical populations of expectant fathers. Or it may be that the MMPI does not pick up transient emotional upheavals, which are reactive

in nature, rather than embedded in more enduring personality structure.

Figures 1 through 8 present group profiles for the total sample, the three symptom groups and the four attitude types discussed in the study.

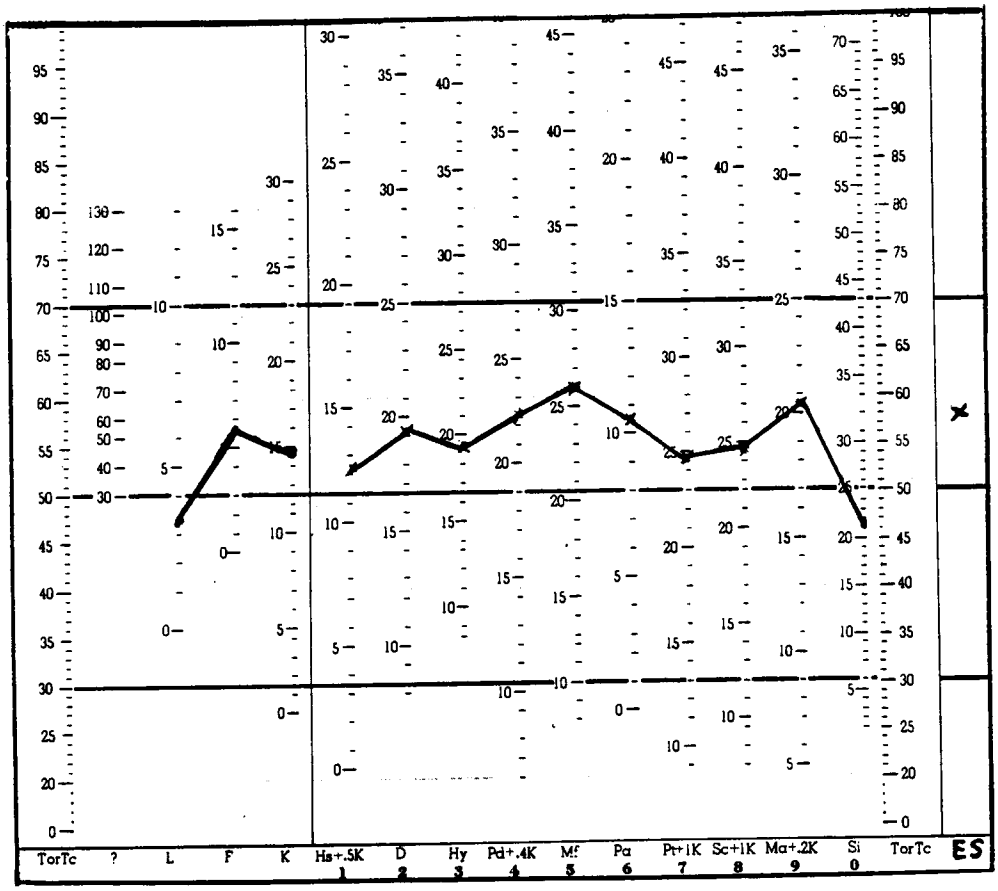


FIGURE 1

MMPI PROFILE FOR TOTAL SAMPLE*

*Source for the Profile Summary Graph is The Minnesota Multiphasic Personality Inventory, New York: The Psychological Corporation, 1948.

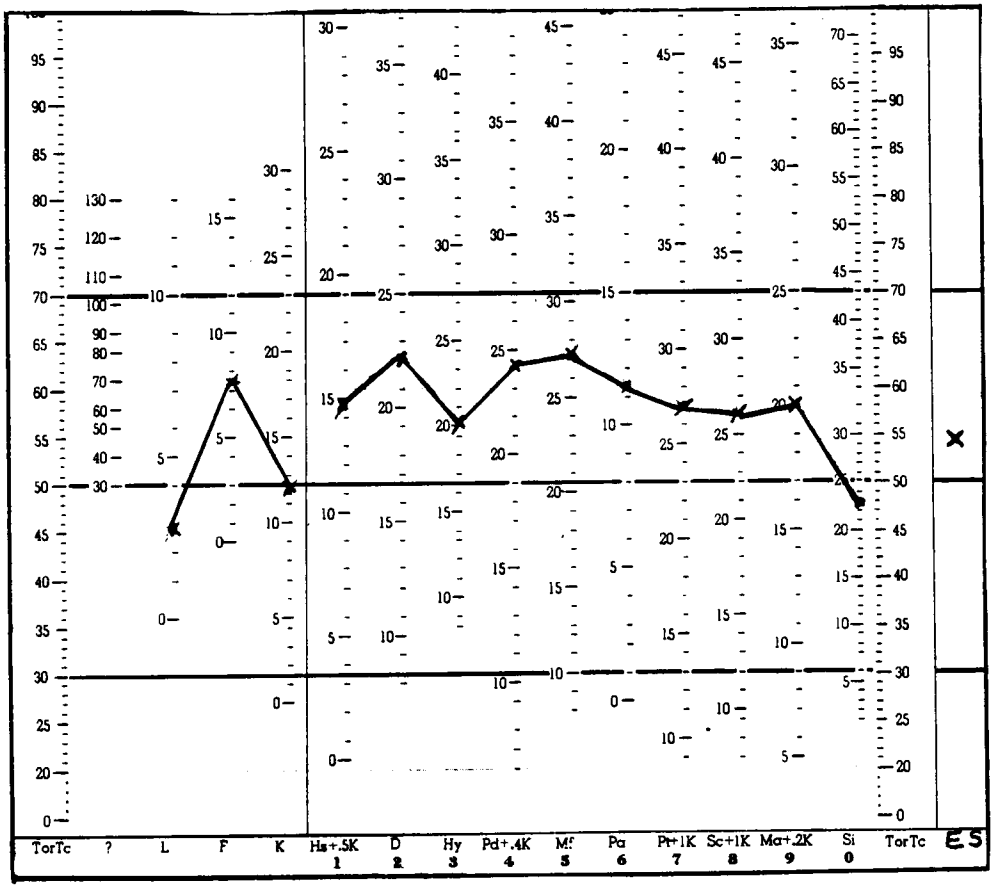


FIGURE 2

MMPI PROFILE FOR HIGH SYMPTOM GROUP*

*Source for the Profile Summary Graph is The Minnesota Multiphasic Personality Inventory, New York: The Psychological Corporation, 1948.

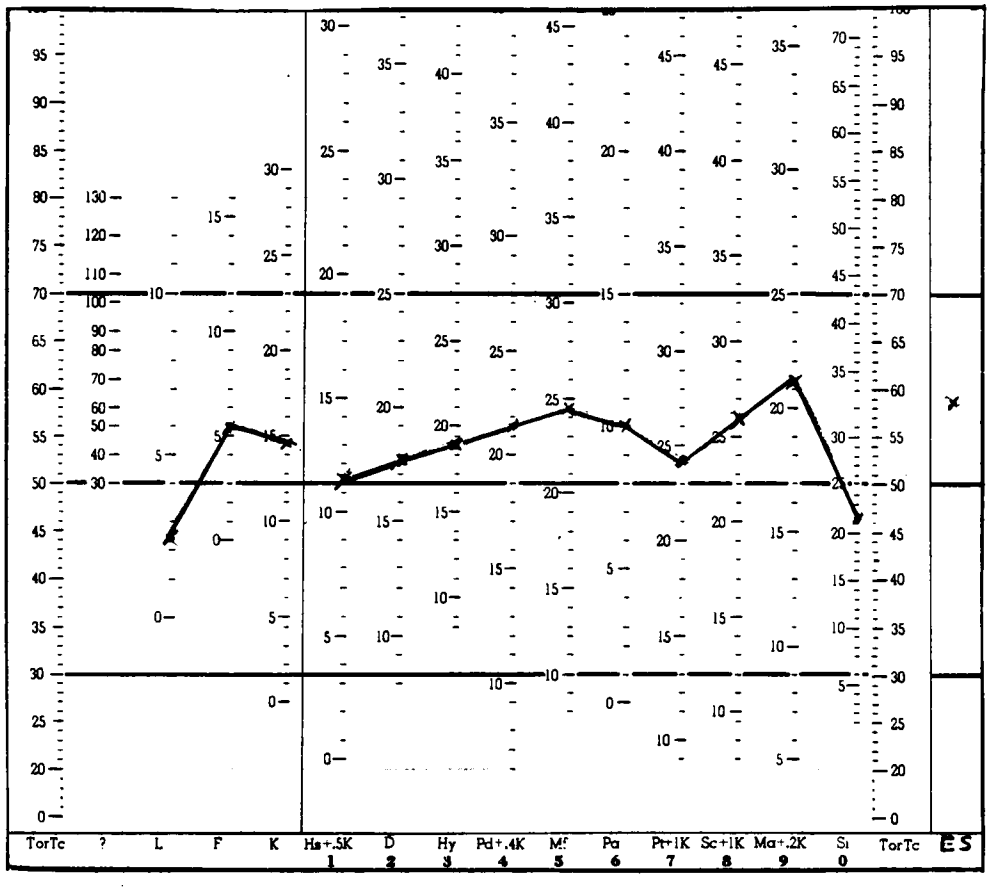


FIGURE 3

MMPI PROFILE FOR MEDIUM SYMPTOM GROUP*

*Source for the Profile Summary Graph is The Minnesota Multiphasic Personality Inventory, New York: The Psychological Corporation, 1948.

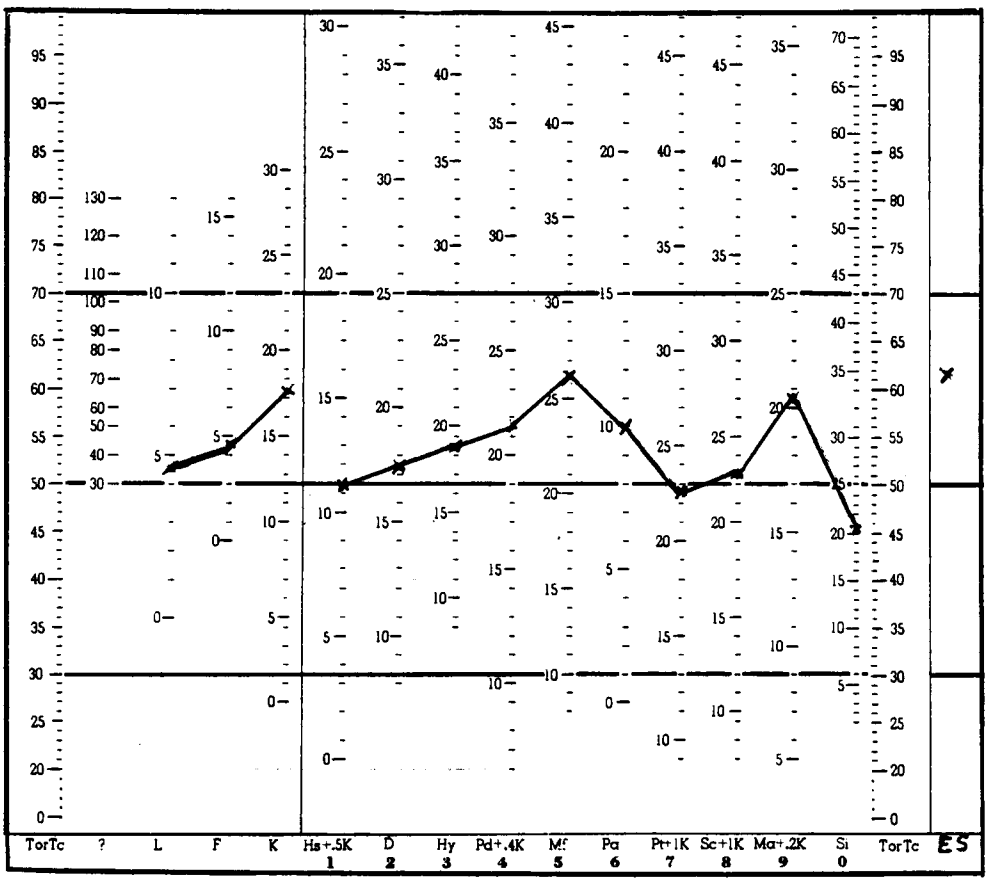


FIGURE 4

MMPI PROFILE FOR LOW SYMPTOM GROUP*

*Source for the Profile Summary Graph is The Minnesota Multiphasic Personality Inventory, New York: The Psychological Corporation, 1948.

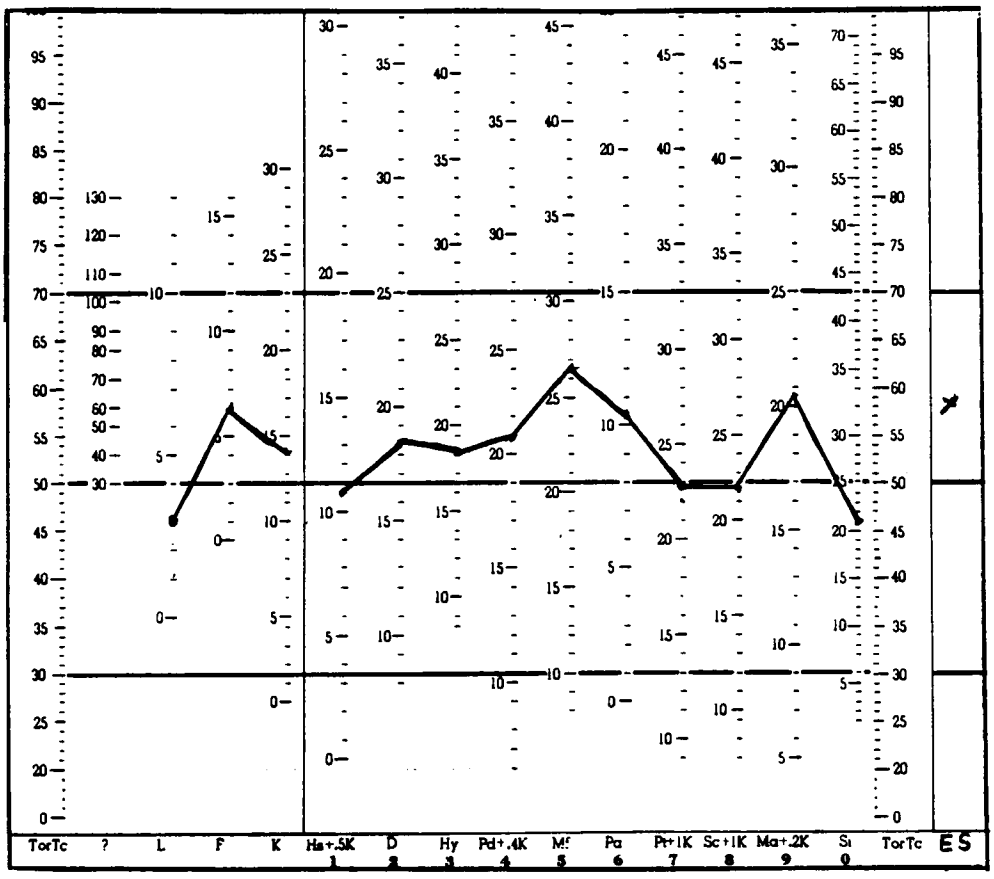


FIGURE 5

MMPI PROFILE FOR EAGER GROUP*

*Source for the Profile Summary Graph is The Minnesota Multiphasic Personality Inventory, New York: The Psychological Corporation, 1948.

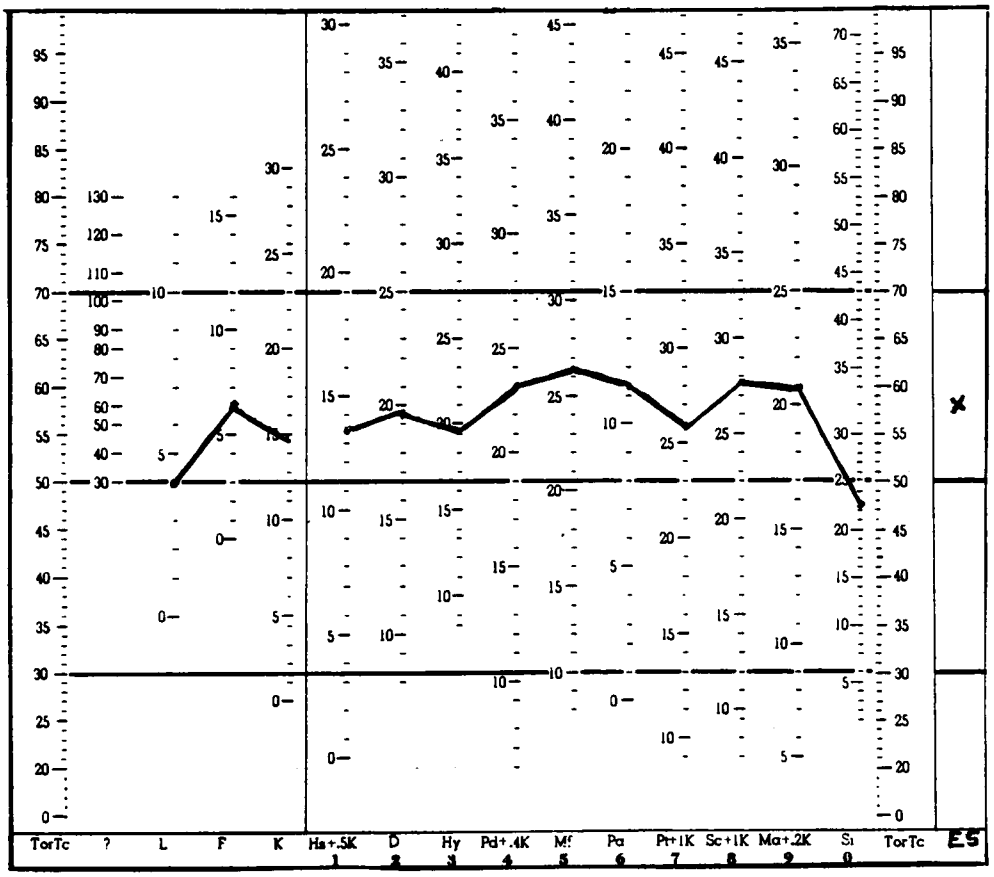


FIGURE 6

MMPI PROFILE FOR WILLING GROUP*

*Source for the Profile Summary Graph is The Minnesota Multiphasic Personality Inventory, New York: The Psychological Corporation, 1948.

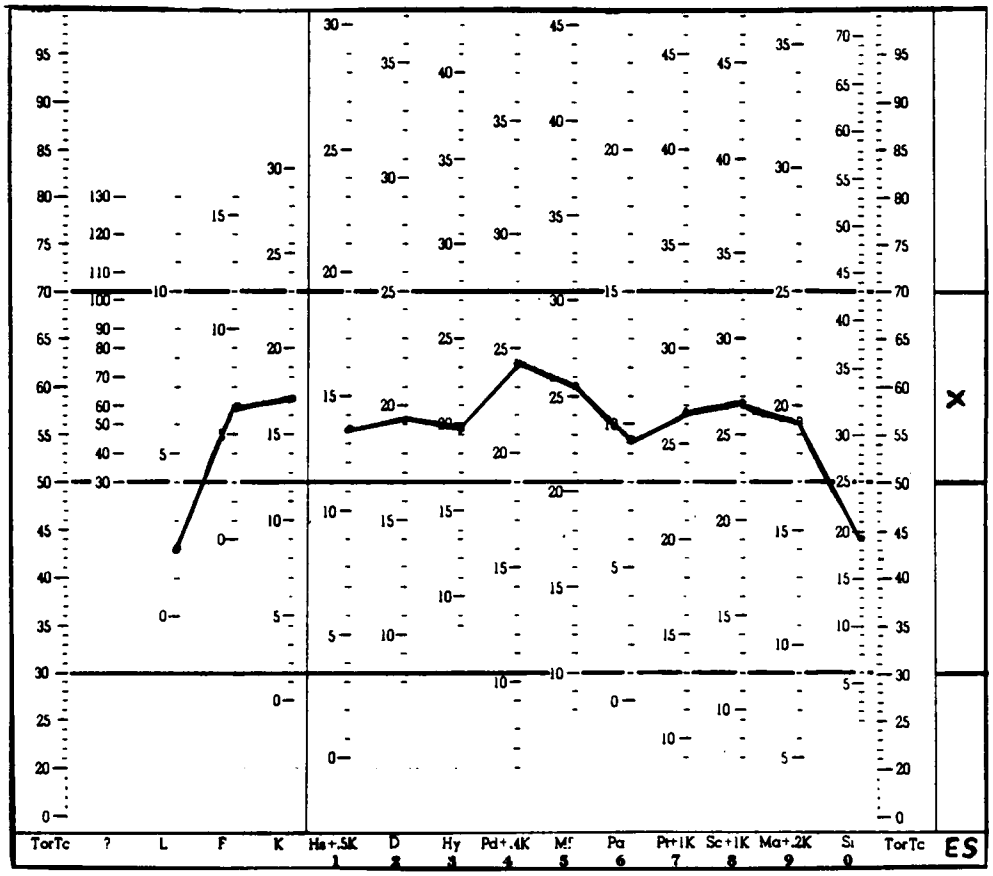


FIGURE 7

MMPI PROFILE FOR RELUCTANT GROUP*

*Source for the Profile Summary Graph is The Minnesota Multiphasic Personality Inventory, New York: The Psychological Corporation, 1948.

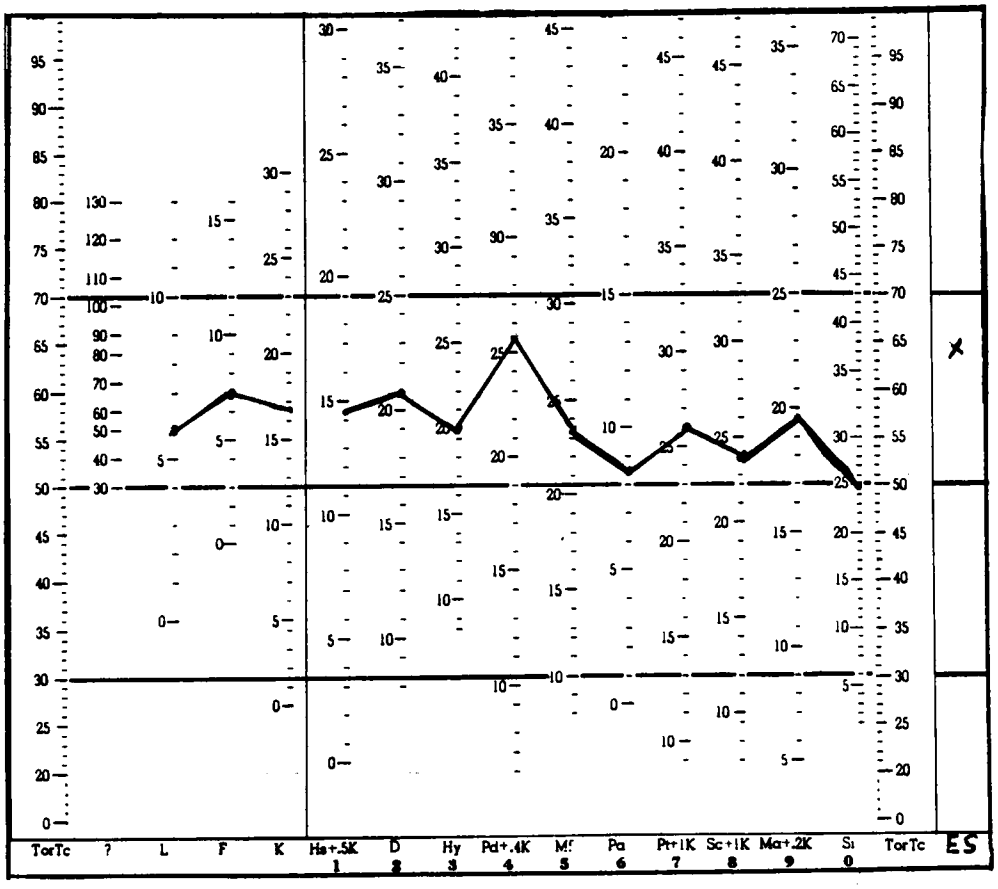


FIGURE 8

MMPI PROFILE FOR NON-ATTENDING GROUP*

*Source for the Profile Summary Graph is The Minnesota Multiphasic Personality Inventory, New York: The Psychological Corporation, 1948.

## APPENDIX D

## COUVADE SCALE ITEMS

2. I have a good appetite. (2)*
3. I wake up fresh and rested most mornings. (20)
9. I am about as able to work as I ever was. (0)
14. I have diarrhea once a month or more. (4)
18. I am very seldom troubled by constipation. (5)
22. At times I have fits of laughing and crying that I cannot control. (2)
23. I am troubled by attacks of nausea and vomiting. (1)
29. I am bothered by acid stomach several times a week. (8)
32. I find it hard to keep my mind on a task or job. (2)
43. My sleep is fitful and disturbed. (1)
55. I am almost never bothered by pains over the heart or in my chest. (14)
63. I have had no difficulty in starting or holding my bowel movement. (5)
72. I am troubled by discomfort in the pit of my stomach every few days or oftener. (1)
125. I have a great deal of stomach trouble. (2)
129. Often I can't understand why I have been so cross and grouchy. (12)
152. Most nights I go to sleep without thoughts or ideas bothering me. (13)
155. I am neither gaining nor losing weight. (12)
158. I cry easily. (2)
159. I cannot understand what I read as well as I used to. (3)
163. I do not tire quickly. (6)
174. I have never had a fainting spell. (8)
175. I seldom or never have dizzy spells. (1)
192. I have had no difficulty in keeping my balance in walking. (2)
214. I have never had any breaking out on my skin that has worried me. (23)
211. I can sleep during the day but not at night. (0)
230. I hardly ever notice my heart pounding and I am seldom short of breath. (10)
236. I brood a great deal. (5)

---

*Numbers indicate number of fathers who reported item indicated.

238. I have periods of such great restlessness that I cannot sit long in a chair. (15).
242. I believe I am more nervous than most others. (10)
263. I sweat very easily even on cool days. (11)*
274. My eyesight is as good as it has been for years. (7)
279. I drink an unusually large amount of water every day. (3)
288. I am troubled by attacks of nausea and vomiting. (1)
303. I am so touchy on some subjects that I can't talk about them. (10)
328. I find it hard to keep my mind on a task or job. (6)
326. At times I have fits of laughing and crying that I cannot control. (5)
335. I cannot keep my mind on one thing. (2)
340. Sometimes I become so excited that I find it hard to get to sleep. (22)
356. I have more trouble concentrating than others seem to have. (4)
405. I have no trouble swallowing. (1)
407. I am usually calm and not easily upset. (6)
424. I feel hungry almost all the time. (7)
462. I have had no difficulty starting or holding my urine. (2)
474. I have to urinate no more often than others. (14)
533. I am not bothered by a great deal of belching of gas from my stomach. (7)
560. I am greatly bothered by forgetting where I put things. (15)
567. Within the past few months, my teeth have given me some trouble. (13)
568. I haven't had any toothaches recently. (7)

---

Source for the Profile Summary Graph is The Minnesota Multiphasic Personality Inventory, The Psychological Corporation, New York: 1948.

*Numbers indicate number of fathers who reported item indicated.

## APPENDIX E

## GENERAL INFORMATION FORM

Please complete each of the following items. Circle the appropriate letter for each answer. Most items will require only one answer. Some items require you to fill in a brief answer. Thank you for your help.

1. Age: _____

2. Month and year of birth _____/_____

3. Race/Ethnic Group:
   a. White/Caucasian
   b. Black/Negro
   c. Oriental
   d. Other_____

4. Years of schooling completed:
   a. elementary school
   b. 1-3 years high school
   c. high school (or G.E.D.)
   d. 1-3 years college
   e. 4 years college (with degree)
   f. graduate school/professional school

5. Present occupation:_____

   Occupational title:_____

6. Gross income last year for family:
   a. below $8,000
   b. $8,000-11,000.
   c. $12,000-15,000.
   d. $16,000-20,000.
   e. $21,000-30,000.
   f. $31,000-40,000.
   g. $41,000-50,000.
   h. $51,000-75,000.
   i. above $75,000.

7. Religious affiliation:
   a. Baptist
   b. Other Protestant
   c. Roman Catholic
   d. Jewish
   e. Atheist or Agnostic
   f. Other_____

8. How actively do you practice your religious beliefs?
   a. actively
   b. somewhat actively
   c. little or not at all

9. Marital status: a. married b. separated c. divorced

10. How many years have you been married to your wife?_____

11. How many children do you have in addition to this pregnancy?
    a. 0
    b. 1
    c. 3
    e. 4
    f. 5 or more

12. In addition to this pregnancy, and your children, how many children does your wife have?
    a. 0 b. 1 c. 2 d. 3 e. 4 f. 5 or more

13. In what month of pregnancy is your wife?
    a. seventh b. eighth c. ninth

14. Was this pregnancy generally planned? a. yes b. no

15. How do you feel, generally, about your wife's pregnancy?
    a. very happy
    b. somewhat happy
    c. accepting
    d. somewhat unhappy
    e. very unhappy
    f. other (if so,what?)
    (for other)_____

16. Do you have any known health problems? (Such as diabetes, cancer, alcoholism, mental or emotional illness, drug dependance, heart disease, etc.)
    a. yes b. no

17. What was your general state of health before your wife's pregnancy?
    a. chronic ill-health
    b. temporary ill-health
    c. average health
    d. very healthy

18. What has been your general state of health since your wife became pregnant?
    a. chronic ill-health
    b. temporary ill-health
    c. average health
    d. very healthy

19. About how many times have you visited a doctor or other therapist during the year before your wife's pregnancy?
    a. 20-50 times
    b. 10-19 times
    c. 6-9 times
    d. 3-5 times
    e. 2 times
    f. 1 time
    g. none

20. About how many times have you visited a doctor or therapist since the pregnancy, for health reasons?
    a. 20+ times
    b. 10-19 times
    c. 6-9 times
    d. 3-5 times
    e. 2 times
    f. 1 time
    g. none

21. About how many times have you visited the obstetrician and/or nurse-midwife with your wife or alone since the pregnancy?
    a. 20+ times
    b. 10-19 times
    c. 6-9 times
    d. 3-5 times
    e. 2 times
    f. 1 time
    g. none

22. About how many times did you visit a dentist in the year before this pregnancy?
    a. 20+ times
    b. 10-19 times
    c. 6-9 times
    d. 3-5 times
    e. 2 times
    f. 1 time
    g. none

23. About how many times have you visited the dentist since your wife became pregnant?
    a. 20+ times
    b. 10-19 times
    c. 6-9 times
    d. 3-5 times
    e. 2 times
    f. 1 time
    g. none

For the following items, answer the items as appropriate for your own family background. If there were major changes in your family while you were growing up, consider your family situation during your early years (to age 10 or 12).

24. Father's occupation (or Step-father's) _____

25. Mother's occupation (or Step-mother's) _____

26. How many brothers and sisters do you have?
    No. brothers _____ No. sisters _____

Please list the sex and present ages of your brothers and/or sisters, including yourself, marked self, in the order you were born.

| | sex | age | | sex | age | | sex | age |
|---|---|---|---|---|---|---|---|---|
| 1st | | | 4th | | | 7th | | |
| 2nd | | | 5th | | | 8th | | |
| 3rd | | | 6th | | | 9th | | |
| | | | | | | last born, if more than 9 | | |

If you were between 9th and last, which were you? _____

27. If any of your brothers and/or sisters died while you were young, please list their sex and age at death, and your age at their death.
    a. sex _____ their age _____ your age then_____

    b. sex _____ their age _____ your age then_____

28. If any of your brothers/sisters had a major or chronic illness or handicap, please describe it briefly, and list their age at the time of onset, and your age at that time.

    a. Condition _____

    their sex ____ their age ____ your age then____

    b. Condition _____

    their sex ____ their age ____ your age then____

29. Present age of father _____ (step-father) _____
If deceased, list his age at death, and your age at his death:

    his age _____, your age then _____

30. Present age of mother _____ (step-mother) _____
If deceased, list her age at death, and your age then:

    he age _____, your age then _____

31. If you experienced major family changes (such as death or divorce) as a child or young adult please briefly describe the changes, and your age at the time of the change. List who you lived with after the change, if appropriate. (eg. father died.; I was with mother and a brother; my sister lived with my aunt)

| | Change | Your age | Family after change |
|---|---|---|---|
| a. | _____ | ____ | _____ |
| | _____ | | _____ |
| b. | _____ | ____ | _____ |
| | _____ | | _____ |

32. If you know of a time when you were separated from one or both of your parents, other than those noted above, for more than a few weeks as a child, please briefly describe the circumstances.

| | Situation | Your age | length of separation (in months) |
|---|---|---|---|
| a. | _____ | ____ | _____ |
| | _____ | | |
| b. | _____ | ____ | _____ |
| | _____ | | |

33. While growing up, who did you feel closer to?
    a. mother  c. step-mother
    b. father  d. step-father

34. Now, who do you feel closer to?
    a. mother  c. step-mother
    b. father  d. step-father

35. In describing your parents and their effect on your family, who would you say was the more dominant person?
    a. mother (step-mother)
    b. father (step-father)

36. During your childhood, how much energy did your father devote to your care, development, and upbringing (when not at work)?
    a. a great deal  d. a little
    b. quite a lot  e. very little
    c. some  f. father was missing

37. During your childhood, how much energy did your mother devote to your care, development, and upbringing (when not at work)?
    a. a great deal  d. a little
    b. quite a lot  e. very little
    c. some  f. mother was missing

38. Which parent seemed to invest more energy in you and your upbringing?
    a. mother (step-mother)  b. father (step-father)

39. Did you have a pet (or pets) as a child?  a. yes  b. no

    a. If you had a pet (s), what was it?
       a. cat  b. dog  c. horse  d. other
       If other, what?_____

    b. If you had a pet, what was your relationship to your pet?  a. very close, playing, companion
       b. somewhat close
       c. distant, pet was 'just around'

Thank you for your help.

## APPENDIX F

## EARLY MEMORIES TEST INFORMATION

Early memories, or early recollections, have long fascinated researchers and clinicians for what they reveal about memory per se, and about the personality of the individual describing his memories. Initially noted for idiosyncratic elements by psychoanalytic clinicians (Mayman and Faris, 1960), early memories grew to be used as a projective technique. Alfred Adler's interest in early recollections, and the development of their use as a projective assessment tool by Adler and his followers expanded their use in both clinical and experimental settings. Early memories (psychoanalytic usage) and/or early recollections (Alderian usage) are currently used as a projective technique for assessment of personality structure and personality variables in both clinical and research settings (Ansbacher, 1973; Attarian, 1978; Ballou, 1978; Hafner, et al, 1979; Eckstein, 1976; Freidberg, 1975; Robbins and Tanck, 1978; Taylor, 1975).

Clinical researchers from the Alderian school, the psychoanalytic and more recently, the object relations school, have found that early memories are useful tools in assessing personality characteristics when analyzed

according to a well-established technique (Manaster and Perryman, 1974; Mayman, 1968; Mayman and Ryan, 1973; Krohn and Mayman, 1974). Whether early memories are described in terms of Alderian lifestyles and interpersonal paradigms, or in the psychoanalytic term of character structure and/or the object relations paradigm, they shed important light on an individual's approach to his life.

In 1975, Taylor reviewed recent Alderian literature on early recollections as a projective technique. She found that early recollections can provide a useful and quick sample of the type of data gathered by longer techniques. Mayman (1960, 1968; with Krohn, 1974; with Ryan, 1973) has done extensive investigation of early memories as a projective technique. He suggests that early memories "can mirror for us an individual's early relationships as he may have experienced them at the time his personal identity was most open to the formative influence of others" (1960, p. 520). Mayman proposes a structure for analyzing early memories which incorporates both a psychoanalytic and an object-relations relationship paradigm (1968; with Ryan, 1972). In one study which attempted to investigate the idea of "object representation" within dreams, early memories, and Rorschach productions, Krohn and Mayman (1974) found high correlations between the "object representation" scores for the early memories and dreams of subjects. Krohn and Mayman suggest

that both early memories and dreams, in their analysis for "object representations," yield a dimension of object relationship which reflects "more about a fundamental pattern of object representation than it does about a general level of psychopathology," (1974, p. 459), which is reflected in Rorschach analysis for object representation. This finding suggests a close and rich link between early memory and dream productions as indications of a person's general capacity for object relations which may be less easily accessible in other projective techniques.

Early memories have been used in a number of research studies, ranging from sexual identity (homosexuality, Freidberg, 1975; Manaster and King, 1973) and vocational choice (Attarian, 1978, Manaster and Perryman, 1971) or college achievement (Rogers, 1977) through psychopathology (Hafner, Fakouri, Ollendick, and Corotto, 1979) and personality (Langs, 1965). Studies have also been done on the use of early memories in psychotherapy (Papanek, 1972) and as a measure of change in counselling (Eckstein, 1976).

## APPENDIX G

## INTERVIEW PROTOCOL

### Images of Birth

1. What kind of thoughts or feelings or images or ideas do you have about the birth of the baby?

   Examples of follow-up questions:
   a. Is there some question of "Will I be me?"
   b. Do you have any thoughts about the birth itself?
   c. Are you expecting things to go well?
   d. Are there any concerns you have about the birth?

### Decision About Attending Birth

2. How did you, or both of you, decide that you were going to be present at the birth?

   or How did you, or both of you, decide that you would have a traditional birth, with you in the the waiting room?

   Examples of follow-up questions:
   a. Were you aware of the options to attend the birth?
   b. Did you have any hesitations about going?
   c. What have people said to you about it?
   d. Why do you want to be there?
   or e. Have you felt any pressure to be there?

### Relationship with Parents

3. Have you noticed any changes in their relationship with you, or yours with them since your wife has become pregnant?

   Examples of follow-up questions:
   a. Are you close to your parents?
   b. What about your wife's parents?

Father's Health

4. Do you have any health problems?

or

5. Have you noticed any change in your general health during the last few months?

6. Have you noticed any changes in your health or body, such as weight changes, sleep disturbances, stomach problems, legaches, backaches, toothaches, bowel changes, moodiness, trouble concentrating?

   Example of follow-up questions:
   a. Did you notice the change (s) before I asked about them?
   b. What are your ideas about it?
   c. What are the (symptoms) like, exactly?
   d. Have you ever had these symptoms or body changes before?

Sympathy Pains

7. Have you ever heard of something called "sympathy pains?"

8. What does it mean to you?

9. Have you heard about them from someone who has had them, or have you just "heard about" them?

10. What is your theory about them?

## APPENDIX H

## STATISTICAL INFORMATION

### TABLE 11

### ANALYSIS OF VARIANCE SUMMARIES FOR MEAN MMPI SCALES BY SYMPTOM GROUPS

| Source | S.S. | D.F. | M.S. | F | Sign. |
|---|---|---|---|---|---|
| Scale L | | | | | |
| Between Groups | 45.14 | 2 | 22.57 | 5.040 | .0112* |
| Within Groups | 179.14 | 40 | 4.48 | | |
| Scale F | | | | | |
| Between Groups | 65.78 | 2 | 32.89 | 3.708 | .0333* |
| Within Groups | 354.74 | 40 | 8.87 | | |
| Scale K | | | | | |
| Between Groups | 193.61 | 2 | 96.80 | 4.282 | .0207* |
| Within Groups | 904.30 | 40 | 22.61 | | |
| Scale 1 | | | | | |
| Between Groups | 117.01 | 2 | 58.50 | 5.798 | .0061* |
| Within Groups | 403.60 | 40 | 10.09 | | |
| Scale 2 | | | | | |
| Between Groups | 190.46 | 2 | 95.23 | 5.602 | .0072* |
| Within Groups | 679.96 | 40 | 16.99 | | |
| Scale 3 | | | | | |
| Between Groups | 21.99 | 2 | 10.99 | 0.788 | .4618 |
| Within Groups | 558.42 | 40 | 13.96 | | |
| Scale 4 | | | | | |
| Between Groups | 55.59 | 2 | 27.79 | 1.301 | .2734 |
| Within Groups | 854.88 | 40 | 21.37 | | |
| Scale 5 | | | | | |
| Between Groups | 47.99 | 2 | 23.99 | 1.340 | .2734 |
| Within Groups | 716.42 | 40 | 17.91 | | |
| Scale 6 | | | | | |
| Between Groups | 24.47 | 2 | 12.23 | 1.187 | .3156 |
| Within Groups | 412.14 | 40 | 10.30 | | |

TABLE 11 (Continued)

| Source | S.S. | D.F. | M.S. | F | Sign. |
|---|---|---|---|---|---|
| Scale 7 | | | | | |
| Between Groups | 138.84 | 2 | 69.42 | 3.505 | .0396* |
| Within Groups | 792.23 | 40 | 19.81 | | |
| Scale 8 | | | | | |
| Between Groups | 87.51 | 2 | 43.76 | 1.096 | .3441 |
| Within Groups | 1597.46 | 40 | 39.93 | | |
| Scale 9 | | | | | |
| Between Groups | 14.66 | 2 | 7.33 | 0.439 | .6477 |
| Within Groups | 667.94 | 40 | 51.83 | | |
| Scale 0 | | | | | |
| Between Groups | 34.86 | 2 | 17.43 | 0.366 | .7164 |
| Within Groups | 2073.18 | 40 | 51.83 | | |
| Scale ES | | | | | |
| Between Groups | 233.95 | 2 | 116.98 | 9.490 | .0004* |
| Within Groups | 493.03 | 40 | 12.33 | | |
| Scale NCVD | | | | | |
| Between Groups | 121.03 | 2 | 60.52 | 10.38 | .0002* |
| Within Groups | 233.16 | 40 | 5.83 | | |

*Significant at the .05 level on one-way analysis of variance.

TABLE 12

ANALYSIS OF VARIANCE SUMMARIES FOR BACKGROUND DATA BY SYMPTOM GROUPS

| Source | S.S. | D.F. | M.S. | F | Sign. |
|---|---|---|---|---|---|
| Mean Age | | | | | |
| Between Groups | 11.66 | 2 | 5.83 | 0.454 | .6385 |
| Within Groups | 514.19 | 40 | 12.86 | | |
| Mean Years Married | | | | | |
| Between Groups | 21.35 | 2 | 10.67 | 1.109 | .3399 |
| Within Groups | 375.23 | 39 | 9.62 | | |
| Sibling Mean Age at Onset of Sibling Illness | | | | | |
| Between Groups | 14.08 | 1 | 14.08 | 0.270 | .6308 |
| Within Groups | 208.75 | 4 | 52.19 | | |
| Subject Mean Age at Onset of Sibling Illness | | | | | |
| Between Groups | 0.75 | 1 | 0.75 | 0.270 | .6308 |
| Within Groups | 182.75 | 4 | 45.69 | | |
| Mean Age at Father's Death | | | | | |
| Between Groups | 13.83 | 2 | 6.92 | 0.256 | .7894 |
| Within Groups | 81.00 | 3 | 27.00 | | |
| Mean Age at Family Disruption | | | | | |
| Between Groups | 81.19 | 2 | 40.59 | 4.823 | .0859 |
| Within Groups | 33.67 | 4 | 8.42 | | |
| Mean Age at Separation from Father | | | | | |
| Between Groups | 42.25 | 2 | 21.13 | 42.250 | .1081 |
| Within Groups | 0.50 | 1 | 0.50 | | |
| Mean Length of Separation from Father | | | | | |
| Between Groups | 9.50 | 2 | 4.75 | 0.194 | .8489 |
| Within Groups | 24.50 | 1 | 24.50 | | |

TABLE 13

EARLY MEMORY DATA FOR COUVADE SYMPTOM GROUPS

| Variable | High | Medium | Low | Total |
|---|---|---|---|---|
| Total Memory Themes | | | | |
| Oral | 9 | 7 | 8 | 24 |
| Anal | 4 | 3 | 6 | 13 |
| Phallic | 27 | 26 | 26 | 79 |
| Phallic - Sexual | 0 | 2 | 1 | 3 |
| Oedipal | 1 | 1 | 1 | 3 |
| Latency | 1 | 0 | 0 | 1 |
| Injury/Hostility Totals | 11 | 9 | 12 | 32 |
| Memory A | 3 | 3 | 0 | 6 |
| Memory B | 3 | 2 | 5 | 10 |
| Memory C | 4 | 3 | 6 | 13 |
| Hostility Present | | | | |
| Males | 6 | 4 | 7 | 17 |
| No Males | 5 | 5 | 5 | 15 |
| Hostility Present | | | | |
| Females | 5 | 6 | 5 | 16 |
| No Females | 4 | 3 | 7 | 14 |
| Active | 14 | 15 | 13 | 42 |
| Memory A | 3 | 7 | 5 | 15 |
| Memory B | 4 | 3 | 3 | 10 |
| Memory C | 7 | 5 | 5 | 17 |
| Passive | 12 | 6 | 13 | 31 |
| Memory A | 9 | 2 | 5 | 16 |
| Memory B | 1 | 2 | 5 | 8 |
| Memory C | 2 | 2 | 3 | 7 |

TABLE 14

SUMMARY OF CHI-SQUARE VALUES FOR EARLY MEMORY DATA BY COUVADE SYMPTOM GROUP

| Variable | Chi-Square | D.F. | Significance |
|---|---|---|---|
| Early Memories | | | |
| Early Memory A | | | |
| Psy./Sex. Stages | 6.398 | 8 | 0.6027 |
| Hostility A | 2.702 | 2 | 0.2589 |
| Males A | 4.000 | 6 | 0.6767 |
| Females A | 1.333 | 4 | 0.8557 |
| Early Memory B | | | |
| Psy./Sex. Stages | 5.347 | 6 | 0.5000 |
| Hostility B | 0.439 | 2 | 0.8026 |
| Males B | 0.782 | 2 | 0.6763 |
| Females B | 3.422 | 4 | 0.4898 |
| Early Memory C | | | |
| Psy./Sex. Stages | 10.048 | 8 | 0.2616 |
| Hostility C | 0.734 | 2 | 0.6926 |
| Males C | 1.489 | 4 | 0.8285 |
| Females C | 1.444 | 4 | 0.8364 |
| Hostility with Males | 2.13 | 4 | >.05 |

TABLE 15

FAMILY DATA FOR COUVADE SYMPTOM GROUPS

| Variable | High | Medium | Low | Total |
|---|---|---|---|---|
| Family Disruption | | | | |
| Death | 1 | 1 | 1 | 3 |
| Divorce | 2 | 1 | 1 | 4 |
| Parental Illness | 1 | 0 | 0 | 1 |
| Separation from Father | | | | |
| Military Service | 0 | 0 | 1 | 1 |
| Parents Separated | 0 | 1 | 0 | 1 |
| Stay with Relatives | 0 | 1 | 1 | 2 |
| Parents Close to as Child | | | | |
| Mother | 12 | 9 | 10 | 31 |
| Father | 2 | 4 | 2 | 8 |
| Both | 0 | 0 | 4 | 4 |
| Parent Close to Now | | | | |
| Mother | 8 | 5 | 7 | 20 |
| Father | 5 | 7 | 6 | 18 |
| Both | 0 | 1 | 3 | 4 |
| Dominent Parent | | | | |
| Mother | 4 | 5 | 5 | 14 |
| Father | 10 | 8 | 11 | 29 |
| Most Energy Parent | | | | |
| Mother | 11 | 12 | 10 | 33 |
| Father | 1 | 1 | 2 | 4 |
| Equal | 1 | 0 | 4 | 5 |
| Sibling Health Problem | | | | |
| Major Acute | 2 | 0 | 2 | 4 |
| Major Chronic | 0 | 0 | 1 | 1 |
| Minor | 0 | 0 | 2 | 2 |

TABLE 15 (continued)

| Variable | High | Medium | Low | Total |
|---|---|---|---|---|
| Pets | | | | |
| Pet | 13 | 13 | 14 | 40 |
| No Pet | 1 | 0 | 2 | 3 |
| Close to Pet | 10 | 10 | 8 | 28 |
| Not Close to Pet | 3 | 3 | 6 | 12 |

TABLE 16

HEALTH VARIABLES FOR COUVADE SYMPTOM GROUPS

| Variable | High | Medium | Low | Total |
|---|---|---|---|---|
| Health Before Pregnancy | | | | |
| Good | 7 | 8 | 11 | 26 |
| Average | 7 | 5 | 5 | 17 |
| Health During Pregnancy | | | | |
| Good | 5 | 9 | 11 | 25 |
| Average | 9 | 4 | 5 | 18 |
| Visits to Dr. Before Pregnancy | | | | |
| 6-9 | 2 | 1 | 0 | 3 |
| 3-5 | 0 | 1 | 1 | 2 |
| 2 | 4 | 3 | 3 | 10 |
| 1 | 5 | 3 | 3 | 11 |
| 0 | 3 | 5 | 9 | 17 |
| Visits to Dr. During Pregnancy | | | | |
| 6-9 | 1 | 1 | 1 | 3 |
| 3-5 | 1 | 2 | 0 | 3 |
| 2 | 1 | 2 | 0 | 3 |
| 1 | 2 | 5 | 2 | 9 |
| 0 | 9 | 4 | 13 | 26 |
| Visits to Obstetrician | | | | |
| 10-19 | 0 | 1 | 1 | 2 |
| 6-9 | 3 | 1 | 4 | 8 |
| 3-5 | 2 | 4 | 3 | 9 |
| 2 | 1 | 2 | 4 | 7 |
| 1 | 6 | 5 | 3 | 14 |
| 0 | 2 | 0 | 1 | 3 |
| Dr. Fear Item | | | | |
| Fear Yes | 5 | 4 | 5 | 14 |
| Fear No | 9 | 9 | 11 | 29 |

TABLE 17

SUMMARY OF CHI-SQUARE VALUES FOR
COUVADE SYMPTOM GROUPS

| Variable | Chi-Square | D.F. | Significance |
|---|---|---|---|
| Education Level | 5.654 | 6 | 0.4630 |
| Income | 5.459 | 6 | 0.4865 |
| Religious Practice | 6.641 | 4 | 0.1561 |
| Preg. Planning | 4.160 | 2 | 0.1249 |
| Attitude Preg. | 5.001 | 4 | 0.2871 |
| Prior Health | 1.107 | 2 | 0.5749 |
| Health During Preg. | 4.290 | 2 | 0.1171 |
| Prior Dr. Visits | 6.686 | 8 | 0.5708 |
| Dr. Visits During Preg. | 9.466 | 8 | 0.3045 |
| Obstetrical Visits | 8.169 | 10 | 0.6123 |
| Dr. Fear Item | 0.095 | 2 | 0.9536 |
| Child Interest | 3.627 | 2 | 0.1631 |
| Family Disruption | 1.333 | 4 | 0.8557 |
| Separation From Father | 5.000 | 4 | 0.2873 |
| Parent Close; Child | 8.824 | 4 | 0.0656 |
| Parent Close; Now | 4.054 | 4 | 0.3987 |
| Dominent Parent | 0.320 | 2 | 0.8521 |
| Parent: Most Energy | 5.185 | 4 | 0.2688 |
| Pet | 1.727 | 2 | 0.4215 |
| Close to Pet | 4.333 | 4 | 0.3628 |
| Sibling Health Problem | 2.100 | 2 | 0.3499 |

TABLE 18

ANALYSIS OF VARIANCE SUMMARIES FOR
MEAN MMPI SCALES BY FATHER TYPES

| Source | S.S. | D.F. | M.S. | F | Sign. |
|---|---|---|---|---|---|
| Scale L | | | | | |
| Between Groups | 31.31 | 3 | 10.44 | 2.150 | .1104 |
| Within Groups | 179.57 | 37 | 4.85 | | |
| Scale F | | | | | |
| Between Groups | 2.86 | 3 | 0.95 | 0.085 | .9678 |
| Within Groups | 412.72 | 37 | 11.15 | | |
| Scale K | | | | | |
| Between Groups | 45.61 | 3 | 15.20 | 0.550 | .6515 |
| Within Groups | 1023.37 | 37 | 27.66 | | |
| Scale 1 | | | | | |
| Between Groups | 64.29 | 3 | 21.43 | 1.740 | .1757 |
| Within Groups | 455.67 | 37 | 12.32 | | |
| Scale 2 | | | | | |
| Between Groups | 25.67 | 3 | 8.56 | 0.387 | .7627 |
| Within Groups | 817.36 | 37 | 22.09 | | |
| Scale 3 | | | | | |
| Between Groups | 24.97 | 3 | 8.32 | 0.580 | .6316 |
| Within Groups | 817.36 | 37 | 14.34 | | |
| Scale 4 | | | | | |
| Between Groups | 87.58 | 3 | 29.19 | 1.343 | .2752 |
| Within Groups | 804.18 | 37 | 21.73 | | |
| Scale 5 | | | | | |
| Between Groups | 30.33 | 3 | 10.11 | 0.580 | .6322 |
| Within Groups | 645.57 | 37 | 17.45 | | |
| Scale 6 | | | | | |
| Between Groups | 25.12 | 3 | 8.37 | 0.776 | .5147 |
| Within Groups | 398.98 | 37 | 10.78 | | |
| Scale 7 | | | | | |
| Between Groups | 112.52 | 3 | 37.51 | 1.710 | .1815 |
| Within Groups | 811.04 | 37 | 21.92 | | |

TABLE 18 (Continued)

| Source | S.S. | D.F. | M.S. | F | Sign. |
|---|---|---|---|---|---|
| Scale 8 | | | | | |
| Between Groups | 323.98 | 3 | 107.99 | 2.956 | .0449* |
| Within Groups | 1351.63 | 37 | 36.53 | | |
| Scale 9 | | | | | |
| Between Groups | 10.18 | 3 | 3.39 | 0.190 | .9024 |
| Within Groups | 660.02 | 37 | 17.84 | | |
| Scale 0 | | | | | |
| Between Groups | 84.19 | 3 | 28.06 | 0.514 | .6754 |
| Within Groups | 2021.57 | 37 | 54.64 | | |
| Scale ES | | | | | |
| Between Groups | 64.24 | 3 | 21.41 | 1.199 | .3236 |
| Within Groups | 660.74 | 37 | 17.86 | | |
| Scale NCVD | | | | | |
| Between Groups | 20.84 | 3 | 6.95 | 0.779 | .5134 |
| Within Groups | 330.04 | 37 | 8.92 | | |

*Significant at the .05 level.

TABLE 19

ANALYSIS OF VARIANCE SUMMARIES FOR BACKGROUND DATA BY FATHER TYPES

| Source | S.S. | D.F. | M.S. | F | Sign. |
|---|---|---|---|---|---|
| Mean Age | | | | | |
| Between Groups | 743.792 | 3 | 47.93 | 4.68 | .0072* |
| Within Groups | 378.59 | 37 | 10.23 | | |
| Mean Years Married | | | | | |
| Between Groups | 53.70 | 3 | 17.90 | 1.931 | .1421 |
| Within Groups | 333.79 | 36 | 9.27 | | |
| Mean Age at Father's Death | | | | | |
| Between Groups | 16.83 | 2 | 8.41 | 0.324 | .7459 |
| Within Groups | 78.00 | 3 | 26.00 | | |
| Mean Age at Mother's Death | | | | | |
| Between Groups | 170.67 | 1 | 170.67 | 3.413 | .3158 |
| Within Groups | 50.00 | 1 | 50.00 | | |
| Mean Age at Family Disruption | | | | | |
| Between Groups | 9.61 | 2 | 4.80 | 0.183 | .8397 |
| Within Groups | 105.25 | 4 | 26.31 | | |
| Mean Age at Separation from Father | | | | | |
| Between Groups | 8.17 | 1 | 8.17 | 0.333 | .6667 |
| Within Groups | 24.50 | 1 | 24.50 | | |
| Mean Length of Separation from Father | | | | | |
| Between Groups | 0.17 | 1 | 0.17 | 0.333 | .6667 |
| Within Groups | 0.50 | 1 | 0.50 | | |

*Significant at the .05 level on a one-way analysis of variance; a Duncan Multiple Range Test indicated that means for reluctant and non-attending groups differed significantly from those of eager and willing groups.

TABLE 20

FAMILY AND HEALTH DATA FOR FATHER TYPES

| Variable | Eager | Willing | Reluctant | Non-Attending | Total |
|---|---|---|---|---|---|
| Family Disruption | | | | | |
| Death | 3 | 0 | 0 | 0 | 3 |
| Divorce | 2 | 2 | 0 | 0 | 4 |
| Parental Illness | 0 | 0 | 0 | 1 | 1 |
| Separation from Father | | | | | |
| Military Service | 0 | 0 | 0 | 0 | 0* |
| Parents Separated | 1 | 0 | 0 | 0 | 1 |
| Stay with Relatives | 0 | 2 | 0 | 0 | 2 |
| Sibling Health Problem | | | | | |
| Major Acute | 3 | 0 | 1 | 0 | 4 |
| Major Chronic | 0 | 1 | 0 | 0 | 1 |
| Minor | 1 | 0 | 0 | 0 | 1 |
| Parent - Close to as a Child | | | | | |
| Mother | 13 | 10 | 4 | 3 | 30 |
| Father | 2 | 3 | 2 | 0 | 7 |
| Both | 2 | 2 | 0 | 0 | 4 |
| Parent - Close to Now | | | | | |
| Mother | 7 | 9 | 1 | 1 | 18 |
| Father | 7 | 4 | 5 | 2 | 18 |
| Both | 2 | 2 | 0 | 0 | 4 |
| Dominent Parent | | | | | |
| Mother | 8 | 3 | 1 | 1 | 13 |
| Father | 9 | 12 | 5 | 2 | 28 |

TABLE 20 (Continued)

| Variable | Eager | Willing | Reluctant | Non-Attending | Total |
|---|---|---|---|---|---|
| Most Energy Parent | | | | | |
| Mother | 16 | 10 | 5 | 2 | 33 |
| Father | 1 | 0 | 1 | 1 | 3 |
| Equal | 0 | 4 | 0 | 0 | 4 |
| Visits to Dr. Before Pregnancy | | | | | |
| 6-9 | 1 | 0 | 2 | 0 | 3 |
| 3-5 | 1 | 1 | 0 | 0 | 2 |
| 2 | 4 | 4 | 1 | 1 | 10 |
| 1 | 3 | 4 | 2 | 1 | 10 |
| 0 | 8 | 6 | 1 | 1 | 16 |
| Visits to Dr. During Pregnancy | | | | | |
| 6-9 | 1 | 0 | 1 | 1 | 3 |
| 3-5 | 2 | 0 | 0 | 0 | 2 |
| 2 | 0 | 3 | 0 | 0 | 3 |
| 1 | 4 | 2 | 2 | 0 | 8 |
| 0 | 10 | 10 | 3 | 2 | 25 |
| Visits to Obstetrician | | | | | |
| 10-19 | 2 | 0 | 0 | 0 | 2 |
| 6-9 | 5 | 3 | 0 | 0 | 8 |
| 3-5 | 4 | 3 | 1 | 1 | 9 |
| 2 | 1 | 3 | 0 | 1 | 5 |
| 1 | 5 | 4 | 5 | 0 | 14 |
| 0 | 0 | 2 | 0 | 1 | 3 |

*Data from one subject missing from this analysis.

TABLE 21

SUMMARY OF CHI-SQUARE VALUES
FOR FATHER TYPES

| Variable | Chi-Square | D.F. | Significance |
|---|---|---|---|
| Education Level | 5.942 | 9 | 0.7457 |
| Income Level | 16.675 | 9 | 0.0541* |
| Religious Practice | 3.999 | 6 | 0.6768 |
| Planned Pregnancy | 1.589 | 3 | 0.6619 |
| Attitude Pregnancy | 4.839 | 6 | 0.5646 |
| No. of Children | 11.029 | 6 | 0.0875 |
| Family Disruption | 10.400 | 4 | 0.0342* |
| Sibling & Health Problem | 6.375 | 4 | 0.1728 |
| Parent - Close as a Child | 3.384 | 6 | 0.7593 |
| Parent Close; Now | 6.481 | 6 | 0.3715 |
| Dominent Parent | 3.430 | 3 | 0.3299 |
| Parent: Most Energy | 12.457 | 6 | 0.0525* |
| Father Energy | 13.944 | 12 | 0.3043 |
| Mother Energy | 4.503 | 9 | 0.8753 |
| Prior Dr. Visits | 3.430 | 3 | 0.3299 |
| Dr. Visits During Pregnancy | 14.494 | 12 | 0.2702 |
| Obstetrical Visits | 19.702 | 15 | 0.1836 |

*Significant at the .05 level.

## APPENDIX I

## DESCRIPTION OF THEME FOCI CLUSTERS

The themes are embedded within the statements below, which relate specifically to various foci. They are fully described as separate themes in Chapters IV and V.

Six separate foci emerged from analysis of father's views. They are: (A) self as father, (B) the physical body, (C) emotions and reactions of the self, (D) the wife/fetus, (E) the baby, and (F) the birth event. The six foci are outlined below, with descriptive statements enumerated, which relate to each focus. Some statements are listed in the first five foci and then repeated in the description of the birth event which was a rich, complex cluster involving some overlap with other foci.

(A) Self as Father. The first focus is that of the father's sense of self as the father, especially as the father of this particular child. It includes reflection on his position as son, husband, and father of other children, as well as his sense of "self." The following statements describe the "self as father" focus.

1. One wonders what exactly is the role of the husband/father to one's wife/family for this pregnancy.

2. One feels the weight of the responsibility to provide for one's family. One feels one to be more serious and concerned about making money to give one's family a good home.
3. One struggles with one's sense of who one is, who one is married to, and who the baby is and who other family members are as fantasies and feelings play in the emerging new identity of father to this child.
4. One notices and observes children and child-parent interactions more than before the pregnancy.
5. One thinks about being around children and one's feelings of comfort or uncertainty around them.
6. One is full of ideas, thoughts and feelings "floating around" inside oneself--suggestive of the changes going on.
7. One feels one's role as husband/father is more what one makes it than one's wife. It may take more work to get clear about it--it is not guided by biology. The more one has a clear sense of one's role for one's specific family, the better one feels and the more some things in one's life are settled, so the changes take less energy to deal with.
8. One is aware of great changes in the role of fathers around childbirth and, depending on one's

upbringing and present situation, one may be struggling greatly with changing one's image of oneself as a husband and father to fill an unexpected role. The clearer one's previous image and role of oneself (for example, in a waiting room), the greater the struggle to meet the expectations of a new and sometimes unexpected role.

9. One considers, judges, and/or wonders how one will be a father to this child.
10. One looks to one's experience--either with one's own children, other's children, or one's thoughts about children--to predict how one will be with this child, recognizing that the child's unique features will also be important ingredients in the relationship.
11. One is very aware of one's family's reaction to the pregnancy and birth. One is pleased or disappointed about their reaction. One would like one's family to be excited and happy about it.
12. One finds oneself thinking about one's parents and one's childhood--one's relationship to them in the past, and now.
13. One often finds oneself gaining some new understanding of one's parents in how and why they did what they did as one thinks about being a parent, especially if one is a new father.

14. One thinks more about a deceased parent than before the pregnancy often with sadness that they won't know/see the child.
15. One thinks about wanting to be better parents than one's own especially better than one's father and feels optimistic about being able to do so, to give one's child what one missed as a child.
16. One has a sense of satisfaction and family, especially with one's first child, in having the child.
17. Having the child will give one the opportunity to be a good parent, to extend one's experience and influence in teaching and raising one's child.
18. Having the child will mean change for one's every day patterns and routines. It means potential in every aspect of one's life, especially in one's relationships with one's wife and other children.
19. One tries to speculate on what and how much change in routines and relationships the child's presence will create.
20. One speculates about one's future routines and role in caretaking. One assesses one's skills in taking care of a "brand new baby" based on

one's experience. More previous experience means less anxiety about one's ability to take care of an infant. Little or no experience (as in the case for many fathers) raises one's apprehension because there is no information with which to speculate.

21. One expects the baby will bring a greater sense of reality of being it's father when it is born--"when it is out and crying," it will be more real, believable, tangible for oneself.
22. One considers one's ideas about raising the child according to one's understanding of how people work, and what must be done for a child to be raised "right." One has a sense of right and wrong, better and worse, things to do to and with the child based especially on one's experience in one's own family.
23. One imagines oneself as a father--providing for, teaching, enjoying being with, and physically taking care of the baby and child, depending on one's view of the role of father and one's hopes for oneself as a father.
24. One expects to fill some roles without question and with little negotiation with one's wife, such as provider, teacher, and enjoyer of the child.

25. One expects to engage in caretaking roles in cooperation with one's wife and expects more negotiation with her in working out how much caretaking one will do with the infant. (This role appears to be a newer role to fathers, and appears to be a role in the domaine of the mother--so fathers sense negotiation is necessary--either to make sure they get to do it--or to get out of doing it.)
26. One knows one cannot control the birth processes, one cannot "make it come out right," and thus one feels limited. One's knowledge of the birth process helps one feel a greater sense of control.
27. One wonders and worries about whether one will be a good parent and do "all the things one is supposed to do in raising a child."
28. One does not know what kind and how much parenting will be "good enough" parenting, and one has some apprehension about it--as though there is some right and wrong, or some threshhold of parenting that will contribute to a well-raised or poorly raised child.

(B) The Physical Body. The second focus is that of the father's physical body. It includes awareness of the role as biological father, the differences between a

father's body and his wife's, and the physical changes, accommodations, and reactions to the pregnancy.

1. One is sometimes surprised to learn how much one's wife's pregnancy and the anticipation of the birth have affected oneself, including one's physical reactions.
2. One perceives one's wife as generally needing oneself more both physically to do things for her and emotionally for support.
3. One struggles with sometimes fleeting, sometimes more pervasive feelings of envy for the wife's role as potentially, and currently, actively closer to, more aware of, and more connected with the baby--her "unfair advantage in being closer to the baby."
4. As one's wife becomes larger and more pregnant, one's life and routines are affected in accommodation to her changes. Such accommodations may be resented, if it brings major changes to one's usual routines.
5. One's excitement and relationship to the baby is grounded in the special knowledge that the baby is a part of oneself--one's own child.
6. One struggles with one's knowledge that the baby is as much one's own as it is "hers", but she (wife), in carrying it, may seem to have more

basic claim. There is never a question of the child being hers--but one feels, sometimes, one must state one's involvement with the baby to remind oneself and others whose baby it is.

7. One realizes one may be pushed to the limits of one's physical and emotional resources by being at the birth.
8. For some, one wants to share the experience of pregnancy and birth as fully as possible, in an almost physical way.
9. For some, one wants to help and support one's wife's experience of pregnancy and birth but one does not want to share the physical experience but remain outside that experience as a separate person. One sees oneself as more able to help and support one's wife during labor by maintaining a sense of separateness from her pain and physical changes.
10. One hopes and expects to make it through oneself without passing out, or otherwise reacting to the physical and emotional impact of the childbirth process.
11. If one has fears or concerns about blood, hospitals, doctors, or one's wife's pain, one expects to be able to handle such concerns and make it through all right.

(C) The Emotions/Reactions of the Self. The third focus involves a father's awareness of his emotional responses to the changes in his life and his expression of those emotions in reactions.

1. One wonders how and what the rolling mixture of feelings will come up with, especially at the birth--feelings like resentment, indifference, unreality, overwhelmed, calm, curious, joy, euphoria, happiness, excitement, etc.
2. One hopes everything will be fine, and one sets one's mind to be generally optimistic rather than focus on the ever present fears and anxieties.
3. One seeks reassurance from past resources, especially private feelings--wisdom or stories of other men, wife's health and condition, birth as a common human experience, religious beliefs, philosophical beliefs, fatalism, etc.
4. One has a mixture of feelings towards one's wife. One tries to maintain optimistic, protective, and benevalent feelings for one's wife, but struggles often with feelings of being left out, with resentment, with apprehension, with envy and other feelings which are uncomfortable and not in keeping with one's view of the role of husband and expectant father.

5. One knows one is to some extent helpless about the childbirth process and one must handle whatever occurs as well as one can.
6. One does not talk to one's wife about one's fears or anxieties if one can refrain from doing so.
7. One finds oneself sometimes wishing for more support and consideration from others including one's wife as one struggles with one's own feelings of expectant fatherhood.
8. One feels one must remind oneself and others of one's essential role as a father--that "she didn't get that way by herself," because there is so much focus on the woman, and for some women, their sense of centrality and completeness in their role seems to discount one's own role.
9. One hopes one's feelings at birth are acceptable to oneself, but one is aware of the potential for disappointments as well as great joy for one's expectations.
10. One trys not to have too many expectations so one will not risk disappointment. One tries to keep the expectations within bounds.
11. For some--one expects to deal with whatever arises and wants to be there with one's wife at the birth.

12. For some--one does not want to actually see any serious problems at the birth because one expects the visual image to be too painful, and too long lasting, and fears its effect on one's relationship with one's wife and family.

(D) The Wife/Fetus. The wife/fetus, almost as a single entity, is a fourth focus for the father. His wife remains wife, but the changes in her and of her change a father's way of seeing her. The wife's physical body is especially important to the father.

1. One tries to predict how one's wife will handle this childbirth, physically, emotionally, and in terms of when the baby might come.
2. One is more aware of one's wife in nearly all ways--and especially physically--than when she is not pregnant.
3. One shares the pregnancy process with one's wife to the degree and in the ways one is comfortable--intellectually, emotionally, physically, psychologically, spiritually.
4. One is aware of the tremendous changes that one's wife undergoes, both physically and, to some extent, psychologically.
5. One is aware of one's wife doing a hard, important job fulfilling an important role at some cost to her.

6. One does not want to see one's wife suffer or undergo pain.
7. One expects one's wife will ungergo pain--perhaps considerable pain--during labor and delivery.
8. One hopes to handle the knowledge of her pain in a way that helps both her and oneself--whether one is in the place of childbirth or elsewhere.
9. One is sensitive to one's wife's feelings in relation to oneself as her husband in childbirth--whether for privacy or for support or for "being there."
10. One is sometimes aware, although one tries not to think about it, and they are very small, that one's wife is at some risk for complications, even life-threatening ones while she is pregnant and moves closer to her delivery.
11. One can put oneself in one's wife's place in contemplating childbirth and realize it can be scary, or very personal, or a tremendously big job, etc., depending on one's perceptions of one's wife's feelings.
12. One wants to share the good aspects of pregnancy and childbirth with one's wife--the excitement, joy, the preparations for the baby, the support and good wishes from family and friends, the attention.

13. One wants to be close to one's wife, to be a good husband to her at this time.
14. One expects one's wife to experience some changes and discomfort during pregnancy and one is pleased when the changes and discomfort appear to affect one less than expected or are less than anticipated.
15. One is aware of "all those hormones floating around in there."
16. One judges one's wife's expertise, experience, and expected skills and capacities as a good mother.
17. One expects or hopes to feel closer to one's wife through the birth experience.
18. One is impressed by a greater understanding of how much "strain and pain the woman goes through" and one does not want one's wife to face such an ordeal alone.
19. One sees oneself as providing one's wife with a person who is "with her." One does not view the medical staff as providing such a role, but sees one's wife as "alone" if one is not present.
20. One hopes to share the birth experience with one's wife--expecting such sharing to lead to closeness and shared joy and sense of shared accomplishment.

21. One hopes and expects one's presence to help one's wife by giving her confidence, easing her pain, letting her know she is not alone, lending meaningful, known support and comfort, calming her when panicky.
22. One is concerned about how one's wife will feel about one being there and about strangers (medical staff) being present.

(E) The Baby. A fifth focus for the father is the baby itself. A father focuses on what the baby will be like and how he is related and will relate to this new person.

1. One has some sense of knowing and relating to the baby now as "that little feller who's been kicking around in there."
2. One feels the baby as an amazing, transcendent, but also routine, common human offspring/creation--a gift from God--an extension of the love of the couple for each other.
3. One is awed by the fact that the baby is both a part of oneself and also a unique, separate individual human being.
4. One is aware, to varying degrees, that the baby is a person with his or her own feelings and unique characteristics, even at birth.

5. One is aware that the baby can be alert and reactive after the birth, and that "communication" can go on to some extent with the baby.
6. One has named the baby--often both formal names and a nickname for it during pregnancy.
7. One wonders and worries about the baby's health and capacities. Will it be average, above average? Will it have a handicap--be below average, retarded? , etc. Apprehension inevitably creeps into one's thoughts about the baby's health. One fights such apprehension, sometimes in a superstitious way.
8. One imagines seeing, looking at, and/or holding the baby shortly after the birth as one feels the reality of the presence and the baby being okay.
9. One senses or knows that the baby's birth will bring more tangible, real feelings of the baby's existence than the pregnancy has brought.
10. One feels a sense of having to wait to meet the baby before really building a relationship with the child--with a sense that one's wife may already have more of a relationship started with the baby because of her biological connection to the child.

11. One expects the baby to change one's present relationship with family members (wife and children), and one sees the child as an intrusion and/or an extension of the other relationships, to be accommodated over time. One knows that more accommodation will be needed in the future in one's relationships the more one feels the child to be an intrusion, and one is working on such accommodation currently.
12. One expects or hopes to feel closer to one's child by being there at birth and going through the birth with both wife and child.
13. One hopes and expects the shared birth will provide a good welcome for one's child.
14. One expects the birth to be better for the baby, with the chance to be held and fed after birth rather than "spanked and rushed off to the nursery."

(F) The Birth Event. The birth event itself is a very important focus for the expectant father. It touches on other foci, but remains the important future event around which other clusters organize. It is the anticipated event which will move the man from expectant to actual father, with the baby born. It is a clear, rich

focus for fathers. The majority of statements reflect views of fathers expecting to be physically present at the birth.

1. One feels growing excitement as the birth time approaches. One is in an exciting time--a time like the anticipation and build-up of emotion one felt as a child before Christmas or birthdays.
2. One thinks about where one will be when the baby is born. One has some specific images related to how one knows the baby is born, is okay, and it's here.
3. One expects to react to the birth according to one's general disposition--from nervousness, joy, being overwhelmed, to little outward show of emotion, quiet happiness, no major emotional change.
4. One hopes one's feelings at birth are acceptable to oneself, but one is aware of the potential for disappointments as well as great joy for one's expectations.
5. One trys not to have too many expectations so one will not risk disappointment. One tries to keep the expectations within bounds.
6. One sees birth as part of one's larger view of the world, human living, and one's own life.

It may be everything from an adventure, miracle, a good thing, a bloody mess, a family event, to a chore, a routine human event, something everyone goes through.

7. One has gained some appreciation for the birth as a hard process as something both the woman and the child go through, i.e. endure and must prevail against.
8. One expects the actual moment of birth--the baby being born--to be the most important moment to be there.
9. One expects to feel and be rivited on the birth when it happens and be totally, intensely focused on watching and feeling what occurs as the baby comes out into the world.
10. One has a sense that being there at the moment of birth is important to one's relation to the child--that one will have been there "from the very beginning," "from the first moment of birth," "when it started," "the very second that it's born."
11. Being present at the birth will give one a chance to see more than the birth of one's child. It is a chance to see something mysterious, transcendent, larger than oneself and family. It can involve "seeing life born," seeing "a miracle,"

seeing "how I came into the world," seeing "human birth," seeing a "mystery" that is related to women, sexuality, and childbirth.

12. Experiencing the birth, not just seeing or watching it is important. One is aware that until it is experienced fully, it cannot be appreciated in all its richness of feeling and perception. One can hear someone else tell it, or see a movie about the birth, but those lack the full, rich, personal experience that being there will provide/insure.
13. It is an event not to be missed, because its fullness and richness, and meaning can never be conveyed--they can only be experienced at the moment of birth.
14. It is a major turning point, a major experience, a major event, in one's life.
15. One's presence at the birth means one will have one's own memory of the event to have for oneself, to have with others including one's wife and the child when older.
16. Being there at the birth means going through the work of labor and delivery with one's wife. It means enduring, persisting, handling whatever comes up as well as one can.

17. One realizes one may be pushed to the limits of one's physical and emotional resources by being at the birth.
18. One hopes it is worth the effort.
19. One hopes, and expects, one's presence will help and support one's wife through a different ordeal.
20. One is willing to be there to help one's wife.
21. One gains a sense of what the birth will be like from a variety of sources. The more direct and immediate the source, the greater the trust in it, and the more the excitement about being present. (e.g. previous birth experience, seeing films, hearing from others, information from class material, little or no information other than TV or media sources).
22. One expects or hopes to feel closer to one's wife through the birth experience.
23. One expects or hopes to feel closer to one's child by being there at birth and going through the birth with both wife and child.
24. One senses one can share the experience of pregnancy and birth as fully as possible, in an almost physical way, and one must choose whether to open oneself completely to such total

sharing/experiencing, or to keep one's distance and maintain one's own perspective clearly.

25. One feels some struggle between one's greater experience and involvement in the experience of the pregnancy and childbirth and remaining outside and slightly distant from the experience, as a clearly and completely separate person.
26. One sees oneself as more able to help and support one's wife during labor as one maintains a sense of distance and separation from the experience, but more able to enter into the excitement, intensity, and sensation of the experience as one involves oneself and moves closer to it emotionally--as one lets one's emotions carry oneself.
27. One approaches the role of supporter and childbirth coach as it fits into one's sense of oneself and one's relationship to one's wife. It can help one feel more important and less a spectator, bystander, intruder in the childbirth process, or it can feel like a burden and a trap in which one is unsure of what one is expected to do and in which one feels one's wife is very unsensitive to one's feelings and desires.
28. One expects to learn a lot at the birth--to have a chance simply to satisfy one's very real

curiosity about childbirth, and about hospital and medical procedures around the childbirth.

29. One expects to continue to learn even more about women, and the mystery of birth, which one has begun to learn about during the pregnancy. One perceives it as generally excluding men and containing some knowledge from which one has felt cut off from and excluded from, but which one now has access to--as though beyond a veil of mystery. Birth will be "like the parting of the Red Sea"--mystery revealed, knowledge explained, liberation from the bondage of exclusion, not belonging, intruder, to the freedom of belonging, knowing, being an equal.
30. One appreciates and understands more about the process of pregnancy and birth from childbirth classes and has more respect for the work and changes involved for one's wife and child.
31. One gains some sense of security in learning about childbirth because one feels one knows more about what to expect.
32. One feels uncertain about exactly what to expect and what will be required of one in the childbirth situation.

33. One fears getting in the way of the medical-professionals to some extent, and hopes one does not interfere, or feel one is in the way.
34. One does not want to be left out, either physically or emotionally, in the minds of one's wife and/or the medical staff, of this very important event.
35. One hopes and expects to make it through the event without passing out, or otherwise reacting to the physical and emotional impact of the childbirth process.
36. If one has fears or concerns about blood, hospitals, doctors, or one's wife's pain, one expects to be able to handle such concerns and make it through all right.
37. One is impressed by a greater understanding of how much "strain and pain the woman goes through" and one does not want one's wife to face such an ordeal alone.
38. One sees one's self as providing one's wife with a person who is "with her." One does not view the medical staff as providing such a role, but sees one's wife as "alone" if one is not present.
39. One hopes to share the birth experience with one's wife--expecting such sharing to lead to

closeness and shared joy and sense of shared accomplishment.

40. One hopes and expects the shared birth will provide a good welcome for one's child.
41. One hopes and expects one's presence to help one's wife by giving her confidence, easing her pain, letting her know she is not alone, lending meaningful, known support and comfort, calming her when panicky.
42. One wonders how one in fact will handle the birth, and speculates and judges oneself and one's wife in trying to predict how it will be handled.
43. One knows one cannot control the birth processes, one cannot "make it come out right," and thus one feels limited. One's knowledge of the birth process helps one feel a greater sense of control.
44. One is concerned about how one's wife will feel about one's being there and about strangers (medical staff) being present.
45. One is aware of the risks and fears which also surround the birth, in terms of complications which may arise, and fears for the wife's and/or baby's health.

46. One knows complications can and may occur and such knowledge affects one's willingness to be present at the birth.
47. For some--one expects to deal with whatever arises and wants to be there with one's wife.
48. For some--one does not want to actually see any serious problems because one expects the visual images to be too painful, and too long lasting, and fears its effect on one's relationship with one's wife and family.
49. One expects the birth to be better for the baby, with a chance to be held and fed after birth rather than "spanked and rushed off to the nursery."
50. One considers one's past birth experiences.
51. For some, one regrets that one missed witnessing the previous child's birth. One feels very cheated, very much having missed out on an important, special event.
52. For some, one's desire to be at the birth comes from one's previous experience there, and happiness at being present.

# VITA

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After teaching in the Philadelphia and Knoxville school systems, she entered the Graduate School of the University of Tennessee, Knoxville. She completed a Internship in Clinical Psychology at the Massachusetts Mental Health Center, Harvard University Medical School in June, 1978. In December, 1982, she received the Doctor of Philosophy degree with a major in Clinical Psychology from the University of Tennessee.

She is married to Barry B. Walton of Little Rock, Arkansas. They have one daughter, Alicia, and live in Knoxville, Tennessee.