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male pregnancy symptoms in urban Colombia

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At first we both were so sick, vomiting every morning, and my husband had diarrhea that just wouldn't stop. I felt tired and faint; there was nothing I wanted to eat. Lately, though, I'm feeling stronger and better. But my husband, the poor thing, he continues to suffer.

(Cali, Colombia; case #180; woman, four months pregnant)

For more than 100 years, scholars have tried to understand why men in many of the world's societies engage in certain ritualized or expressive behaviors during their wives' pregnancies, parturitions, and postpartum recoveries. Analyses have sought the meaning these behaviors have either for the men involved or for the society as a whole. Explanations of why men act in ways perceived by others as characteristic of pregnant or parturient women have ranged from theories of biological or psychological causation (Bettelheim 1962; Gates 1944; Munroe, Munroe, and Whiting 1973; Roth 1893; Rubel and Spielberg 1966; Trethowan and Conlon 1965) to analyses of the sociological, sociopolitical, ritual, or adaptive functions that the behaviors could serve (Bachofen 1861; Paige and Paige 1981; Radcliffe-Brown 1926; Rivière 1974; Tylor 1889; Wilson and Yengoyan 1976).

Although all men's pregnancy responses have usually been regarded as a unitary phenomenon, Kupferer (1965) convincingly shows that this obscures important variation within the observed patterns. To rectify the situation, Newman (1966) proposes that the term "ritual couvade" be used to designate the prohibitions on productive or other activities that a man in many tribal societies is expected to observe after his wife bears a child. It is often believed that failure to practice these ritual behaviors may bring illness or other harm to the newborn. Aside from these conscious behaviors, men in many societies also experience involuntary "pregnancy" symptoms. Newman suggests the terms "psychosomatic couvade" or "psychogenic couvade" be used to designate the symptoms the husband of a pregnant woman may experience during his wife's pregnancy. Men's pregnancy symptoms are, in fact, very common throughout the world (Munroe, Munroe, and Whiting 1981:619). Similar manifestations, including nausea, vomiting, lassitude, dizziness, body aches, and appetite disturbances are found in a wide variety of cultural settings.

Research on men's pregnancy symptoms (couvade) typically seeks to explicate the meaning of the various symptoms for those presumed to be suffering. This paper considers the significance of such symptoms as reported by a group of pregnant women for their male partners. It is hypothesized that women with few sources of extraconjugal social support report partners' symptoms more often than those with more abundant social resources because such women are more dependent on their partners. This paper therefore examines how illness symptoms are differentially labeled by individuals in dissimilar social situations. [conjugal roles, women's roles, social networks, urbanization, Colombia, Latin America]

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The similarity of symptoms found in many different cultural contexts led some investigators to examine transcultural causes for these manifestations. John Whiting and his students conducted the most extensive body of research on the psychogenic *couvade* from this perspective. Their work is part of a general class of cross-cultural research that analyzes the relationship between early childhood experiences and adult behavior and seeks to specify the sociocultural conditions that evoke particular patterns (for reviews of this literature, see Munroe and Munroe 1975; Munroe et al. 1981). These researchers report that men manifesting pregnancy symptoms show a greater latent preference for the female role, as measured by standardized tests of sex-role performance. In this view of socialization, gender identity is depicted as a zero-sum game with feminine qualities expressed at the expense of masculine ones. The manifestation of pregnancy symptoms by men is therefore taken as evidence of a "sex identity conflict," and the symptoms are said to represent an unconscious wish by men to experience pregnancy directly.

Some of the methods used by these investigators to discover pregnancy symptoms in men have been indirect, with wives or significant others being asked whether the men under investigation manifested pregnancylike symptoms. This circuitous approach has been taken because it was assumed that men, especially those with "sex identity problems," would probably not reliably report the existence of symptoms that might compromise their masculine self-image. In such studies, symptoms reported by others were presumed to exist whether or not the men under investigation concurred. Psychological tests were then administered to men with and without reported symptoms to discover possible systematic differences in the personality organizations of the two groups. To date, however, there have been no attempts to analyze the characteristics of those who report pregnancy symptoms in their male partners. Reports of pregnancy symptoms by women could well be a means by which they express something about themselves, their conjugal relationships, and their own views of their partners' attitudes toward the pregnancy.

The discussion that follows is a departure from previous approaches to the study of men's pregnancy symptoms. I do not consider men's reports of such symptoms or their manifest behavior. Instead, I examine reports by a group of pregnant, urban, lower-class Colombian women of the pregnancy symptoms exhibited by their partners¹ and analyze the significance of these symptoms for the women who report them. Rather than proposing a general cross-cultural explanation for male pregnancy symptoms, this preliminary analysis refers only to Cali, Colombia. I intend to show that specific social structural conditions are associated with women's reports of their partners' pregnancy symptoms in that city.

Symbolic interactionism provides the theoretical perspective from which Caleñas' reports of partners' pregnancy symptoms are analyzed. From symbolic interactionism comes the understanding that reality is not an objectively structured entity to which human beings must adapt but instead is socially generated from the actions, reactions, perceptions, and inferred meanings that individuals attribute to all phenomena (Schutz 1962; Berger and Luckman 1967). The ambiguity inherent in all the activities that comprise daily social life is resolved through the meanings individuals attribute to events and situations.

The distinction that medical anthropologists and medical sociologists make between disease and illness is derived from the symbolic interactionist perspective. While disease denotes a measurable deviation from some biological norm, illness is a subjective view of processes that individuals define as abnormal or pathological. In interactionist terms,

illness is a social state created by human evaluation; it is a symbolic ordering of given events or states of affairs by the application of a label. Consequently, it is not an entity but a meaning used to explain, organize, and evaluate these events or states of affairs. . . . [Illness therefore] involves the allocation of the individual concerned to a social status. This carries implications for that in-

dividual's behavior and relations with others. Thus, the definition of someone as ill has consequences beyond the mere attachment of a label (Locker 1981:4-5).

The social scientific literature includes a large number of studies that delineate the social processes by which individuals come to label themselves, or be labeled by others, as ill; other research shows how illness labels influence subsequent patterns of social interaction or behavior (see Twaddle and Hessler 1977; Waxler 1974; Chalfant and Kurtz 1971; Cole and LeJeune 1972; Schur 1971; Telles and Pollack 1981; Fabrega 1974; Ruble 1977). Lay attributions to the illness state are often derived from the sequences in which symptoms are experienced or reported, by prior experiences with apparently similar or dissimilar disorders, and by awareness of local epidemics, family history, environmental hazards, and the like. Davis's (1963) classic study of families with children who contracted poliomyelitis clearly illustrates how illness labeling is situationally determined. He reports that several parents diagnosed their children's initial symptoms of sore throat, stomach pain, and fatigue as either common childhood ailments or the return of some previously experienced condition. In other cases, where parents believed their children had previously claimed illness to gain attention, the symptoms are attributed to that same source. The parents of both groups of children initially left their symptoms untreated or used home remedies, but none sought medical advice at this stage. Only one family interpreted its child's earliest symptoms as possibly indicative of polio, and the parents were the first to seek medical assistance for the child. They knew of previous cases in the neighborhood and were aware of the disease's contagious mode of transmission. Davis's study, as well as those of Cowie (1976) and Robinson (1971), convincingly shows how the processes by which meanings are attributed to health and illness events are determined by the interaction between biological and sociological phenomena.

The labeling perspective thus reveals that signs must be interpreted as illness symptoms if the symptoms are to be considered significant and that underlying physiological processes are much less important. Koos (1954), for example, reports that although lower back pain is common among lower-class American women, it is not regarded by most as symptomatic of any disorder; rather, it is an expected part of daily existence. Similarly, Clark's (1970) research in a Mexican American community shows that diarrhea among teething infants is considered a normal concomitant of the teething process and is ordinarily not treated unless it persists. Findings such as these led Zola (1966) to reexamine the results of epidemiological studies of the health status of Americans. He reports that such studies routinely uncover large numbers of untreated disorders—in some cases two-thirds to three-fourths of all existing conditions—that are never brought to a physician's attention. Moreover, he found that neither the type of condition nor its seriousness in the eyes of physicians discriminates between those who *feel* sick and those who do not. Zola (1966:616) concludes, "Such data as these give an unexpected statistical picture of illness. Instead of it being a relatively infrequent or abnormal phenomenon, the empirical reality may be that illness, defined as the presence of clinically serious symptoms, is the statistical *norm*."

Zola (1966:617) suggests that "selective processes" operate when signs are labeled as symptoms of illness, and he posits two variables that may influence this selective process: the actual prevalence of the sign in the population and its congruence with dominant values in the society. Subsequent research has shown a host of other features that influence the selective processes by which signs are perceived as symptoms of illness. Individuals may engage in such a process in order to accomplish valued goals, such as exemption from routine or onerous role obligations (O'Neil and Selby 1968; Uzell 1974) or mobilization of social support (Gussow and Tracy 1968; Goffman 1963). In addition, societies may use illness labels to more easily control deviant behavior (Waxler 1977;

Scheff 1966) or to provide a legitimate outlet through which individuals can express their dissatisfaction with the existing social system (Waitzkin and Waterman 1974).

It should be apparent by now that selective processes must also operate when pregnancy symptoms are reported by or for men. Disorders that would otherwise go unnoticed, unlabeled, or attributed to other sources such as overwork or gastroenteritis, are labeled as pregnancy-related symptoms by the person experiencing them or by others.

research methods

The data presented here were collected during research on how Colombian women diagnose their own pregnancies and how they make decisions about pregnancy outcome (Browner in press). Interviews were conducted in a Cali public health-care center, during the summer of 1978, with 207 pregnant women who came there for prenatal care. All interviews were conducted by the investigator or her Colombian assistant, a registered nurse with extensive experience in social science interviewing. Because it was hypothesized that factors involved in the self-diagnosis of pregnancy would vary according to the number of times a woman had been pregnant, the original study population was constructed to contain an equal number of women who were pregnant for the first through the sixth or more times. All women who came to the health center for prenatal care between 26 June and 9 August, 1978, and who qualified for interviewing based on the number of previous pregnancies comprised the original study population.

One morning, about three weeks into the interviewing process, the following conversation took place (case #170):

- Interviewer: How did you know that you were pregnant?
Informant: (28 years old; eight months pregnant; third pregnancy): I felt sick all over (*maluquera en el cuerpo*) with vomiting and chills. My period didn't come.
Interviewer: What was the first symptom that you felt?
Informant: I didn't feel well (*maluquera que me dio*).
Interviewer: And was anything else different?
Informant: I would vomit and food made me sick (*fastidio a las comidas*). Then my husband's tooth began to ache. . . .

Curious as to whether this informant's effort to link her husband's symptoms to her own pregnancy was idiosyncratic, we proceeded to ask the remaining 120 interviewees whether their partners had earlier in their pregnancy or were then experiencing "pregnancy" symptoms. When the interviewing was completed, I discovered that more than 60 percent (73/120) of the women reported symptoms in their partners. An analysis of the women's reports of their own and their partners' symptoms revealed no association between the two (see Tables 2 and 3), and I concluded that reports of their partners' pregnancy symptoms were independent of the women's own experiences (cf. Munroe and Munroe 1971:13).

It must be emphasized that all of the data reported here are based on reports by the pregnant women themselves. I did not observe the men's behavior, nor did I interview them on this subject. I do not know if the women's reports would be denied by the men or if the men whose partners did not report symptoms would themselves report symptoms. However, the types of symptoms the women reported lend support to my assertion that it was the women themselves who labeled these manifestations as pregnancy related. As Table 1 indicates, most of the symptoms the women reported were derived from their own observations; they did not need to rely on their partners' self-reports.

Table 1. Distribution of 113 pregnancy symptoms reported in partners.

Eating disturbances	
Cravings	15
Avoidances	11
Lack of appetite	6
Diarrhea	5
Weight loss	1
Increased appetite	1
Acidity	1
	<hr/>
	40 (35.4%)
Aches and pains	
Teeth, face	16
Head	8
Stomach	3
Body	1
	<hr/>
	28 (24.8%)
“Morning sickness”	
Nausea, lightheadedness	13
Vomiting	10
	<hr/>
	23 (20.3%)
Mood changes	
Irritability	4
Increased alcohol use	1
	<hr/>
	5 (4.4%)
Other	
Tiredness	7
Skin blemishes	6
Salivation	2
Chills	1
Fever	1
	<hr/>
	17 (15.0%)

descriptions of the setting, the study population, and the data

Cali, Colombia's third largest city, is typical in its recently accelerated rate of growth of many contemporary Latin American urban centers. During the past 30 years, Cali's size has increased from less than 250,000 to its 1981 population of more than 1,000,000. Several factors differentiate Cali from the rest of Colombia and lead to its reputation as an open and progressive city. Historically, Cali was southern Colombia's trade and commercial center, moderating the conservative impact of the Catholic Church and the ruling elite. In addition, the construction of a railroad and a paved highway connect the city to the Pacific port of Buenaventura 120 km to the west. Cali's location in the heart of the rich Cauca Valley has facilitated its development as an agricultural refining and processing center. Migrants from all parts of Colombia and Ecuador come to Cali with the hope of finding industrial employment; the actual scarcity of these jobs, however, means that few realize their goals. Most of the employed of both sexes work in the service sector of the economy (DANE 1975:51).

The women interviewed ranged in age from 14 to 40, with the majority in their 20s (mean age = 24.1, s.d. = 5.9). Like many *Caleños*, the great majority of the study population was born outside the city and had migrated with their parents or on their own (only 27 percent reported their birthplace as Cali). As a group, the women were not particularly well educated: three-fourths had five years or less of primary schooling (mean = 4.3, s.d. = 2.3), about the same as the national average for women (DANE 1975). Eighty-seven percent of

those interviewed were married or living in stable consensual unions at the time of the interview (55 percent in consensual unions and 32 percent legally married), which partly accounts for the fact that just 13 percent currently were working for wages, generally in some form of domestic service. More than three-fourths of the women had at some point in their lives worked for wages, although most retired upon initiating a conjugal union or becoming pregnant.

The informants' partners ranged in age from 17 to 57 and were an average of 5.5 years older than the women (mean age = 29.6, s.d. = 8.8). As was the case with the women, the majority (70 percent) of the men had been born outside of Cali. The men were, on the average, better educated: 40 percent had continued their education beyond the 5 years of primary school (mean = 5.4, s.d. = 2.9), about the same as the national average for men (DANE 1975). Despite their education, however, the majority of the men were unskilled laborers: 23 percent in construction, 20 percent as small vendors, 18 percent as service workers, and 8 percent as factory employees. Nearly 25 percent found work as taxi or truck drivers, and this constituted the most highly skilled occupational group among the male partners of the interviewees.

All respondents were able to comprehend the question, "Has your partner had any pregnancy symptoms?" (*¿Ha tenido su marido algunos síntomas del embarazo?*). Most of the women gave either affirmative or negative replies; the six who said they did not know are deleted from the following discussion. As reported above, 73 of the informants responded affirmatively to the question. Nearly half of the men for whom symptoms were reported were said to have suffered from two or more symptoms, yielding a total of 113 symptoms (see Table 1).

Eating disturbances constitute more than one-third of the reported symptoms and make up the largest single category. These include cravings for specific foods, such as liver and potatoes, fruits, fish, and pig's or cow's feet, as well as dislike for normally favored items, such as beans and lentils, or food in general. "He only craves foods he sees in the streets," and "He's lost his taste for home cooking," were often reported by the *Caleñas*. A diminished appetite and weight loss were also noticed in some men. Aches and pains constitute one-fourth of the reported symptoms, with toothaches and facial swelling being the most common. Vomiting and nausea make up one-fifth of the symptoms. Negative mood changes such as increased irritability, with the woman often perceiving herself or her children as the specific targets of her partner's ill temper, constitute 4 percent of the symptoms, and 15 percent are idiosyncratic or difficult to classify, including tiredness, skin blemishes, excessive salivation, chills, and fever.

I examined the relationship between the types of early pregnancy symptoms the women reported for themselves and those they reported for their partners to determine whether the symptoms the women reported for the men were simply male imitations of the women's experiences or projections of female experiences onto their partners. No obvious relationship between women's and men's early pregnancy symptoms was discovered.

As Table 2 indicates, the overwhelming majority of the women manifested physiological or emotional symptoms that they attributed to the pregnancy. Less than 10 percent (11/114)

Table 2. Reported pregnancy symptoms in informants and their partners ($\chi^2 = .001$, n.s.).

		Partner	
		Yes	No
Informant	Yes	66	37
	No	7	4

reported no symptoms other than the cessation of menstrual bleeding, compared to 36 percent (41/114) who reported no symptoms in their partners ($\chi^2 = .001$, n.s.). Like the men's symptoms the women's symptoms covered a wide range of disturbances, including nausea and vomiting, food cravings, body pains, and mood changes. However, the fact that a woman experienced a particular symptom did not make her any more likely to report this symptom in her partner. For example, nausea, vomiting, and lightheadedness were the most common symptoms the women reported for themselves. Table 3 shows that women who experienced these symptoms were no more likely than the rest to report such symptoms in their partners ($\chi^2 = .001$, n.s.). Further evidence of the fact that the men's pregnancy symptoms were not mere reflections of the women's own symptoms is seen for food cravings reported for both. Each was said to crave a different item: one woman longed for liver while she said that her partner craved pig's feet (case #260); another craved cheese although she reported that her partner hungered for apples and avocados (case #253). The social significance of these reported male pregnancy symptoms is considered in the following sections.

the dynamics of conjugal organization in Cali from the women's perspective

In this section, I briefly describe women's views of the nature and quality of female-male interaction in Cali, focusing especially on conjugal relations during the pregnancy and postpartum periods. Although these observations refer specifically to lower-class women, women of other social classes report experiences similar to those described here. This material provides a context for the analysis of Caleñas' reports of their partners' pregnancy symptoms, to be discussed subsequently.

The social and ideological segregation of gender roles in the lower classes throughout mestizo Latin America has by now been amply documented and described (Pescatello 1973; Carlos and Sellers 1972; Lewis 1963). The female and male domains are physically and organizationally discrete, and both groups use Divine or biological imperatives to justify the immutability of the existing arrangement. The nuclear family is widely reported to be the domestic ideal, with men having exclusive or primary responsibility for economically productive activities and with women maintaining total responsibility for housework and child care. Urban growth in Cali and throughout Latin America has increased the number of women who at some point in their lives have worked for wages, but most women continue to derive their primary identity from the traditional wife-mother role. However, while marriage or a stable union and motherhood are explicitly articulated goals for most Caleñas, in reality the two are not equally valued: the former is seen by many as a means of attaining the more valued latter goal, rather than as an end in itself.

Despite, or perhaps because of, the interdependency that this strict gender-role patterning normally generates in these poverty-stricken neighborhoods, women's interactions with current or potential sexual partners are generally highly charged and permeated by

Table 3. Reports of nausea, vomiting, and lightheadedness in informants and their partners ($\chi^2 = .001$, n.s.).

Informant		Partner	
		Yes	No
	Yes	11	67
	No	5	31

distrust and suspicion. Prior to pregnancy, interaction centers on a man's efforts to seduce a woman into a sexual encounter by implying a future commitment and on her attempts to secure such a commitment from the man she sees as most likely to actually comply. At this time, the satisfaction of a woman's own sexual needs is usually of secondary concern. While many male Caleños "play the field," simultaneously courting a number of women, the women are less likely to do the same, because if pregnancy does occur it would be more difficult for them to support their claim on the putative father. However, while caution and distrust characterize a woman's relations with a sexual partner prior to pregnancy, upon becoming pregnant a woman feels even less independent because her immediate options sharply decline.

Cali's current demographic picture shows more women than men, with the greatest imbalance in the reproductive age group (DANE 1975). Although in theory one man could support more than one woman, in practice the economic resources to which most lower- and working-class men have access make this a relatively uncommon arrangement. In addition, there are few secure job opportunities for women, especially for those with children. Domestic service is the main source of employment for lower- and working-class women, but most women with dependent children find they are excluded even from this option (Browner 1979). Kin are neither a consistently available nor uniformly dependable ongoing source of economic support. These structural factors are coupled with men's often capricious behavior in conjugal matters, partly because no legal or social sanctions are imposed on a man who has abandoned a woman by whom he has fathered a child.

Caleñas are therefore cynical about men's motives when men make sexual advances: *Les pican y se van* ("They sting and leave") is one aphorism many female informants used to express this cynicism. A Caleña summarizes many women's actual experiences with and feelings about men, as well as the fears of an even greater number:

As the saying goes, marriage and the shroud come down from heaven. [A man] will whisper in your ear until he finally convinces you, painting birds of gold, and then, when the hour comes, you've already been grabbed, to take it however you can. . . . Marriage is a horrible thing. Of course you can only learn this from firsthand experience. But later, when you're all washed up, when you've been taken to hell, *that's* when you finally understand (author's field notes, 1975).

Pregnancy is thus a period of special concern for Caleñas, many of whom are preoccupied by the fragility of their conjugal situations. This preoccupation has a basis in fact. Although, as reported above, the mean age of the study population is just over 24 years, more than 21 percent (25/114) of the women reported at least one previous union; and although all women in the study population were pregnant when interviewed, 23 percent (26/114) reported their present union as being of a year or less duration. This means that many of the women were either in conjugal situations that they considered insecure or that had not yet been tested over time. Abandonment during pregnancy was a commonly reported reason for termination of their previous unions. As one informant (case #302) reported:

The first time I was pregnant, my [first] husband and I were living with his parents. We hadn't talked about having a child but I never thought that it would be a problem for us. The problems I had then were with my mother-in-law, who was very selfish, and my father-in-law, because he expected me to do all the work around the house. But when [my husband] realized that I was pregnant, to my surprise he went and brought home another woman to live with him. Then he picked a big fight with me and he threw me right out of the house.

This woman chose to terminate that earlier pregnancy rather than try to raise the child without male assistance.²

Men who do not abandon their partners during pregnancy may intensify the frequency or seriousness of extraconjugal affairs. Many men also engage in unusually heavy drinking at

this time, commonly resulting in increased wife and child abuse. Heavy alcohol consumption and extraconjugal affairs have the similar effect of diverting economic resources from the domestic group and heightening a woman's sense of vulnerability. In some cultural settings, women see pregnancy as a way to push a man into a commitment (Lewin 1974). For Caleñas, the opposite is the case: they fear that pregnancy might break a relationship entirely or at least lead to diminished interest and attention by their partners. Although their preference is for a stable union, women report that they lack the means to ensure this outcome.

conjugal insecurity and men's pregnancy symptoms

During pregnancy, then, many Caleñas are particularly concerned with the future stability of their conjugal unions. This concern rests on economic considerations to a large extent, for pregnant women encounter extreme difficulty when seeking employment. While stable unions are valued by women primarily for economic reasons, they may also provide important sources of social and emotional support (Browner and Lewin 1982). Nevertheless, a few pregnant women do in fact work for wages and, at least in theory, alternative sources of economic, social, and emotional assistance can be provided by relatives, neighbors, and friends. It would thus be expected that women without access to earned income or alternative support sources would suffer more severely the effects of a broken or damaged union than would those who do not rely exclusively on male partners. These women might well be especially sensitive to signs that they interpret as a man's commitment to paternal responsibilities. In Caleñas' eyes, male pregnancy symptoms are one such sign. One informant (case #281) articulated this when she remarked, "[Hector] suffered so much at the end of my last pregnancy, I was sure he was going to really love Amalia when she was born". I therefore hypothesized that women who relied exclusively on their conjugal partners for economic, social, and emotional support would be more likely to report pregnancy symptoms in their partners. If the hypothesis is confirmed, it would indicate that reports of symptoms would represent expressions of female dependency and of women's wishes that their partners make a genuine economic, social, and emotional commitment to fatherhood.

A variety of tests were performed to examine the relationship between the women's sources of available economic, social, and emotional support and the likelihood that they would report pregnancy symptoms in their partners. Their most direct economic resources—a resident conjugal partner and their own source of employment—were considered first. No association with either of these two variables was found. As previously indicated, only 13 percent of the study population were not living with a partner at the time of the interview. However, as Table 4 shows, these "separated" women reported symptoms in their partners about as often as did those with resident partners ($\chi^2 = .65$, n.s.). I use the term "separated" as it is used by women in Cali, to refer to an ongoing union without the immediate likelihood of coresidence. In this study population, some of the separated women were maintaining long-term economic, social, and sexual relationships with men who lived with other women, and coresidence between the women and their partners had never occurred, although future changes could bring about a different configuration. In other cases, the couples had lived together for a time but did not share a residence at the time of the interview. Nevertheless, visiting and other types of exchange, including sexual relations, continued between the couple on a regular or intermittent basis. Women who were thus separated perceived their conjugal situations to be no less stable than did women with resident partners. The length of their unions demonstrate that this in fact was the case: 73 percent of the separated women reported their unions to be of more than one year's

Table 4. Social correlates of Caleñas' reports of partners' pregnancy symptoms.

	Symptoms	No symptoms
Resident partner ($\chi^2 = .65$, n.s.)		
No	11	4
Yes	62	37
Employment ($\chi^2 = .09$, n.s.)		
Working or worked until pregnant	16	10
Never worked or only in distant past	57	31
Kin resources ($\chi^2 = 2.99$, $p < .1$)		
None or only affinal	39	15
Consanguineal	34	26
Social resources ($\chi^2 = 4.39$, $p < .05$)		
Isolated loose-knit network	26	7
Integrated close-knit network	47	34
Neighbors and friends ($\chi^2 = 3.49$, $p < .1$)		
2 or less	55	24
3 or more	18	17

duration, as did 78 percent of the legally married women and 79 percent of those in consensual unions. Lack of coresidence, then, did not influence the likelihood that women would report symptoms in their partners.

Reports of partners' pregnancy symptoms were not found to be associated with the women's employment experience (see Table 4; $\chi^2 = .09$, n.s.). Working women or those who had worked immediately prior to pregnancy were as likely as the rest to report symptoms in partners, demonstrating that an independent economic base did not lead to differences in women's projections of symptoms. This may have been true because the vast majority of women had no recent work experience: only 13 percent were employed at the time of the interview and another 10 percent had worked prior to becoming pregnant. The latter group stopped working soon after the fact of pregnancy was established, some because they wished to, some because their partners recommended or required it, and some because they were discharged by their employers. As Table 5 shows, separated women were the most likely group to be working for wages ($\chi^2 = 15.11$, $p < .001$), demonstrating the validity of Caleñas beliefs that a resident partner and paid work are mutually exclusive options.

The proposed relationship between the availability of social and emotional resources and women's reports of partners' pregnancy symptoms was considered next. The hypothesis is consistent with a growing body of literature that seeks to establish that the presence of social supports can minimize perceptions of emotional stress (Henry 1958; Bovard 1959; Cassel 1974a, 1974b; Kaplan, Cassel, and Gore 1977; Dean and Lin 1977; Antonovsky 1979). This approach has received only mixed empirical confirmation (see Lin, Light, and Woefel 1982 for a review). Data supporting such an association in a multiethnic Israeli population are offered by Datan and her colleagues (Datan, Antonovsky, and Maoz

Table 5. Marital status and women's employment experience.

Marital status ($\chi^2 = 15.11$, $p < .001$)	Working or worked until pregnant	Never worked or only in distant past
Consensual union	15	50
Married	3	33
Separated	8	5

1981). Using a variety of indicators, they show that large and stable social networks facilitated middle-aged women's adaptation to menopause. Similarly, in a North American population, La Rocco, House, and French (1980) report that perceived social support, which they define as workers' beliefs that support was available from work supervisors, co-workers, family, and friends, mitigated the negative psychological effects of job-generated stress. Also, Burch's (1972) study of bereavement and suicide shows the risk of suicide to be nine times greater among single men who suffer the death of their mothers than among married men who experience the same loss. She also reports that men who had less contact with their relatives were more at risk than others of suicide (see also Cobb 1976). Findings such as these demonstrate some of the ways by which social and emotional resources can moderate the negative impact of stressful environmental stimuli.

As hypothesized, symptoms in partners were least often reported by women who had ample kin-based social and emotional support. Table 4 indicates that symptoms were reported by slightly more than one-half of the women who lived with their own kin or interacted at least once a week with any consanguineal relative. By comparison, partners' symptoms were reported by nearly three-fourths of the women who lived in nuclear households and had no relatives with whom they socialized at least once a week or who resided or interacted at least once a week with only their partners' kin ($\chi^2 = 2.99, p < .1$).⁴

It should be noted that symptoms were reported in about the same proportions by women who lived with or near only their partners' kin (71 percent) and by those who had no relatives of any kind with whom once-a-week contact was maintained (73 percent). This pattern is explained by the nature of in-law relations, which women in Cali often find problematic (cf. Collier 1974; Denich 1974; Lamphere 1974). Some Caleñas regard their female in-laws as allies, and they unite to evoke male behavior that will be satisfactory to them both. A mother-in-law and a daughter-in-law, or a man's sister and his partner, sometimes join in an effort to stop his drinking, to convert him to Protestantism, or to dissuade him from migrating. More often, however, female in-laws are competitors for the man's attentions and resources. Competition is often face-to-face, as when a woman tries to discourage her future daughter-in-law's interest in her son by providing ongoing bulletins of his promiscuous encounters. Other efforts are less direct, as when a man's sister and his partner each seek out regular opportunities to make him aware of defects in the other woman's character. Hence, many of the pregnant women who lived with or close to only their partners' kin were insecure in their domestic situations. They were unable or unwilling to count on these relatives for social or emotional assistance. Instead, they directed their efforts toward drawing their partners closer to them, seeking ways to encourage the men's identification with the paternal role, even at the expense of the filial or sibling one.

The data that allow us to analyze the women's total social resources give stronger statistical support than do the kinship data alone for a hypothesis associating reports of pregnancy symptoms in partners and a weak social support system (see Table 4). Women are classified as "integrated" if they lived with consanguineal kin or socialized with at least one blood relative at least once a week or if they had three or more neighbors and friends with whom similarly frequent interaction was maintained. By contrast, women are classified as "isolated" if they had no kin or only affinal kin available for regular and frequent interaction (i.e., coresidence or a minimum of one visit per week) and less than three neighbors or friends with whom this same frequency of interaction was the rule. Whereas only slightly more than one-half of the integrated women reported pregnancy symptoms in partners, nearly 80 percent of the isolated women did so ($\chi^2 = 4.39, p < .05$). This indicates that neighbors and friends were also important sources of social and emotional support for the pregnant women in this study. Holding the kinship variable constant, the data show that

those with larger friendship networks reported partners' symptoms less often than did those with small or nonexistent friendship networks ($\chi^2 = 3.49, p < .1$).

Research by Bott (1957) on the organization of urban British family life helps to explain the above patterns. She demonstrates that the nature of a couple's extraconjugal social resources influences the organization of that couple's domestic life. Couples with close-knit social networks made up largely of kin and neighbors who know each other will be less interdependent than will couples with loose-knit social networks that are composed largely of geographically dispersed relatives and friends who do not know one another. By interdependency, Bott refers to the division of labor within the household and to the extent to which a couple's domestic activities are carried out jointly or independently. Couples with "joint conjugal role-relationships" share many activities and spend their leisure time together, while those with "segregated conjugal role-relationships" carry out household tasks independent of each other and spend their leisure time with members of their own sex rather than with their spouses. Bott hypothesizes that the type of social network a couple maintains influences the degree of role segregation in the couple's conjugal relationship, with couples with close-knit networks maintaining more segregated relationships than those with loose-knit networks. This is because couples with close-knit networks have kin and neighbors readily available to help with household and other tasks, while those with loose-knit networks must depend on and help each other because they lack alternative sources of support.

The patterns that Bott describes have broader implications than simply explaining the division of domestic labor. She writes,

When many of the people a person knows interact with one another, that is when the person's network is close-knit, the members of his network tend to reach consensus on norms and they exert consistent informal pressure on one another to conform to the norms, to keep in touch with one another, and, if need be, to help one another. . . . But when most of the people a person knows do not interact with one another, that is, when his network is loose-knit, more variation on norms is likely to develop in the network, and social control and mutual assistance will be more fragmented and less consistent (Bott 1957:60).

In a modified form, Bott's perspective can be used to illuminate the circumstances under which Caleñas report pregnancy symptoms in their partners. Bott sought to explain the integrity of conjugal units in industrial society and to demonstrate how external factors shape their internal form. Her analysis thus examines the kinds of social support that different types of networks provide their couple-members. In the discussion here, the units of analysis are not couples but individual women; their male partners are regarded simply as nodes in the women's own networks. This analysis therefore shows how variation in the amount of support provided by different types of networks influences women's perceptions of vulnerability during pregnancy.

Although I lack comprehensive measures of network density, approximate measures can serve as a starting point for the discussion. Earlier, I categorize women as "integrated" and "isolated" based on the size of their social networks and the frequency with which they interacted with its members. I now employ the following rationale to equate these terms with Bott's use of close-knit and loose-knit networks: the networks of the integrated women comprised friends, neighbors, and consanguineal kin who resided in the women's own households or in their neighborhoods and who they visited at least once a week. Under these circumstances, the members of the women's networks had opportunities to become acquainted with one another, especially since the informants resided in densely populated lower-class urban neighborhoods. The networks of the integrated women can therefore be characterized as close-knit. By contrast, the networks of isolated women contained only agnatic relatives and in some cases a small number of neighbors or friends. The women's

other friends and consanguineal kin were dispersed throughout the city, state, and country, and even abroad; visiting with the vast majority of these network members did not occur on even a weekly basis. The members of these “thinner,” more dispersed social networks would not have much opportunity to know and interact with each other independent of the women themselves. These more isolated women can therefore be characterized as having loose-knit social networks.

An analysis of the internal organization of Caleñas’ social networks helps to explain why women with close-knit networks reported partners’ symptoms less often than the other women. Such networks provided them with multiple sources of social and emotional support that diminished their need to rely exclusively on their conjugal partners. More important, however, the awareness of the *potential* availability of alternative sources of support provided the women with a greater sense of security and less need to project paternal interest in the pregnancy. Women living with or near their own kin, for example, were more likely to indicate that they were not particularly fearful of being abandoned and that they would eventually find another partner, if necessary. By comparison, those women living in isolated nuclear situations expressed more fear and tended to be less optimistic.

Close-knit networks were advantageous for another reason. As previously indicated, the relatives, neighbors, and friends who make up such networks interact regularly with ego and with each other. They would thus be expected to share and advocate common standards of appropriate behavior. In Cali, those women who are mothers and those who care about them both want men to assume financial and social responsibility for the offspring engendered. Both groups try to evoke this desired behavior through informal social pressure and positive example, with individual network members reinforcing one another’s efforts. For example, when Berta’s brother learned of her pregnancy, he rushed to congratulate Derley, his childhood friend and work associate. He told Derley he was proud that the union had reached this stage and that he himself would not have to worry about his sister now, for he knew Derley was a serious man and would be responsible for his family’s needs (author’s field notes, 1975). Furthermore, the members of women’s close-knit networks are more willing to use informal pressure to ensure male compliance. As friends and blood kin, they are likely to have the women’s own interests at heart.

The women in this study group who had loose-knit networks found themselves doubly disadvantaged—they did not have easily mobilized sources of social support, nor were network members as likely to exert informal pressure on male partners on the women’s behalf. This probably explains why women who had only partner’s kin and very few friends nearby were as likely as women without any available sources of extraconjugal social support to report pregnancy symptoms in their partners. Like all Caleñas, these women can never be sure of their partner’s commitment. But unlike those with close-knit networks, they also cannot count on support from neighbors and relatives.

conclusions

Until now, interpretations of men’s pregnancy responses have been conducted from the perspective of the presumed actors in this drama—the men considered to be actually suffering the symptoms. Attention has focused on identifying the social circumstances under which these behaviors would occur; for example, discovering how some men’s early childhood experiences evoke unresolvable emotional conflicts over gender identity that are vividly expressed during their wives’ pregnancies. Such interpretations have concentrated on understanding what male pregnancy responses reveal about men’s views of themselves as men. The analysis offered here is of a different sort. I examine the conditions under which women articulate something about their own fears during pregnancy. I argue that in

the absence of secure extraconjugal social supports, pregnant women who are unsure of their partners' commitment express this concern by defining certain common signs of illness as male "pregnancy" symptoms. This analysis differs from more conventional ones in its consideration of the role women play in labeling men's responses to pregnancy and in its examination of the social conditions under which women regard such responses as significant.

Throughout this paper, I emphasize the preliminary character of this formulation and the tentative nature of these findings. Carefully designed research is clearly needed to systematically explore the issues raised. More precise data are needed, for example, on the relationship between conjugal instability, social resources, women's fears of abandonment, and women's reports of partners' pregnancy symptoms. This would require the development of more sensitive indicators than have been used here. On a different dimension, data on men's reports of symptoms related to pregnancy, along with measures of their own concerns regarding their present or future performance in the paternal role, would also be useful. We might ask if men who view themselves as "good fathers" or "good providers" themselves report symptoms with greater or lesser frequency than do men who are indifferent to paternal responsibilities. Data collected from both pregnant women and their partners would allow for comparison and an analysis of the reasons for deviations when they occur.

The explanation for men's pregnancy responses suggested here is intended to apply only to a particular type of social setting where intense female dependency and extreme social isolation generate vulnerability caused by fears of abandonment or a partner's loss of interest. These preliminary data do not allow us to determine whether the Cali situation is unique. However, research conducted in the United States by Robert Munroe and Ruth Munroe (1971) demonstrates that wives in this society commonly report pregnancy symptoms in their husbands. It would be instructive to examine the relationship between differences in the availability of kin and friendship resources, degree of dependency on the wife's part, and women's reports of partners' symptoms.

As worldwide modernization and urban growth continue into the 21st century, the nuclear family will become a more common domestic form and many women will come to rely exclusively on men to meet their social and economic needs. Further investigation of women's reports of pregnancy symptoms in their partners may reveal that these reports are one way women express their concern about their increasing dependency.

notes

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¹ In Colombia the terms *el marido* and *el esposo* are used without distinction to refer both to legally married and consensually mated men. The term "partner" is used here to describe men in both kinds of conjugal situations. No significant differences between legally married and consensually mated women were found in this study, although women in legal unions were more likely to have continued their education beyond primary school ($\chi^2 = 3.85, p < .05$).

² In an earlier study (Browner 1976) of abortion decision making by 108 *Caleñas* with unwanted pregnancies, fear of abandonment, or its reality, was the most common reason women gave for seeking to end their pregnancies by illegal abortion. As one woman reported, "[I wanted an abortion

because] I didn't have anyone to help me with anything at home any more so I knew I was going to have to work, and no one would take me in. In private homes, they don't give [maids'] jobs to women who are pregnant" (Browner 1976:78). And another, "I was. . . . upset to see that I had two children already. . . . and how I've suffered for it. . . . he yelled at us all the time, he treated them like he didn't love them. So I said to myself, 'What do I need another baby for? So that someday he'll go off and leave us all?' " (Browner 1976:79).

³ It should be noted that this study population probably overrepresents the number of *Caleñas* in stable conjugal unions. As mentioned, six women (5 percent) were deleted from the study group because they did not know whether or not their partners had experienced symptoms; all but one of these reported they had had only a transitory relationship with the father of the child. As indicated, many pregnant women also see no immediate prospect for male support and seek to end their pregnancies by illegal abortion.

⁴ The significance level for these data has been set at .1 due to the small sample size and difficulties in controlling for the effects of confounding variables (see Blalock 1972:159-163; Thomas 1976: 459-460). These findings should therefore be interpreted as suggestive but not conclusive. Ethnographic data have been used throughout the discussion to provide additional support. Further testing of these relationships is the next step toward more confidently identifying the nature and extent of the associations.

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103. Father, Mother, and Child

A. R. Radcliffe-Brown

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Diane N. Ruble

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