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A Qualitative Exploration of the Couvade Syndrome in Expectant Fathers

A. Brennan, S. Marshall-Lucette, S. Ayers & H. Ahmed.

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Abstract

The aim of this qualitative study is to explore the nature and duration of male partners somatic and psychological symptoms, across gestation and parturition, collectively called the Couvade syndrome. Fourteen men with expectant partners aged 19-48 years from diverse social and ethnic backgrounds were interviewed. The data was processed using qualitative analytical software WinMAX Professional and the emerging themes and sub-categories identified and analysed. The first was “*Emotional Diversity in Response to Pregnancy*”, that varied with time and other factors and also included mixed and polarised feelings such as excitement, pride, elation, worries, fears, shock and reluctance. The second was “*Nature, Management and Duration of Symptoms*”, which revealed the types and duration of physical and psychological symptoms experienced by men. Attempts at managing these were influenced by social and cultural factors. Physical symptoms were more common than psychological ones, and their time course demonstrated trends similar to those reported for the Couvade syndrome. Although the former were reported to their GPs, no definitive diagnosis was made despite medical investigations being performed. The third theme, “*Explanatory Attempts for Symptoms*” was influenced by cultural beliefs and conventions like religion, alternative medical beliefs or through the enlightenment by health care professionals in the process. Some participants were unable to find explanations for symptoms but some perceived that they were related in some way to the altered physiology of their female partners during pregnancy. These findings highlight the need for further research to acquire deeper insight into men’s experiences of, and responses to, pregnancy as a way of explaining the syndrome.

Key Words: Couvade syndrome, Modern Couvade, Sympathetic pregnancy, Pseudo-pregnancy, Pseudocyesis.

Introduction

The Couvade Syndrome is a phenomenon which occurs in industrialised countries around the world. It affects the male partners of pregnant women who experience a range of physical and psychological symptoms with no pathological basis (Klein, 1991; Mason & Elwood, 1995). However, one case study has reported a Couvade syndrome equivalent in an African-American woman during both of her twin sister's pregnancies (Budur 'et al.' 2005). Conner & Denson (1990) identified 3 main groups of symptoms commonly associated with the syndrome. The first group included the gastrointestinal symptoms nausea, heartburn, abdominal pain, bloating, and appetite changes. The second group comprised upper respiratory disturbances like colds, breathing difficulties and epistaxis, in addition to pains like toothache, leg cramps, backache and urogenital irritations. In the third category, psychological symptoms such as changes in sleeping patterns, anxiety and worry, depression, reduced libido and restlessness were reported. The symptoms are chronologically connected to pregnancy and their course appears to follow a U-shaped pattern over the duration of gestation (Schodt, 1989), as the symptoms appear in the first trimester, temporarily disappear in the second and reappear in the third trimester. This has been confirmed by the timing of medical consultations for them (Lipkin & Lamb, 1982). The symptoms classically cease abruptly at birth or shortly within the postpartum period.

Problems of Definition

Early accounts tended to medicalise the syndrome as a psychosomatic disorder (Trethowan & Conlon 1965; Trethowan, 1968). Enoch 'et al.' (1967) refer to it as an

“uncommon psychiatric syndrome”. However, the syndrome does not appear in the nosologies of the Diagnostic Statistical Manual of Mental Disorders: DSM-Version 1V, (American Psychiatric Association 2000) or the International Classification of Diseases: ICD-Version 10, (World Health Organisation 1993). The reason for this is not clear, but the syndrome is idiopathic, and according to classic definitions, is not specifically related to physical or psychological illnesses. Furthermore, Couvade symptoms are by definition non-specific and transient, which hamper attempts to discriminate them from symptoms that do have a pathophysiological basis. Its diagnosis is principally made by exclusion (Schodt, 1989; Mason & Elwood, 1995). While these somatic symptoms are concurrent with pregnancy the fact that they are not associated with disease may cause some to question whether it is a syndrome at all. In 1991 Klein argued that the syndrome was a poorly understood phenomenon which might be explained by problems of definition, inconsistencies in its criteria and the use of multiple and varied measures across studies.

Moreover, the fact that the syndrome is an unconsciously and involuntarily determined phenomenon (Klein 1991) may complicate efforts by physicians to explain it, and attempts by those affected to understand it. Yet Mayer & Kapfhammer (1993); Magalini & Magalini (1997) suggest that the syndrome is the man’s conscious imitation or simulation of his partner’s symptoms during gestation. Those in the medical profession may sometimes overlook lay narratives of the syndrome and its social context in their efforts to medicalise it. Despite this, lay conceptions of the syndrome continue to be influenced not only by medical knowledge but also by the lived and personal experience

of those affected by the symptoms. Likewise, Falkum & Larsen (1999) argue that accounts of illness are based on existing knowledge and explanations which express individualised views based on beliefs and experience. Thus, those who have Couvade syndrome constitute a valuable resource when it comes to rationalising and making sense of its symptoms. Moreover, this understanding is often influenced by their respective socio-cultural contexts. All these factors were influential in deciding the qualitative nature of this study.

Incidence and Socio-Demographic Factors

The syndrome's incidence has a wide international variation, and early reports from the U.K. have a wide range of 11-50% (Trethowan & Conlon 1965; Dickens & Trethowan, 1971). Bogren (1984) found an incidence of 20% in Sweden. In the USA, Clinton (1987) and Brown (1988) reported a much higher incidence of 94-97%. Khanobdee **'et al.'** (1993) estimated an average incidence of 61% among Thai males; while Tsai & Chen (1997) reported a similar incidence of 68% among Chinese men. The global incidence of the syndrome has also been demonstrated by reports of its presence in France (Sizaret **'et al.'** 1991), South Africa (Chalmers & Meyer, 1996), Russia (Marilov, 1997) and Serbia (Koić **'et al.'** 2004). However, one country where the syndrome has sparsely been reported is Australia (Condon, 1987), which might reflect reluctance to admit such symptoms in what is perceived to be a "macho culture". Its relationship with socio-demographic factors such as age (Bogren, 1989), educational level (Lipkin & Lamb, 1982), social class (Strickland, 1987), number of previous children (Sizaret et al, 1991) planned or unplanned pregnancy (Bogren, 1983, 1984; Clinton, 1986; Strickland, 1987)

all show inconsistent findings. The only exception is ethnicity where a higher incidence among black men has been consistently reported (Munroe & Munroe, 1971, Munroe **'et al.'** 1973, Clinton, 1986). These disparate findings might be explained by problems of sample size variation, cultural and age differences across studies, socio-economic class variability and geographical distributions.

Theoretical Concepts

A plethora of theories have been put forward to account for the origin of the Couvade syndrome. Psychoanalytical theories propose that it emanates from the man's envy of the woman's procreative ability (Bohem, 1930; Rapheal-Leff, 1991). Another perspective maintains that it occurs because pregnancy for the expectant man acts as a catalyst for the resurgence of ambivalence and Oedipal conflicts (Gerzi & Berman, 1981; Barclay **'et al.'** 1996; Bartlett, 2004). Other psychoanalytical theories propose a relationship between the syndrome and the man's rivalry with his unborn child (Malthie **'et al.'** 1980; Kapfhammer & Mayer in Brahler and Unger 1996). It is not surprising, therefore, that those male partners in such studies have often been referred to psychoanalysts or psychiatrists for treatment given the idiopathic nature of the syndrome and its failure to be diagnosed by physicians. Studies exploring a psychoanalytical basis for the syndrome are mainly case reports, which might be prone to subjective interpretation and difficult to generalise. Psychosocial theories propose that the syndrome is a reactive process to the marginalisation of men during pregnancy (Mayer & Kapfhammer, 1993; Chandler & Field, 1997). However the feminist perspective rejects this, and argues instead for the increased and active participation of men during pregnancy and birth (Masoni **'et al.'** 1994; Polomeno, 1998). Psychosocial theories also propose that the syndrome arises

because of men's transitional crisis to prospective parenthood (Jordan 1990; Imle, 1990; Klein, 1991).

Paternal theories propose a relationship between men's involvement in the pregnancy, role preparation and the syndrome (Weaver & Cranley, 1983; Raphael-Leff, 1991; Drake 'et al'. 1998). This might imply that a transitional crisis is less likely to occur if the male partner is better prepared for his new role but the fact that he is, still predisposes him to the syndrome, which contradicts psychosocial theories. Other paternal theories propose an association between the syndrome and anxiety (Trethowan & Conlon, 1965; Strickland, 1987; Brown, 1988). It is difficult, however, to determine whether anxiety is the cause or consequence of the syndrome. The use of varied measures of anxiety across studies further complicates the issue. To date only two studies by Storey 'et al.' (2000), and Berg & Wynne-Edwards (2001) support a hormonal basis for the syndrome. The findings of both indicated a significant increase in men's hormonal levels of prolactin and oestrogen but lower levels of testosterone and cortisol. These hormonal changes were associated with the display of paternal behaviours as well as Couvade symptoms. These findings support paternal theories which propose men's involvement in pregnancy as an antecedent of the syndrome. However, both investigations failed to assess the well documented but confounding relationship between paternal stress and anxiety with elevated levels of cortisol and the somatic symptoms of the syndrome. The literature reveals a dearth of studies testing these theories except those examining the syndrome's relationship with pregnancy involvement, role preparation and anxiety.

Despite a predominance of literature on the syndrome during the 1980's and 90's, little has been published between 2000 and 2006. This might reflect fluctuating interest over the decades seen also with other subjects that do not receive significant scientific attention from public and independent funding bodies that usually express more interest in common health problems. The transient nature of the syndrome which affects otherwise healthy males, and the relative ignorance about its exact definitions and possible impact even in academic circles might also explain the deficit.

Rationale for Qualitative Approach

The rationale for using a qualitative approach to investigate the Couvade syndrome is fourfold. Firstly, the fact that the syndrome continues to be poorly understood by those affected and by the health care professionals they consult necessitates the need for an independent and in-depth exploration of male partners own perceptions and experiences of it. This approach is likely to reveal insights into the nature of the symptoms and their relationship to pregnancy. Secondly, the qualitative approach could offer an alternative perspective in understanding male partners perceptions of the syndrome, as opposed to the currently predominant medical perspectives within the literature. Thirdly, it enables exploration of the syndrome in a naturalised and holistic manner, making recourse to individuals' social and cultural contexts in the process, and whether these influence the ways in which it is managed and explained. Fourthly, the approach is ideally suited to allow further theoretical contributions to be made or existing ones to be confirmed or developed.

Study Approach, Aims and Objectives

A phenomenological approach was chosen for the study based on the lived experiences of male partners with the Couvade syndrome. The aim is to explore the emotional, physical and psychological characteristics of the syndrome and their explanations, as perceived by men with pregnant partners. Its specific objectives are to:

- Explore male partners experiences of pregnancy, including their feelings and aspects of involvement, to assess concurrence with current theoretical propositions for the Couvade syndrome.
- Explore the nature and duration of male partners physical and psychological symptoms experienced across the three trimesters of pregnancy and labour as defining criteria of the syndrome.
- Explore male partners accounts of whether and how these symptoms are investigated and managed making comparisons with the published literature.
- Identify the timing of symptoms and their cessation in male partners and compare with those reported in published literature.
- Explore male partners explanatory attempts for their symptoms, to determine their meanings and possible social and cultural influences.

Methods

Access and sampling

A purposive sample of 14 men were recruited from the Foetal Medicine Unit of a large teaching hospital in London which serves a large Asian and Afro-Caribbean population. The main investigator approached the men when they attended pre-scanning information sessions with their partners around the tenth week of the pregnancy, which provided them with details of the ultrasound scan procedure, potential pregnancy anomalies and details of antenatal care. Prior to these sessions the investigator introduced himself to the couples and provided an outline of the study and its purpose making no mention of the “Couvade syndrome”, but rather “men’s health during their partners’ pregnancy”. Participants were offered the opportunity to ask questions about the study and provide their contact details. Thirteen male partners agreed to participate, six who had no children, five who had one child each, and two who had two or more children each. Four other men who were first time parents were also recruited from an Internet website specifically designed for the study namely, www.pregnancyandfathers.com to reach a more heterogeneous group. Inclusion and exclusion criteria were established to reduce the likelihood of confounding symptoms. The inclusion criteria were:

- Over 18 years of age.
- Can read, speak and understand English at a level suitable for the full completion of the interview.

- Partner has a confirmed pregnancy for which the recruited person is the biological father.
- Be willing to be interviewed.
- Have experienced a minimum of 4 physical or psychological symptoms whose onset coincided with the pregnancy.

The selection procedure involved completing short questionnaire requesting information about male partners' symptoms. A list of thirty-five symptoms (27 physical and 8 psychological) was developed from the literature on the Couvade syndrome. The symptoms comprised 12 gastro-intestinal, 3 genito-urinary, 4 respiratory, 2 oral/dental, 2 generalised aches/pains and 4 other symptoms which did not fall into these anatomical categories. There were also eight psychological symptoms relating to sleep, mood, emotional affect, motivation, cognition and coping. Men with four or more symptoms whose onset coincided with the pregnancy were included.

The exclusion criteria were:

- Under 18 years of age.
- Unable to speak or write English at a level suitable for the full completion of the interview.
- Receiving current treatment for illnesses that might produce physical symptoms similar to those of the Couvade syndrome, e.g., inflammatory bowel disease, viral infections like chronic fatigue syndrome, herpes, glandular fever, meningitis, thyroid problems, any form of cancer, anaemia or relevant chronic disease.

- Receiving current treatment for any form of mental disorders that might produce psychological symptoms similar to the Couvade syndrome, e.g. depression or manic phases of affective disorder, anxiety disorders, schizophrenia and other relevant psychoses or neuroses.
- Partner has confirmed medical problems with her pregnancy, e.g., gestational diabetes, hypertension, pre-eclampsia or other relevant maternal disorders.
- Partner has a high-risk pregnancy, e.g., antenatal haemorrhage, foetal/maternal blood group incompatibility and similar conditions.

Three men did not fulfil the study selection criteria because of language difficulties, having less than 4 physical symptoms and a partner with a high-risk pregnancy and so were excluded. Subsequently the selected number for the study was fourteen men. The socio-demographic characteristics of the study population are summarised in the Table.

Ethical Considerations

Permission for the study was sought from the Local Research and Ethics Committee. Men who indicated their interest and satisfied the study entry criteria were invited to participate. They were provided with an information sheet and a written consent form for audio-interview recordings to be performed in their own homes. It was made clear that their decision to participate or opt out of the study would not affect the subsequent care that they or their pregnant partners receive. Anonymity was preserved during the interviews and other aspects of the research process, through the use of pseudonyms for study participants and their partners if they referred to them by name. All forms of data were kept on a computer protected by a security password. Tapes/magnetic discs and

other documents related to the interviews were stored in a locked cupboard in a secure room. Data were treated with strict confidentiality.

Methods

Data Collection

Study participants were telephoned to arrange a suitable time for the interview. The purpose of the study was described to participants whose aim was to explore their feelings about the pregnancy, experience of physical and psychological symptoms and accounts of how these were managed and attempts to understand their symptoms. Details of the interview procedure were provided concerning its location, length of time, method of recording, management of interruptions and instances where clarification was needed. The interviews were conducted in the participants' homes during the evening time and lasted between 60-90 minutes. Female partners were requested not to be present lest this affect male partners' level of disclosure. A male researcher carried out all the interviews to take account of potential gender interaction effects between the interviewer and informants. This was in keeping with Levine & DeSimone's (1991) observation that men often confide more readily to an interviewer of the same gender and report less to someone of the opposite sex. Moreover, the same researcher throughout also helps promote consistency and uniformity across the interviews. Prior to data collection, the researcher spent considerable time examining aspects of the pregnancy experience for men to increase awareness of personal prejudices, viewpoints and assumptions. These were then "bracketed" (Ashworth 1999) or set aside, so as not to influence the process and maintain neutrality and objectivity. An open-ended conversational stance was used

along with field notes to capture the interview context. An interview guide piloted prior to the interviews was also used for the systematic sequencing of topics or issues to be explored as follows:

1. Participant's feelings and emotions in response to and during each trimester of pregnancy

- Men's and partners' feelings and emotions, whether positive, negative or both, in relation to pregnancy.
- Male partner's rationale for any identified feelings and emotions.
- The type and degree of men's involvement in the pregnancy e.g. attendance at scans, involvement with the unborn baby, attendance of antenatal classes, practical, financial and emotional support for pregnant partner.

2. Participants' experience of symptoms during each trimester of pregnancy: The nature and duration of symptoms, accounts of how these were assessed and managed

- Nature and duration of physical symptoms.
- Nature and duration of psychological symptoms.
- Account of how symptoms were assessed and managed, and by whom.
- Cessation patterns for symptoms.

3. Explanations and meanings for symptoms

- Men's explanations and meanings for individual symptoms and/or these as a whole.
- Explanations and meanings for individual symptoms and/or these as a whole by those consulted.

- Difficulties or failures in explaining symptoms, individually and/or as a whole either by men themselves and/or by those consulted.

Data was collected until it reached a point of saturation and redundancy, where no new information or insights seemed to emerge

Method of Analysis

An inductive approach based upon the analytic procedures of Colaizzi (1978) and Boyatzis (1998) was used namely thematic content analysis which ran concurrently alongside the process of data collection. A professional transcriber undertook transcription of the tape-recorded interviews, and the interviewing male researcher performed the analysis. The data was processed using the qualitative software package WinMAX Professional (Udo Kuckartz, BSS, Berlin, Germany 1998). The individual interviews were labelled M1-M14 (M1 = first interview, M14 = last interview). All the transcripts were scanned line-by-line and potential labels describing respective data segments were assigned manually and then later by the above programme. Categories and sub-categories were generated based on participants' recurrent words or phrases within the data sets. Data segments were cross-indexed with the original interview transcripts that were re-read and checked against field notes to ascertain the contextual meaning of the data. Key categories and sub-categories with their appropriate data segments were then organised in a meaningful sequence, reflecting the aim of the study. This was followed with the identification of relevant concepts prior to establishing possible relationships between these.

In this process, three key themes emerged, which were used to describe the participants' accounts, supported with verbatim examples. This was followed by attempts at interpretation of the meanings from the data sets. The personal meanings of participants' experiences were interpreted using their "lived perspectives" to represent their reality and seek possible justification. Conceptual meanings were interpreted by making reference to individual participants' social and cultural contexts as well as the pregnancy in explaining their perceptions and experiences. Two independent researchers were invited to read the interview transcripts in order to validate the sub-categories and themes. Three participants also reviewed their transcripts to ensure trustworthiness, accuracy and confirmability of the data prior to analysis.

Results

Three themes emerged from the data, namely "*Emotional Diversity in Response to Pregnancy*", "*Nature, Duration and Management of Symptoms*", "*Explanatory Attempts for Symptoms*". The relationship between the analytic sub-categories and higher order themes are illustrated in the Figure.

1. Emotional Diversity in Response to Pregnancy

Men's experiences of the pregnancy from its announcement up to the birth were demonstrated through their feelings, worries and concerns, response to demands and involvement with partner and unborn child. A myriad of mixed feelings were expressed, which varied in intensity over time. Twelve men indicated their sense of excitement at the news of conception, especially in cases where it was their first child,

... Wow it was am-a-a-zing when I first heard that Sarah was pregnant as we'd only been married for a short time. I remember announcing it in the pub to all my friends the next evening that I was to become a new father I was really elated. I was excited for about four weeks afterwards... (M: 2).

In addition, three men expressed ambivalence where the pregnancy was unplanned,

... Yeah well it was a delight and in a way horror as well... (M: 12).

Feelings of shock to unanticipated pregnancy and a transitory reluctance to accept it also surfaced,

... It was a bit of a bombshell mate since we was using some prevention at the time you know what I mean? Later on I took it on board I guess ... (M 8).

After the period of announcement the initial excitement gradually lessened. Nevertheless, positive feelings continued for nine of the participants as the pregnancy progressed and even intensified during the third trimester. Six men indicated that the pregnancy precipitated feelings of closeness and intimacy with their partners especially during and after the period of the first ultrasound scan,

...We actually got very close after that period my wife and I, we hadn't been married very long, and it sort of really brought us that much closer...(M:13).

Men's closeness to their pregnant partners was also displayed by their feelings of protection which involved health precautions and environmental prohibitions,

...I tried to get Sarah out of the house a bit more but we kept out of smoky pubs because of her condition at that time...(M: 2).

While the pregnancy generated positive feelings it also precipitated worries and concerns. These were mainly in response to the demands of the pregnancy, what it signified in terms of its potential effects on the health of the partner and unborn, its impact upon the conjugal relationship and other siblings, financial commitment, accommodation space, prospective parenthood, antenatal preparation and maternal care. The demands of pregnancy were largely pragmatic, emotional and financial. Men's practical support such as shopping, lifting heavy items, care of siblings and housework increased as the pregnancy progressed and the women's physical capacity declined. Many men responded empathetically and sensitively to their partners' emotional state especially in cases where they were tearful, anxious and vulnerable. Male partners also seemed to have a contextual understanding of the woman's emotional state,

...There were times when Eileen would start crying for no reason and need a big hug from me and the boys to cheer her up. I suppose that was her hormones tough at the time...(M: 6).

While many men were responsive to demands demonstrating awareness of their partners physical and mental stresses as the pregnancy progressed, their feelings were not always congruent with their actions. For example, some men harboured feelings of resentment, lack of patience and irritability although these were not expressed directly to their partners,

...There was definitely 'a shortness', an anger, a lack of patience and irritation because there's too many things that I was thinking that I had to do for her...(M: 13).

Another participant expressed his frustration with his partner's increasing demands across the stages of pregnancy and felt that she should be able to do more for herself despite her condition.

Worries and concerns centred on the health of the partner and unborn child, whether the pregnancy would go to term, prospective parenthood and its responsibilities, how other siblings would react to the newborn child, insufficient accommodation space and financial commitments especially among those whose salaries were low or who were unemployed. Three participants expressed worries concerning the health of the unborn based on their lay conceptions when the first ultrasound scan was performed,

...I was worried 'cos I thought he wasn't right he might be..what
ya' call it..a Mongol or something...(M: 8).

When it came to prospective parenthood and its anticipated responsibilities eight men expressed mixed feelings. These included positive anticipation and longing for fatherhood, a realisation of its responsibilities and the sense of meaning it created in their lives,

...Becoming a father I think of many responsibilities I have for wife
and child, it also give meaning to my life. I knew that have child
change everything for me and family...(M: 9).

Conversely, prospective fatherhood led to feelings of worry, uncertainty and apprehension for others who were expecting their first child,

...Well I guess I was worried about becoming a dad...it's a lot of
responsibility ya' know what I'm sayin'...(M: 8).

The majority of men participated in antenatal preparation such as attending ultrasound scans and antenatal classes but the feelings that these invoked were again mixed and seemingly influenced by cultural expectancies on some occasions. On one hand there were those who actively and willingly participated in antenatal classes with their pregnant partners but on the other hand there were those who seemed reluctant to do so because of the impact on their feelings. Others questioned their relevance and even led to a sense of empathic distance from the pregnancy,

...Oh 'yeh' I went to a few of those mother classes as well. I mean they 'was getting' me to do some exercises that Hope was 'doin'. I just felt like a bit of a plonker man. I mean it wasn't ME 'havin' the kid was it? ... (M: 3).

On some occasions antenatal classes were perceived as not being inclusive for the man,

...The focus of antenatal classes in my view is always on the woman and not on the man... (M: 10).

Men also contrasted their position with that of their pregnant partner when it came to antenatal care and felt their feelings were overlooked in the process,

... I did feel a bit of an outsider at the time... I mean it's not as if I felt I should be the centre of things then but I sometimes wondered if people really know what its like for the other half when a baby comes along ... (M: 2).

The feelings of the twelve men who attended the ultrasound scans varied and were sometimes influenced by cultural expectancies. For three men the scan unveiled the reality of the unborn baby through direct visual confirmation. For others it created feelings of apprehension about whether the health of the unborn was "normal". Other men reported that it drew them closer to their partners. Not all men wished to know the

gender of the baby but those who did displayed contrasting feelings when it was confirmed. This was classically illustrated by two Asian participants where a boy was confirmed in one case and a girl in the other. The former stated,

...I felt very exhilarated when it was confirmed that we were going to have a boy...(M: 7).

The other indicated,

...Well if I'm honest with you I felt a little disappointed since I was hoping for a boy...(M:10).

Men's emotional responses were sometimes linked to aspects of their involvement with the pregnancy and/or their unborn child. Their involvement in both took a number of forms which included commitment to demands, attendance and participation in antenatal care, preparation for the baby and choosing names, seeking confirmation of the unborn baby and evidence of paternal-foetal attachment. Men's involvement with, and vicarious confirmation of, the unborn mainly occurred through the ultrasound scans and when they felt or listened to their partner's abdomen for evidence of the baby kicking. Both the reality of the unborn baby and prospective parenthood were reinforced in such instances. For one participant the audible evidence of his partner's "quickening" early in the second trimester confirmed,

...I used to try and listen to the baby in Sarah's tummy. What I do remember is feeling the kicking ...am-a-a-a-zing and it really brought home to me that I was a dad or would be very soon ...(M: 2).

2. Nature, Management and Duration of Symptoms

This theme centred on the men's experiences of physical and psychological symptoms and their time course over the pregnancy, with accounts of the ways in which they were managed and by whom in addition to their cessation patterns. The identification of symptoms by men revealed insights into the ways in which these were experienced and their reality, intensity and level of distress. The most commonly reported physical symptoms were gastrointestinal, genitourinary, and musculo-skeletal and some other symptoms which could not be classified anatomically. Gastrointestinal symptoms included stomach pains/cramps (*n*-13) vomiting (*n*-7) and appetite disturbances (*n*-6). Men described their stomach pains as distressing and varying in intensity from an "ache" or initially "mild" to getting progressively "stronger" or severer,

...My stomach pains were very much like a build up of a woman's contractions as she's giving birth, they start mild and then get stronger and stronger and stronger. That's exactly what these stomach pains were like for me, you know they started mild and got stronger and stronger and stronger... (M: 13).

Vomiting mainly occurred in the mornings and on some occasions was also displayed concurrently by pregnant partners,

...I was throwing up and retching a lot and couldn't keep anything down both Beverly and me... (M: 8).

Appetite disturbances took the form of either increased or decreased appetite with some participants experiencing both alternatively. Some indicated that their appetite was insatiable and that hunger continued no matter what had been eaten. Occasionally, increased appetite and specific food cravings were linked,

...I was constantly hungry all the time and had an unstoppable craving for chicken kormas and poppadams. Even in the early hours of the morning I would get up and prepare myself one. It was strange to say the least... (M: 14).

The most common genitourinary symptom was difficulty with micturition (*n*-5). Men reported that it took them a long time to urinate especially at night and that it was painful,

...Another thing, going for a piss was really hard...it was evil man! (M: 3).

The most commonly reported musculo-skeletal symptom was back pain (*n*-5). Among the other symptoms was tiredness (*n*-10), which some men described as disabling and accounted for their lethargy,

...I was tired all the time day and night it took all my strength to do anything... (M: 4).

Less commonly reported symptoms were gastrointestinal including abdominal distension (*n*-3), diarrhoea and constipation (*n*-3), food cravings (*n*-2). Musculo-skeletal comprised leg cramps (*n*-1). Upper respiratory symptoms such as sore throat (*n*-3), colds (*n*-1), cough (*n*-1) and epistaxis (*n*-1). Oral-dental symptoms were toothache (*n*-3) and sore gums (*n*-2). Other symptoms included lethargy (*n*-4), weight loss (*n*-4), weight gain (*n*-2), fainting (*n*-1).

In contrast to physical symptoms, psychological ones were less common, and included insomnia (*n*-12), feelings of depression (*n*-6) and irritability (*n*-3). Men described their insomnia as difficulty in getting off to sleep coupled with nocturnal restlessness and short intermittent sleep,

...Oh sure my sleep was terrible, I could never seem to get off.

I'd be tossing and turning in the bed all the time... (M: 6).

Insomnia appeared to be linked to other symptoms such as tiredness and lethargy, or pregnancy-related worries and demands while feelings of depression were related to irritability,

...Well I suppose I felt quite low about the problems with my health ... (M: 14).

Less commonly reported psychological symptoms included those related to sleep, mood disturbance, emotional affect, motivation, cognition and coping ability. One unexpected result was that a mere three men reported anxiety each within one of the trimesters of pregnancy only.

Symptoms were managed by men themselves and/or by those whom they consulted. In addition to visiting their doctors six men initiated self-management of their physical symptoms, four of whom sought advice or treatment remedies from their local high street pharmacy. One Chinese participant initiated his own dietary remedy which appeared to be in keeping with his cultural beliefs,

...My appetite was very bad and it was very important to have hot food
to make the dampness go away... (M: 9).

Men only requested help in relation to their physical but not psychological symptoms. The people consulted were health professionals (general practitioners (GP) and/or dentists), one complimentary therapist (Chinese Herbalist) and one church minister. A total of eleven men consulted their GPs during the first and third trimesters for symptoms such as stomach pains, painful micturition, episodic fainting and respiratory problems and their dentists for toothache ($n=3$). Participants perceived that their GPs took their symptoms seriously, as indicated by the thorough assessment and the number and type of

investigations performed. Assessment included physical examinations, blood or/urine tests, blood pressure monitoring, computerised tomography (CT) scan and electroencephalography (EEG) to check brain activity. Management strategies included medical advice, referral to a counsellor and prescriptions, mainly in the form of analgesics. In each case no underlying pathology for symptoms was found and hence no definitive diagnosis made. One participant illustrates the idiopathic nature of his symptom of episodic fainting despite a multitude of investigations,

...He did an examination and a blood test and referred me to the hospital for a number of other tests. I had some done on my head, for one of these I had a scan of my brain but when the results came back they were all clear and my doctor seemed quite puzzled... (M: 14).

For men who had dental examinations a similar trend was evident causing one participant to temporarily doubt the reality of his symptom,

...I had a lot of pain in one of my back teeth. I thought it was the one where I had a filling so I went to my dentist and she told me that my tooth was OK and did not need any work doing on it. When this happened I began to think I was imagining everything but I know I didn't imagine it and I was very frustrated that no one thought that anything was wrong with me except myself...(M: 5).

In relation to the time course of symptom development, the onset of physical symptoms was mainly in the first trimester of pregnancy. Many of these symptoms temporarily disappeared in the second trimester and re-emerged again in the third trimester often with greater intensity. The symptoms seemed to cease temporarily during the second trimester,

and permanently at birth or shortly in the postpartum period as reported by eleven men. One of these confirmed the abrupt cessation of his stomach pains at the moment of his partner's delivery,

...It went, literally. The baby had started to come and that was the point where I had to leave the delivery room and I couldn't have walked more than 10 or 15 yards and it just went totally, like someone turning the light off, the pain just went. I thought it was very strange because it had just gone, so I went back into the delivery room and I had a son... (M: 13).

However, three other men developed symptoms for the first time in the second trimester. Two of them acknowledged that tiredness did not permanently cease in the immediate postpartum period. Psychological symptoms displayed a similar time course of start / cessation pattern, although a greater number of symptoms either commenced in or persisted during the second trimester. Some symptoms, e.g., insomnia and early morning waking, persisted well into the postpartum period.

3. Explanatory Attempts for Symptoms

Men's attempts in making sense of their symptoms and acquiring meaning were illustrated in the explanations they provided, sometimes influenced by cultural beliefs and conventions like religion, alternative medicine or through the enlightenment by health care professionals in the process. All the men interviewed provided explanations for their symptoms referring to them individually and generally. Some men revealed insights into the contextual meaning of their symptoms, as did their partners,

...Well the stomach pains were like aching especially in the mornings. There was me and Marcel comforting each other

about our tummy pains and you know what she said to me
one time, ‘which one of us is pregnant you or me’?... (M:4).

Men also reflected on the onset of their symptoms and acknowledged these as coinciding with their partners’ pregnancy. In one case a participant made a comparison between the periods before and during pregnancy in assessing the onset of his symptoms,

...Yes I had a lot of things wrong with me then. I just
couldn’t understand what was happening to me at the time
I mean I had none of these problems before and then they
all seem to come at once during my wife’s pregnancy...(M: 5).

Other men acknowledged their symptoms arose as a consequence of the worries and concerns which the pregnancy generated and in some instances being “in sympathy” with their partners. Men perceived that symptoms such as food cravings, abdominal pains and insomnia, arose because their partners had also experienced them,

...She was a devil at night because she she’s be turning in the
bed all the time so I didn’t get much sleep myself either...(M: 6).

In other cases male partners drew analogies between their abdominal pains with those of their pregnant partners during the pregnancy and labour. In doing so one participant attempted to make sense of this symptom by comparing its intensity with that of his partner and attributing its transfer from her to him,

...I think I was in more pain than she was. It seemed like my pain
was worse. It was almost as if she was transferring the pain on
to me that sort of transferral thing you get sometimes. It was
very much like that because she was in pain, her contractions
were fairly strong but she couldn’t push and as that was happening

my stomach pain was building up and up and getting worse and worse... (M: 13)

On another occasion a participant resorted to his religious beliefs to explain the meaning of his symptoms. He subsequently attempted to verify his spiritual perceptions with his church minister, who subsequently prayed for him and his partner,

...I have often tried very hard to think why all these things happened to me. When I look back I think that the problems with my health came about because of the forces of the enemy (Satanic) attacking us and making me sick. Satan hates Christian families you know!... (M: 4).

Men's explanations for their symptoms were also influenced by their cultural beliefs and dietary patterns. For example, a Chinese participant attributed his poor appetite to ingesting too many "damp foods". He consulted an herbalist who confirmed the same and suggested that he should include more "hot or spicy foods" in his diet. On another occasion an Asian participant explained his indigestion and diarrhoea by eating too many chillies the evening before.

Causal explanations for physical symptoms were most common where one symptom gave rise to another. In this context, weight gain was interpreted as resulting from increased appetite while weight loss occurring from decreased appetite. Symptoms were also perceived as arising from common viruses and infections such as breathlessness from colds and stomach pains from a transient viral infection or food poisoning. Sometimes health professionals shared participant's explanations for these symptoms but without confirmatory evidence. However, dentists consistently based their failure to

provide explanations for toothache on their dental examinations all of which confirmed no underlying cause.

While participants did not consult for psychological symptoms they still tried to make sense of them which they perceived as arising from the financial, physical and emotional demands of pregnancy as well as concerns about the health of their partner and unborn baby during gestation. Other participants perceived that psychological symptoms occurred because of physical ones and seemed preoccupied with their impact on general health. Feelings of depression, anxiety, preoccupation and irritability were all explained in this way. Only in one case did a health professional interpret physical symptoms as having a psychological basis by a suggested referral which appeared to negate the participant's experience,

...He said there was nothing else he could do and suggested that he could arrange for me to see a counsellor. This made me REALLY angry. It was as if he did not believe that I had all these problems with my stomach and getting sick...(M: 14).

Six men showed difficulty in their attempts to understand their symptoms, as did the health professionals they consulted. In these instances men often resorted to supposition or conjecture in the process,

...As I've already said they might have had something to do with my wife's pregnancy but I don't know what exactly... (M: 7).

For some men their symptoms still constituted a sense of "mystery", "confusion" and "puzzlement" when considered in hindsight,

...I don't know mate it's still a mystery to me...(M: 3).

In these cases they continued searching for answers and even sought enlightenment from the interviewer in doing so,

...Well I'll tell you now I am baffled by the whole thing, I mean if you or my doctor couldn't tell me, who could... (M: 6).

Those GPs who were unable to definitively diagnose or explain symptoms often made broad or generalised, non-descript diagnostic statements instead such as, "you're run down", "you're stressed" or "you're generally under the weather".

Discussion

Pregnancy triggered a mixed range of emotions for the men in the study especially at the news of their partners' conception. Men expecting their first child unsurprisingly exhibited initial feelings of excitement but others displayed ambivalence, feelings of shock and reluctance precipitated by an unexpected or unplanned pregnancy. Lewis (1982) acknowledges this diverse display by proposing that news of the partner's pregnancy often evokes a broad range of emotions in men. As the pregnancy progressed so too did its reality, significance and impact on the conjugal relationship, its physical and emotional demands, the realisation of prospective parenthood triggered by different aspects of its care and related health concerns. These unsurprisingly led to a myriad of different feelings and opposing emotional responses some of which men kept covert from their partners. Men may have felt that by expressing these openly they would have caused their partners further distress at a time when they were emotionally labile. Pregnancy-

related financial demands generated worries for those men who were unemployed or on low salaries.

Men's varied feelings about prospective parenthood, its roles, responsibilities and demands, were most likely influenced by first-time parenthood ($n=8$) or previous parenting experience ($n=6$). Certainly those who were first-time parents were more apprehensive and uncertain but whether this made them more susceptible to a transitional crisis and thereafter the syndrome as psychosocial theories suggest (Jordan 1990; Klein 1991), is unclear. Nevertheless, it was curious that all men displayed known features of the syndrome despite their parenthood status.

Men did not always feel that antenatal preparation was inclusive for them but one needs to carefully consider the evidence to determine whether this arose out of choice or fact. During antenatal classes some felt marginalised because of the attention their partners received, or felt on the periphery because of what they perceived as a specific gender focus on women, while others showed a reluctance to participate in them. Exclusion out of choice probably reflected cultural or traditional expectancies of gender roles and caused some men to question and curtail their participation accordingly. These feelings of exclusion for whatever reasons, may have contributed men's susceptibility to the syndrome as some psychoanalytical theories suggest (Mayer and Kapfhammer 1993; Masoni **'et al.'**1994).

Men's feelings to the ultrasound scans were mixed for a variety of reasons but those in relation to the gender confirmation of the unborn appeared to be the result of cultural pressures or expectancies. For a number of men ultrasound confirmed the reality of their baby where previously this was vicarious. The ultrasound scans also unveiled men's innermost concerns about the health of the unborn. Indeed, their degree of attachment to the unborn may have conditionally rested on this confirmation through ultrasound, although there was no direct evidence for this in the study. Weaver and Cranley (1983) have acknowledged this as part of the process where men through technological visualisation attempt to make contact with their unborn child which in itself constitutes a significant indicator of paternal attachment and involvement. Men's involvement as well as the reality of imminent fatherhood was also demonstrated when they attempted to listen for signs of the unborn baby's kicking during the period of the woman's "quickenings". Since the majority of men demonstrated involvement and varying degrees of attachment to their unborn these may have been related to the onset of the Couvade syndrome as Weaver and Cranley (1983) have shown.

Many of the physical symptoms which men experienced were identical to those of the Couvade syndrome confirmed in a number of investigations (Chalmers and Meyer 1996; Tsai and Chen 1997; Thomas and Upton, 2000). Men's stomach pains and vomiting in particular, commonly compares with those most prominently displayed by pregnant women. Evidence for their concurrence between both partners seems suggestive of men's attunement to, or identification with, their partner's display of them (Mayer & Kapfhammer 1993; Magalini & Magalini 1997). Alternatively, men's vomiting might

simply have occurred because of smelling or hearing the sound of their partners vomiting which caused them do likewise. This is feasible in the first trimester but it would not explain its persistence in the third when the pregnant woman's morning sickness ceases. The finding of a an alternative occurrence of increased and decreased appetite for some men replicates a similar trend reported by Conner and Denson (1990) and Khanobdee **'et al.'** (1993). Some men indicated that their increased appetite was linked to food cravings while decreased appetite might have arisen because of vomiting and anxiety. The less commonly reported symptom of abdominal distension especially in the third trimester coincided with a time when women are most heavily pregnant but weight gain was the most probable cause. Alternatively, it might have indicated pseudocyesis or "phantom pregnancy" which includes a progressive swelling of the abdomen and whose presence has been linked to the Couvade syndrome (Mayer and Kapfhammer 1993; Koić **'et al.'** 2004).

The most commonly reported psychological symptom was insomnia which men explained resulted from worries and anxieties concerning their physical symptoms and the pregnancy itself. Its reoccurrence in the third trimester may have been additionally affected by their partner's nocturnal restlessness due to being heavily pregnant at that time. Feelings of depression are difficult to compare or contrast with other work given the dearth of literature on antenatal paternal depression. However, there was some evidence to suggest that the number and distress of men's physical symptoms were the cause. Few men reported anxiety which was surprising as this finding contrasts with other studies confirming its prominence and relationship with the syndrome (Strickland 1987;

Brown, 1988). Overall, the physical and psychological symptoms which men experienced closely identified with those of the Couvade syndrome reported in the literature. In addition, their presence across a heterogeneous and culturally diverse but rather small sample was confirmed.

Consultation and accounts of symptom management were partially influenced by socio-cultural and religious beliefs. The fact that many men consulted their G.P.'s suggests that they perceived their physical symptoms as serious and/or distressing. The fact that none consulted for psychological symptoms does not mean that they were perceived less so but most likely reflected reticence to admit them because of social or cultural taboos. The timing of consultations mainly in the first and third trimesters confirmed similar trends for those of the Couvade syndrome in the Lipkin and Lamb (1982) study. The failure to specifically diagnose or show a physiological basis for physical symptoms is consistent with the defining criteria of the syndrome identified in other studies (Klein, 1991; Mason and Elwood 1995). Their onset and cessation periods demonstrate the same (Trethowan and Conlon 1965; Clinton, 1987). However, the persistence of sleeping problems and tiredness for some men into the postpartum was unsurprising given the likelihood of the newborn baby's nocturnal crying.

The findings show that male partner's attempts to explain and provide meanings for their symptoms were influenced by lay, cultural and religious beliefs which have not been considered in other studies. A number of men possessed contextual insights concerning the relationship of their symptoms to pregnancy or made attempts to understand them in

this way. Men's inability to explain their symptoms and those whom they consulted likewise confirms the widely acknowledged idiopathic nature of the Couvade syndrome (Klein 1991).

Limitations

The main limitations of the study were its small sample size and generalisability of findings given the unique nature of the data. Men may have reported more symptoms because they volunteered for the study while those less commonly reported may simply have arisen within one of the sample's sub-groups. Demographic influences such as culture, social class and reproductive history on symptom reporting were likely to be influential and in some cases may have led to underreporting. Selective recall of distressing symptoms is also likely to have affected reporting, a common methodological problem in symptom reporting research, acknowledged by Pennebaker (1982). The study's results are compared with literature on the Couvade syndrome some of which is dated for reasons mentioned earlier. The interpretations of the findings, which at times may be speculative, also uses supporting evidence confirming the syndrome in these men. The nature, time course, consultation outcomes and explanations for symptoms compare favourably with those documented for the Couvade syndrome and its criteria, but others might cast doubt on this, implicating men's normal responses to pregnancy instead.

Conclusion

This was the first phase of a three-part study exploring pregnancy-related symptoms of the Couvade syndrome among a highly heterogeneous but small group of men within the

U.K. Using an inductive analytic approach, the findings of the study demonstrated men's mixed display of emotional responses to pregnancy and different aspects of their involvement within it. Men identified a range of physical and psychological symptoms including their reality, intensity, duration and cessation many of which closely resembled those of the Couvade syndrome. Patterns of men's consultation were influenced by socio-cultural factors and religious beliefs. Men's accounts of how symptoms were managed confirmed that health professionals treated them seriously but failed to definitely diagnose or find a pathological basis for them as confirmed in previous reports of the syndrome. Explanatory attempts for symptoms revealed that some men had contextual insights into their relationship with pregnancy while others resorted to lay, cultural and religious beliefs in making sense of them. There were those who experienced difficulties in explaining them and resorted to supposition or conjecture in the process. Health professionals showed similar difficulties.

From a theoretical standpoint the feelings that men experienced in response to and during pregnancy highlights their emotional vulnerability during this period. The event of pregnancy signals many changes in men's lives some of which are perceived apprehensively. Health professions need to be mindful of the socio-cultural and emotional contexts of antenatal care for male partners where they may be confronted with the reality of prospective fatherhood including concerns about its roles and responsibilities and gender of the unborn. If men's emotions are overlooked in antenatal care this might contribute to or exacerbate somatic symptoms as suggested by psychoanalytic and psychosocial theories. Men's active involvement in the pregnancy

does not necessarily serve as a protective factor but may make them equally susceptible to those less involved. Expectant men's physical and psychological health needs need to be addressed in current antenatal care provision. A greater awareness of the syndrome is warranted given its physical and emotional consequences not only for the man but also his pregnant partner. Future attempts to understand, explain and manage the syndrome may be best served if socio-cultural and psychological contexts are considered as they have in this study. Future clinical interventions should aim toward increasing men's understanding of the transitory nature of symptoms and their spontaneous disappearance despite their distress.

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