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AN ETHNOGRAPHY OF PREGNANCY IN OUR CULTURE

by

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ABSTRACT

The essay describes ethnographically some of the special experiences of married women during pregnancy. Data were collected among middle class women in Vancouver, British Columbia, by means of observation, interviews, and a questionnaire.

Material relates to 1) the social relationships of pregnant women to other people, 2) some of the social customs practiced during pregnancy, 3) the social readjustments which occur as a result of pregnancy, and 4) preconceived notions about pregnancy in our culture.

The essay concludes that during pregnancy, certain kinds of communication with other persons (particularly kin, good friends, and medical personnel) provide a means by which women learn to orient themselves to the physical and social realities of pregnancy and motherhood. This communication entails the mutual exchange of knowledge and feelings, and the content and function of these exchanges are discussed.

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Supervisor

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I. INTRODUCTION

Pregnancy and childbirth are experiences shared by a major part of the adult female population the world over. Because of their universality, full ethnographic descriptions of the social customs surrounding them could provide valuable cultural and cross-cultural material, for the birth of children is among the most significant social milestones in a woman's life, since it changes her status and role in society.

A few such descriptions exist in the literature of anthropology, though generally speaking, full descriptions of pregnancy and childbirth are uncommon.[1] For our own culture, ethnographies on these subjects do not exist.[2]

This paper provides an ethnographic account of some of the special experiences married women have during pregnancy. It shows that these periods in a woman's life are more than biological episodes. The nature and scope of their social

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1. See Bibliography for a partial list of ethnographies in which pregnancy is mentioned.
2. References:
   An Inventory of Family Research Studies in Canada (1963-1967). Ottawa: Vanier Institute of the Family, 1967.
   International Bibliography of Research in Marriage and the Family 1900-1964. Minneapolis: University of Minnesota Press, 1967.
   Mogey, John. Sociology of Marriage and Family Behavior 1957-1967. The Hague: Mouton, 1969.
   Goode, William J.; Hopkins, Elizabeth; McClure, Helen M. Social Systems and Family Patterns. Indianapolis: Bobbs Merrill Co., 1971.
   Sociological Abstracts, 1963- present.

relevance is the subject of the paper.

Data for the study were collected in the Vancouver, British Columbia, metropolitan area over a period of approximately fifteen months. The data consist of observation (i.e., pregnant women were observed in everyday social contacts), as well as interviews with selected informants, who were chosen because they gave information easily and because they showed a general sense of social awareness. For a portion of this time, I was myself a participant observer, during my own second pregnancy. My informants were chosen from among married women enrolled in prenatal classes sponsored by the Vancouver Metropolitan Health Services and by the National Childbirth Trust. Most of them were having their first babies, and all but one were interviewed two months to one week prior to the estimated date of birth. The lone exception had given birth, prematurely, five weeks before the interview. The scope of the study includes the nine-month period of pregnancy but not childbirth itself.

By far the majority of informants were young Caucasians with Grade 12 or higher education, married to men of similar backgrounds. An effort was made to keep the sample fairly uniform. Some of the women were employed and of these a few planned to return to work after the birth of the baby, though this was the exception. Their husbands were steadily employed at jobs ranging from skilled labour to professional positions. All lived in relative comfort and anticipated some degree of advancement in life style in the future. Their orientation was, loosely, speaking,

middle class. Generally, this is the kind of person who avails herself of the services of prenatal classes, though they are open to everyone.

The material I gathered proved relevant for the study in several ways, as those pertaining to:

1) the relationship of pregnant women to family members, friends, professional medical personnel, strangers, and casual acquaintances. Of interest were regularly recurring acts and inferred attitudes of various kinds which clearly indicated a shift of status and role from the pre-pregnant state:

2) the social customs and amenities practiced by and for pregnant women;

3) the impressions of the women themselves concerning the social adjustments involved; and

3) preconceived notions concerning childbirth and the responsibilities of parenthood, insofar as these are part of the cultural milieu.

Of course, these categories are not mutually exclusive and are not treated as such in the report.

Work with the informants was casual during the initial phases of the study. That is, much information was gathered through conversations between informant and investigator and by fortuitously overhearing conversations of others. In addition, the talk between teacher and students in the prenatal classes was instructive.

During the second phase, eight interviews were recorded

on tape, six of which were used in this report. In each case, the interview was conducted in the home of the informant. They lasted from forty-five to seventy-five minutes. Transcripts of these were useful not only for their information content, but also because they provided this information in the woman's own words. Brief descriptions of three of the informants appear at the end of this chapter.

Thirdly, I elicited further information by means of an open-ended questionnaire, a copy of which appears as an Appendix. Ten of these were used in reporting the data.

Frequently, I had occasion to reflect upon my own dual role in this project of ethnographer and participant, and for a time I questioned the seeming incompatibility of these roles. As the project went on, however, it became evident that my own pregnant condition was working to my advantage, inasmuch as my informants actually gave information much more fully to me in my pregnant state than earlier in the study when I was not pregnant. Also, as a participant, my intuitive feel for the subject provided a means of interpreting the material gathered from each informant. It is clear to me that my personal involvement in the subject set up a positive condition for communicating with my informants, a factor which helped me to formulate the main thesis of this presentation.

Description of Three Informants.

Anne, age 28, has been married for seven years to a clothing salesman at Woodward's. This is their first baby.

Before marriage Anne was an airline stewardess, and has maintained the physical glamour and social responses associated with that profession. After marriage she worked as a secretary for five years in the airline offices in Vancouver.

Although she and her husband are Catholics, they practiced birth control for the first year of their marriage so that she would not be forced to give up her job as a source of income, on the belief that a couple should establish itself materially before beginning a family. However, when several years had passed and she had not become pregnant, the couple sought medical help and, learning that a low sperm count made pregnancy unlikely for them, they were in the process of adopting a baby when Anne at last became pregnant. In her eagerness to confirm the pregnancy, Anne had a laboratory test just ten days after missing her period, an unusually short interval. In his eagerness to confirm the pregnancy, her husband phoned the doctor's office to obtain the test results from work and then proceeded to tell his co-workers, relatives and several friends before realizing that he had not yet informed Anne. The deviation from normal proceedure is a source of amusement for her, and probably occurred because he had been anxious about his low sperm count.

I interviewed Anne in the ninth month of her pregnancy at her home in a new housing development in Surrey. In terms of material possessions -- furnishing, clothing, automobiles -- the family is comfortable. They have traveled to Europe and Asia by taking advantage of employee benefits from the airline.

They entertain frequently, have many friends, but I gather that she has few close friendships. Family ties are close but not intense. Parents, siblings, in-laws, and aunts and uncles live in Vancouver. The couple have no hobbies or outside activities, but devote a considerable effort toward home maintenance.

Anne projects an image of physical and emotional strength, and I gathered at our interview that these qualities are very important to her. All of my informants, in fact, seemed eager for me to believe that they were doing the "right" thing, such as taking good care of themselves physically, educating themselves concerning proper health habits, making good preparations for infant care, and adopting a positive frame of mind concerning birth. These are things which are encouraged in the literature as a means of insuring success and are, therefore, not surprisingly, the things which my informants wanted to communicate to me, not only in my role as researcher, but also as someone having the same experience.

Carol was the oldest (mid-30's), longest married (11 years), and most highly educated (two M.A.'s) of informants. Yet these factors did not make her significantly different from the others as concerns her pregnancy.

This is not to say that there was nothing unusual in her handling of the situation, for she had chosen an unorthodox way of announcing her pregnancy, which was not to announce it at all to out-of-town relatives and friends until after the baby's birth. In fact, her plan did not work, for Carol ended up telling her mother during the seventh month in order to insure that

she would not hear the news second hand from a relative who lives nearby. She said that she had not wanted her mother to worry about her during the pregnancy at a time when she was also caring for an ailing sister. Later in our conversation, however, it emerged that in her small home town in North Dakota, news of pregnancy becomes the focus of gossip which she considered degrading and meddlesome, and so her plan to keep the secret relates to her desire to break from this tradition, as she had apparently done before, by seeking education instead of marriage and family life within the community. She stated that her childhood friends had never understood her life style and had frequently asked her why she didn't have children, a line of questioning which Carol felt was tactless and cruel.

Carol and her husband Tom, a university professor, live in a new housing development in South Vancouver. They have no kin living in Vancouver. They share hobbies such as photography and motorcars, as well as interests in literature and music, and live quietly, without intense relationships with friends. They had at the time lived in Vancouver for one year, during which she had worked as a librarian at a secondary school. Previously, while living in the States, she taught English in Secondary school before returning to the university to get a degree in Library Science.

Suzanne, who is about 20, became pregnant while living in the Queen Charlotte Islands, where her husband was working at a mining camp. As there was no doctor nearby, she was flown out to Charlotte City to a doctor to confirm her condition, as well

as for regular monthly check-ups, although she was in excellent health. Had they stayed there, she would have been flown to Vancouver or Charlotte City prior to her due date to make sure that the baby could be born in a hospital, with a doctor in attendance. The only medical personnel available at the camp were an industrial first-aid man and a former nurse.

However, the couple moved to Vancouver when Suzanne was four months pregnant. Shortly thereafter, they made a trip to the Interior to announce the pregnancy to relatives, although an aunt who lives in Vancouver thought that they really should have called home immediately to let her mother know, rather than waiting to tell her in person. In spite of all the advice her mother offered concerning how she should care for herself during pregnancy, Suzanne had consistently disregarded this and preferred to ask the doctor or public health nurses.

II. BASIC OBSERVATIONS

The average married Canadian woman has 2.4 children,[3] a statistic which is relevant in this study for two reasons.

First, it provides a perspective from which to view my sample of informants. Most were pregnant for the first time, and on the average, could expect to be pregnant again only once or at most two more times. So although the sample is heavily weighted in the direction of first pregnancies, in light of future expectation, however, this fact does not seriously detract from its representativeness.

Secondly, (and more important) the statistic shows that during her thirty-five years of reproductive capacity, a woman in our culture fulfills this physical potential only two or three times, a fact which makes each pregnancy an event in which a woman invests a considerable amount of thought and emotional energy. The fact that contraception and abortion are accepted both in spirit and in fact, means that one may choose the time to become pregnant somewhat at will, when certain economic and physical living conditions are "right". Likewise, a woman tries to do the "right" and medically accepted things during pregnancy in order to insure a safe delivery and a normal

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3. Reference:
Mitra, S.; Romaniuk, A. Parsonian Type I Curve -- Fertility Projection Potential. Paper presented at American Statistical Association Annual Meeting, Aug. 15, 1972.

baby, factors which she feels are all the more essential since she will have this experience so seldom.

In recent years a growing number of readily available publications describe pregnancy and childbirth as emotionally and spiritually fulfilling events in a woman's life, and are thus conditioning women to view their pregnancies as intensely personal events in which they themselves take major responsibility and from which they gain special rewards.

Another recent trend takes this glorification of pregnancy a step further by preparing the husband-father to care for his pregnant wife and assist her during labour and delivery. Some prenatal classes specifically stress this option. Culturally, this trend is relevant for two reasons. First, cross-culturally it is rare to find the husband-father directly involved in any support capacity during the birth of children, except through such institutions as the couvade, and even then, he has no physical contact with her. Secondly, in our own urban culture, hospitals have maintained strict rules against the involvement of men in their wives' deliveries, as this interferes with the smooth operation of the facilities.

This step away from standard accepted practice perhaps reflects a changing concept of the relative roles of husband and wife, inasmuch as men are voluntarily involving themselves in what has previously been the domain of women, i.e., life-giving. These trends indicate that some effort is being made to heighten the quality of the experience.

The option also apparently exists now to pre-determine the sex of the unborn child by following a procedure developed recently by a medical research group.

Thus, married couples have a number of options, basic of which is the choice to have children or not; they may decide when to become pregnant, and how often. Beyond that, they may choose to manage the pregnancy and birth in a number of medically and socially accepted ways. These topics are openly discussed in the public media.

For all these reasons, talking with the informants about the relevant topics was open and easy in almost every case, and reluctance on the part of the informants to give answers to questions, due to embarrassment, was rarely encountered, although on a few occasions, informants quite predictably would not venture into topics about which they were fearful (this is discussed in Section IV). On the contrary, informants occasionally volunteered information of a very personal nature with no embarrassment whatever, even though, to most of them, I was a total stranger.

In fact, I have found that women in our society are more than willing to talk about their pregnancies, often going into considerable detail about such occurrances as morning sickness, the sensations of movement of the fetus in utero, and the inconvenience of having an enlarged abdomen. They talk a lot about pregnancy, not only among themselves, but to other women who have had babies.

Moreover, it is quite socially acceptable to talk about

these things in mixed company, with the males joining in the general frivolity which often accompanies these conversations or expressing sympathy when appropriate. Among persons who have all experienced a pregnancy, everyone feels free to join in, and tell of their own experiences or those of their wives or friends. The tone of these conversations may become quite intimate.

The topic can continue at great length, as is reflected in the following remark overheard at a party, "Oh, no, we'll be here all night; they are talking about childbirth."

Mothers of young children, for whom the experience is still quite vivid, seem to enjoy telling their experiences and hearing about others. In fact, it is very easy to trigger this sort of talk among gatherings of women under a variety of circumstances. I have observed and on several occasions purposely stimulated conversations between casual groups of young mothers, who were strangers to one another, while their children played together in the park. In each case, an off-hand remark about having babies was sufficient to trigger the dialogue. A spirit of comraderie is evident on these occasions, for seldom does the topic engender controversy, as might develop during talk about other domestic topics, such as child-rearing or eating habits.

Moreover, women frequently seek out occasions to talk about the subject. At prenatal classes, for instance, groups of women usually cluster together during the coffee break to talk about pregnancy and baby care, as if the sharing of this experience were sufficient to cancel out differences they might

have.

Quite often, these conversations resemble "war stories", for what usually happens is that each person singles out those features of her pregnancy and delivery which are somewhat unusual and which had to be handled with a degree of courage and endurance. The fact that some informal acknowledgement is usually given to the one who had the most unfortunate experience also points toward a strong element of oneupmanship.

There is, on the other hand, usually some expression of amazement when someone indicates that she has had an especially easy time of it, and this may indicate that good fortune either has prestige value or that it provokes antagonism since it runs counter to expectation. The fact that so much talk centers around the complications of having a baby reveals an underlying belief or assumption that it is a "hard" thing to do. This perhaps stems from the medical orientation which treats childbirth as if it were a medical crisis. Indeed, professionals in the field of childbirth education see it as their task to "decondition" these beliefs in their students.

A woman is likely to be included in on these conversations initially when she first tells others that she is pregnant:

Informant: (a former secondary school teacher) I found that as soon as they find out you're pregnant, the adults in the staff room -- they talk about their experiences and the old wives' tales would come out and they'd go on and on.

MP: What did they say to one another?

Informant: They'd describe the pains and so on and the delivery . . . And I had this experience, too, when I had another ailment. I don't generally admit to having it, because when I do,

I invariably say it to someone who says, "Oh, my mother-in-law had this, or my sister, and they died on the operating table." I don't know why people enjoy talking about their ailments. Some people are just morbid and enjoy talking about it.

As the informant suggests, some persons find these tales distasteful and will refrain from participating. It is also true that, for reasons of tact, persons will refrain from telling experiences which might frighten a woman who is expecting her first baby. During the coffee break at a prenatal class, for instance, one mother was describing in graphic detail the complications which had occurred during her two previous deliveries to three others who were pregnant for the first time. A mother of two who was listening in was visibly uneasy and tried to smooth the situation over by assuring the girls that such complications are rare.

It is also in poor taste to engage in such talk in the presence of a childless woman who is known to be infertile or whose advanced years preclude her ever becoming pregnant, unless her role cancels out this restriction, e.g., if she is a nurse or counsellor. There are two reasons for this. First, her lack of experience makes her ineligible to communicate in this area, and second, there is always the chance that she might be made to feel inadequate by her failure to fulfill this biological function. Closely related to the latter is the assumption of many people that all women wish to become pregnant and that married women are expected to have babies.

Therefore, one must observe a few rules of etiquette when conversing about such matters, though these restrictions

are few in number. One is free to discuss her experiences if others in the group have shared them, and is in fact, spurred on by the response of others in the groups, as long as she does not offend the feelings of others. Yet, as in most other matters of tact and etiquette, the rule is frequently transgressed. Often the eagerness of some women to tell of their own experiences blinds them to the negative responses of others. Thus, a pregnant woman finds herself in a position where she is privileged to share with others a special set of experiences. As one informant said:

> It's surprising, you know; I mean I'd really sort of never noticed pregnant women before I got pregnant -- I wasn't interestad in it, and I had no girlfriends who were pregnant before. And it's funny, since you're pregnant, you sort of look at the different pregnant women. I don't know, it's so different; you're so changed, <u>in yourself</u>.

To say that a change has taken place in yourself is to say that a basic alteration has occurred in the conception of self and is reflected in social interaction, and that a meaningful turning point has taken place in a persons's identity. Moreover, this informant implies that the change is permanent, that it goes beyond the nine-month pregnancy. Before pregnancy, women have little reason to orient themselves to this way of thinking or to identify with those who do. Pregnancy changes all that.

Viewed in this way, for married women in our culture, the period of pregnancy constitutes a sort of female rite of passage, for having experienced this sequence of events, she can never be the same again. Talking about this to others serves

to reinforce this fact, as well as to acknowledge the bond between those who share it.

Here is where the factor of expectation comes in. Married couples are expected to have children -- to be able to have this experience in common. A common attitude is that every woman really wants to become pregnant.

MP: They expected you to have a family?

Informant: Oh, yeah.

MP: When someone gets married, do you think their relatives expect them to have a family?

Informant: Oh, I think so, especially older people -- like, not our generation so much. Like I feel that when people get married nowadays -- um, like I myself don't expect them to have a family right away.

MP: What do you mean by right away?

Informant: Well, within, say, a year or two. I sort of think, well, now the way it is you sort of get married and you maybe live in an apartment for a few years and sort of have a good time. Say your parents and wife work and you sort of get a few material needs, and then you think of a family. Whereas before, it seemed like for my mother and father and for my aunts and uncles that they got married and had children right away, and that was it.

. . . . . .

MP: Do you feel that people expect you to raise a family when you get married?

Informant: Very much so.

MP: What do they do if you don't?

Informant: I don't think they are intentionally cruel, but the word is cruel, I think. Because I have several friends who couldn't have their own children and eventually adopted. And in some cases it was quite hard on them. They almost had to adopt. Oh, we'd go home for the summer and be introduced

around and some of them say, "How many children do you have?" And when you tell them they say, "None?! What's the matter with you?" That's a direct quote, which if said to one or two of my girl friends who were trying desperately to have children they would have run off in tears. I think that it was rude, tactless. Not intentional at all.

Often, pressure like this is put on childless couples by relatives and friends, and this may become a source of hard feelings and of tension between friends.

People show zero tact where interrogating the childless is concerned, couples say. Why not? Have you been to a doctor? The couple in turn feel no compunction about the bald lie. "That's right, we can't have them," is the simplest way to close the subject . . . In-laws are almost by definition inconsolable. When the Rosenbergs finally brought home a cat, Mother-in-law cried for joy: "Now you're a family!" The idea is that if married people have no child, they are just playing house. 4

What would appear to be a private matter between a man and a wife has a peculiarly public dimension, for people can and often do feel free to ask questions about family planning, whereas similar candor in discussing such matters as financial affairs and sex would be considered inappropriate and tactless. In fact, this is not such a private matter at all, for people are remarkably casual in approaching it.

Informant: I asked her (a good friend) if she wanted another baby and ...

MP: Would you feel that freedom to ask a question like that if you hadn't had one yourself?

Informant: No, probably not, I guess. Like people say to me now (the informant had just had a baby girl), "Wayne wanted a boy; how long are you going to wait before you have another

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4. In "Childless by Choice", by Gail Sheehy. New York, January 20, 1969, p. 38.

baby?" I haven't really thought about it, you know. I think I'd like to have one fairly soon afterwards.

MP: That's interesting. That's a really personal question.

Informant: Yes, it's true.

. . . . . .

MP: Is this an area of your life that people feel free to ask you personal questions?

Informant: They must, because they don't ask other questions like that. Another thing, many of them have not gone beyond high school. You see, by husband has gone to school quite a bit and has a doctorate, and I have three degrees, and it's always "What on earth do you want to get more schooling for?" So they have their families and we have our degrees. I am not saying that one is better than the other. They have lovely families. There's just no understanding. We've had to give up a family for a few years.

Thus, a pregnant woman arouses the interest, sympathy, and acceptance of others who have themselves become altered by this experience. In fact, ideal conditions for communication come into play in the case of pregnancy in our culture.

1) Most married couples in the culture have had this experience.

2) Although a pregnant woman is fulfilling her biological potential, still she is expected to restrict the number of times she does so. The means for doing this are widely shared and openly discussed, not only on the level of interpersonal communication, but in the mass media as well.

3) Thus, a woman who has decided to be pregnant shares with others not only the experience itself, but the experience of having made that decision, and all that that implies. From these two factors, there exists a dual bond.

4) If, on the other hand, her pregnancy is accidental, this is openly acknowledged and there are others who have had this experience, as well, and make no secret of admitting it.

5) The commonality of the experience of pregnancy unites individuals who are separated by virtue of neo-local residence rules and primary family groupings in our culture, and thus provides one kind of link, at least during the child-bearing years, between people who live quite separate existences and have few other opportunities for shared experience.

6) Pregnant women are highly visible to others on the one hand, and self-conscious of their own condition on the other. This mutual awareness serves as a constant reminder of the existence of potential communication channels. It gives license to total strangers to refer to a woman's pregnant condition without offending her or placing himself in a vulnerable position, so long as he is tactful. Likewise, it loosens restrictions on intimate conversation between casual friends.

7) Indeed, pregnancy may create a special category of friends with whom one shares detailed information about pregnancy and childbirth, as well as related topics such as lactation, and virtually nothing else. While these friendships may broaden into more generalized relationships, they are just as likely to end when childbearing ends.

These various factors suggest that pregnancy in our culture provides a focus for communication between people, particularly between women. One thing that this indicates is that

pregnancy is important and valuable in the culture. That is, although women place restrictions on their natural reproductive capacity, pregnancy itself has not lost its value. On the contrary, it can be argued that its relative rarity elevates the importance of each pregnancy, not only to the woman herself, but it also heightens the degree of interest which is shared by others and expressed in various communication events.

Furthermore, the natural capacity to reproduce on the one hand and the cultural necessity to limit reproduction on the other is one of life's dilemmas in our culture. Women must cope with this situation, and the tensions which flows from it. Hence, the need to resolve it and the desire to talk about it are joined in a logical relationship, inasmuch as communication permits a pregnant woman to orient herself regarding her condition, as well as giving those who have been previously pregnant an opportunity to re-orient themselves regarding this important facet of their lives. Not only is there a mutual flow of information, but a more important means of mutual support and reinforcement.

The next three chapters develop these ideas more fully.

III. MAKING THE ANNOUNCEMENT

Although a normal pregnancy lasts for approximately nine months (or forty weeks), there is reason to believe that a person does not assume the social identity of a pregnant woman for some time following conception. A woman can control the time at which this occurs by choosing a particular time to make her pregnancy known to others. This act of communication varies between individuals, but follows a general, predictable pattern, which I will describe in this chapter.

If a woman wants to become pregnant, she usually anticipates its onset. Therefore, women who are not practicing contraception are generally on the alert for symptoms of pregnancy. Suspicion of pregnancy generally occurs when two menstrual periods are missed, and is intensified if and when there are such symptoms as nausea, drowsiness, breast changes, and the like. Since it is not uncommon, however, for a non-pregnant woman to miss a period or two, the majority of women in the sample visited their doctor to make sure, for women in our culture rely upon medical tests and/or examination to verify the pregnancy. A laboratory test may verify the pregnancy as early as two weeks after conception, but a test this early may not be reliable. Four to six weeks is generally accepted as more reliable.

Most feel that following this procedure protects the individual from the possible embarrassment of having to retract

the announcement that she is pregnant when in fact she has some other gynecological condition.

However, some women do not have early symptoms, and if they are oblivious to missing their periods, they may not suspect for three or four months (in some unusual cases, even longer).

There are unusual examples of women who let everyone know that they think they are pregnant almost right from the beginning. Three times during the study, I heard of women telling friends that they were pregnant when they were but a few days late getting their period -- in other words, before medical verification was possible. In each case, no one took them seriously, and in fact, as time proved, none of them was really pregnant. The concensus of the informants was that they had acted foolishly. Such behavior was outside cultural expectations, if the reaction of my informants was typical. (Incidentally, all three women already had children. For reasons described below, it is not likely that a woman would do this in her first pregnancy, nor is it typical of women with subsequent pregnancies.)

When medical verification is obtained, she may then feel free to tell others of her pregnancy. This usually occurs between the second and fourth months. It is not uncommon to purposely wait until after three months have elapsed, since miscarriages are common before this time and rare thereafter. Most women tell their husbands when they suspect that they are

pregnant, and he is therefore usually the first to know.

The timing and manner in which the announcement is made to others, however, proved to be interesting. A few make the announcement as soon as medical verification is obtained:

Informant: Oh, gosh, I started telling people as soon as I knew.

MP: When was that?

Informant: Oh, I think I was two months pregnant.

MP: After you had been to the doctor?

Informant: Yeah.

. . . . . .

Informant: I tried not to tell anybody, but I did. I wanted to keep it a secret, but I couldn't.

MP: Is it your nature to want to say something?

Informant: Yeah. I was all excited, you know. Good news. I wanted to share it with friends.

Yet, it is more common, particularly among women having their first babies, to let the news leak out slowly:

Informant: I told one girl at work.

MP: This was real early in your pregnancy?

Informant: Just one girl -- not the rest. I told her not to tell anyone else.

MP: Why?

Informant: For one thing, we had a lot of girls at work that blab around to everybody; then everybody would know. They'd come over and ask you all kinds of questions and get nosy. I did not want them to know right away.

. . . . . .

MP: Did you tell any of the other teachers?

Informant: No, not one. I told the principal, and asked that he not tell anyone. He respected my confidence, and he said he didn't care what I said -- "You could tell anyone anything, and it won't come from me." One lady guessed and came right out and asked when the baby was due. I can't lie . . . so, confronted with something like that, I just asked that she not say anything . . . Otherwise, I didn't admit it until the very last day (of school, when she was six months pregnant).

A statement to the effect that "I asked that he/she not tell anyone" appears three times in the two conversations just cited. It also came up frequently during the casual conversations I had with other pregnant women. In fact, few women I talked to had blurted out the news. Rather, the information was handled in a rather secretive way at first, as if to avoid suddenly facing the social consequences that such an announcement would bring.

Some have special reasons for doing this. One woman who had experienced a frustrating series of miscarriages and gynecological difficulties told no one of her pregnancy until changes in her figure became so obvious that they required some explanation. She said she did not want to face the embarrassment and sense of failure that yet another misfortune would bring, and therefore did not want to expose herself to the social involvements of pregnancy until she had reasonable assurances of success.

Significantly, I think, the women in the interview sample who had tried for quite some time to become pregnant did not follow this pattern of letting the news leak out slowly, but broke the news quickly and enthusiastically, as if waiting

had made them eager to accept the changes in life style and the well-meaning support from friends that this announcement would bring.

I believe that most women know, consciously or unconsciously, that to present themselves as pregnant women will inevitably cast them in a new set of relationships and that they can not avoid this. Therefore, the timing of their announcement depends on their readiness and willingness to take part. Those who are eager to participate announce early; those who are ambivalent hold off until such time as they can comfortably cope with it. While individual emotional make-up may enter into this choice, there are also valid social reasons why anticipating the involvement of motherhood can be an ambivalent experience.

First of all, to become pregnant, especially for the first time, marks the beginning of the most irreversible turning point in the life of a woman in our culture. As long as she can keep her pregnancy secret, she can avoid having to begin the necessary adjustments. For a woman's relationship with her children is legal and binding -- and unlike marriage, it can not be dissolved by legal process. She is morally committed to care for her child until he can care for himself, a period of at least eighteen years. Furthermore, living in nuclear family units means that the care of children can not easily be delegated to other female family members, and although the society provides for some agencies outside the home to take the place of a mother's care should she wish to pursue other goals, the

dual responsibility of parenthood and career are heavy. The satisfaction of raising children must be balanced against satisfactions which are available to women outside the home. And for a woman who already has children, it means the additional burden of caring for an infant, a prospect she may greet with mixed or even negative feelings, as this example illustrates:

> "Dear Ann Landers: I had not seen my sister in three years. She is 40 years old and her two children are grown. When Erma and her husband met me at the airport I was shocked to see that she had become so heavy. Immediately I concluded she was pregnant and I said so. She became furious and shouted, "You are out of your mind! I have a thyroid condition, but it's under control now ." . . . I left Madisson on Tuesday. The following Friday I received a telegram from Erma. It read, "Guess who gave birth to an eight-pound boy." I'm burned up because my sister lied to me. Why would a person do such a crazy thing? Surely she knew I'd learn the truth eventually. Help me understand. I am -- BAFFLED AND BOILING.
>
> Answer: I suspect your 40-year-old sister was less than thrilled when she learned she was pregnant. Her refusal to make the announcement spared her the embarrassment of discussing her condition . . . "

On the other hand, anticipating the birth of a baby is not a negative prospect, either. On the contrary, most women that I interviewed sincerely wanted a baby and were willing to commit themselves to the raising of a child or children. It is perfectly normal for anyone to want two alternatives with equal intensity; and so it is not surprising for a woman during early pregnancy to want to be a mother as much as she wants to retain a career or to follow some other course.

For these reasons, many women do not want to expose themselves unnecessarily to the questions of friends who may not realize the delicacy of the predicament, until some of the

ambivalence has been resolved, as it usually is as time goes on. By mid-pregnancy, most women have become pregnant in the full social sense, and most of my informants enjoyed the interaction which this implies. But the fact that one informant planned to tell none of her many out-of-town friends about her pregnancy until after the baby's birth shows that one can look with distaste on the whole phenomenon and prefer to opt out of it.

Once the announcement is made, the responses are usually lighthearted and supportive.

Informant: We noticed that as soon as they (friends) found out they were just elated. Some of the ladies were so excited and happy for us. And the men, too. I was surprised and some of them would come out and say it was the most wonderful experience in their lives and they'd go on and on.

The news spreads quickly among family, friends, and co-workers. An informant said: "I think people are curious and want to know." Asked what people had said when they had made the announcement, women consistently reported such phrases as, "It's wonderful," "It's a happy time for everyone," and "Most people expressed their joy and congratulations with hugs and kisses." One girl reported that someone had asked "Did you want the baby?" which illustrates the degree of frankness which is considered appropriate among friends.

It is seldom necessary for the couple to tell more than a few people for it to spread through their entire social circle. For this reason, couples carefully observe certain priorities when breaking the news, in the belief that certain people have the right to know before the news becomes public

knowledge. The following example illustrates this:

Informant: On Father's Day, he (Husband) wrote to his folks and I wrote to my mother. And the reason, mainly, for telling our mothers (at that time) was that we stopped by to see a relation in Washington (an aunt of the informant) and of course, she guessed -- and I didn't want my mother to hear second hand.

MP: So, the people that you see every day didn't really know until it became obvious.

Informant: That's right. Except for two people that I told. They were close friends and I know that they weren't seeing the obvious and that they might be hurt if they found out from someone else.

Husbands frequently play a large part in breaking the news. Making announcements, in fact, seems to be one of the few roles the husband has during his wife's pregnancy. So one must take into account that there are two people deciding who should know first:

Informant: I wanted to keep it to myself for a little while. But my husband was . . . the opposite . . . He had to tell everybody. Well, all his friends, everybody. He wouldn't keep it a secret . . . I used to tell him at times, "Well, wait til I want to tell them."

MP: I wonder why this is. It happens many times.

Informant: Did you do it, too?

MP: Are you surprised to hear that?

Informant? Yeah, I am. I figured most girls, they'd like to tell everyone right away. Well, even my mom and dad, I didn't tell them until I went home. Like, I didn't tell them in a letter or anything. Everyone thought, "Oh, you should." . . . my husband's aunt, she says, "Oh, you should tell her as soon as you find out. You shouldn't wait." I waited til I went home in May for a visit.

MP: So other people had known about it for a couple of months?

Informant: Some people down here. The ones my husband had told.

MP: Once your parents knew about it, did you then feel free to . . . ?

Informant: Well, then I didn't mind telling everybody because I didn't think I should tell everybody else first and not them.

An informant who had been childless for seven years had the following experience:

Informant: Oh, like I was probably the last one to hear that I was pregnant. Because he (Husband) phoned up -- the next day he phoned the doctor's to find out the results (of the pregnancy test). . . He phoned the doctor that morning to find out if it was positive or negative. And it turned out positive, so he went and started to phone everybody .. all my relatives, and he told everybody at work, and then he phoned me to tell me (laughter). So by the time I heard about it, everybody else knew.

When she tells whom he called, she lists "my relatives" first; since she was not actually present, she could not know if this was actually true. Yet she put relatives first because probably in her own mind, this was the natural thing to do. The whole incident amused her, but the fact that she herself was the "last to hear" was especially funny, since it was such a bizarre twist on what one would normally expect.

Many of the women assumed that one would tell one's close relatives first, as there were several conversations which followed this hypothetical pattern:

MP: Who did you tell about your pregnancy?

Informant: Oh, such and such a friend.

MP: How about your relatives?

Informant: Oh, I told them when I first knew, before I told anyone else.

Consistently, everyone in the sample exercised some order to priorities because not to tell certain relatives first, especially the parents of both husband and wife, is a breech of etiquette that is sure to cause hard feelings. Many had gone out of their way to tell their parents before the information reached them second hand. By the same token, other categories of kin and best friends are told before the public at large.

Sisters were frequently named as having a right to know and occasionally aunts and uncles (whether maternal or paternal was unspecified) were mentioned. Significantly, brothers were never mentioned, nor were husband's sister or brother. My own interpretation of this is that the incest taboo limits communication between brother and sister on information related to sex, and sex and pregnancy are linked by cause and effect in our culture. As one man said to me, "When a woman becomes pregnant, you know for sure she has a sex life. Before that you're not really sure."

Of the other kin categories, grandparents were mentioned once, and cousins never. This probably reflects the general absence of interaction with these categories of kin in adult life.

To summarize, the informants I interviewed, as well as those who answered the questionnaire, consistently listed those who had the right to know in the following order: husband, mother and father, in-laws, best friends, sisters, and then other less-frequently mentioned kin and friends. In the following geneology table, the solid areas indicate those persons who have an absolute

right to know first, and the shaded ones have a secondary privilege. Since most of my informants were having their first babies, none mentioned children as having a right to know. Women with children would perhaps have included them in their list of obligations.

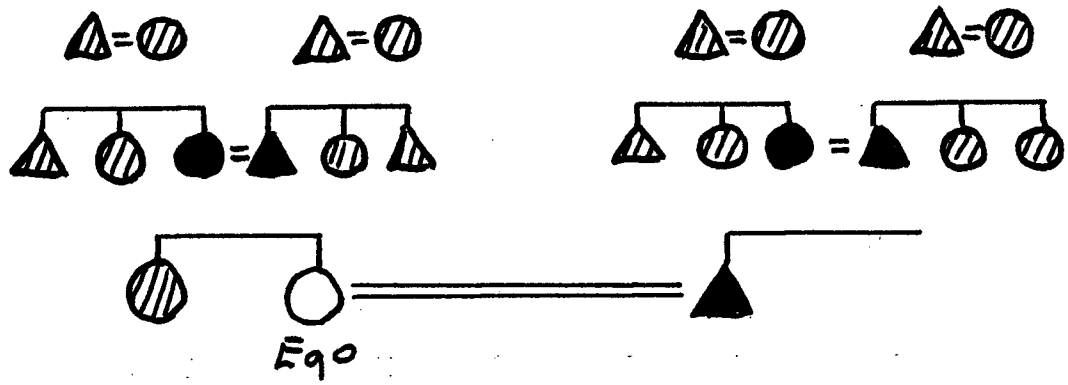

FIGURE 1 Kin who have a right to know first about a pregnancy (solid areas) and those who may be told second (shaded areas).

Note that this list of priorities relates only to those who have the right to know first, and not to those who have preference when communicating other experiences related to pregnancy, such as discussions of physical symptoms and of childbirth itself, for which communication is limited almost entirely to peer group members -- friends and sisters -- and medical personnel. A discussion of this appears in the last chapter.

If parents and best friends have a right to hear the news first hand, the best way to insure this is to tell them

first, which might necessitate postponing any announcement at all until a visit to a distant home or a phone call or letter.

So it appears that a woman is obligated to break the news first to some of her kin, but having done so, she is then free to communicate fully with her friends and other peers, with whom she will actually share the experience.

IV. CARE AND SUPPORT

Although reproduction is a normal physiological function in man, as well as in the rest of the animal world, a childbearing woman in many cultures nevertheless receives the services of an experienced and/or trained practitioner. In our own culture, this need is served by a special branch of medicine, and indeed most urban North Americans can not imagine having a baby without the services of a qualified physician for both pre-natal care and delivery.

Furthermore, most women rely almost entirely on the medical profession to tell them what to do during pregnancy, for few women in our culture have had the practical experience of living closely with pregnant women from whom they could take an example. Life in the nuclear family isolates young women from one another, so that what one learns from the experiences of pregnant sister, sisters-in-law, cousins, aunts, and friends is piecemeal and is likely to focus on certain aspects of pregnancy which are worthy of mention (i.e., nausea and other discomforts), rather than on life in general, which is more subtly altered.

Consequently, this often fosters the notion that pregnancy is an unusual (and to some people, even abnormal) condition. At the very least, this gives it an air of mystery. There is a general belief that having a baby is "hard" and fraught with danger, but that proper medical care can minimize these factors.

Moreover, few women outside of the medical profession have witnessed the birth of a baby (human or any other species), nor have they even seen a woman in labour. One public health nurse who has taught prenatal classes for many years makes it a practice to ask her students if any have ever been with a friend or relative during labour, and rarely gets an affirmative reply. This is because women are removed from normal physical and social surroundings to the structured environment of the hospital before labour becomes advanced.

In addition, the fact that babies are born in hospitals, whereone usually goes for treatment of critical illness, reinforces the idea that childbirth is a medical crisis.

Articles which frequently appear in women's magazines and other sectors of the popular press, have drawn attention to the number of hazardous situations which might develop if proper prenatal care is not obtained. For this reason, and because of the great trust that people place in the medical profession, women are grateful for the availability of medical care during pregnancy and will go to lengths to obtain it:

Informant: Well, we were in the Queen Charlotte Islands, like. My husband was working down there . . . There's a first-aid man there who was studying to become a doctor and didn't quite finish because of the war and there's nurses there now. But usually the girls go out to have their baby. You know, ahead of the time they go out, wait till the baby is born and go back.

MP: Do they go to Vancouver or just to the closest hospital?

Informant: Vancouver or Charlotte City. It depends, you know. If they have relatives out here they might sooner come out here and stay with them.

MP: Would it have made you feel uneasy to be there now?

Informant: Yeah, I think so.

MP: Would you have been scared about it?

Informant: I think I probably would be -- more so than being out here. But out here I don't find there's much to worry about. You're close to your doctor and the hospital.

When advice is needed, it is the doctor who is called, to the exclusion of anyone else; if he were not available for some reason, another member of the medical profession might be substituted, but according to my informants, rarely would one consult a relative or friend who is a layman. Students in one prenatal class were specifically warned against asking anyone outside the medical profession for advice of any kind. In case the doctor was not available, the students were encouraged to call the public health unit in the area.

Informant: Oh, I think you should ask your doctor. In California, my doctor said, up to seven months you can do what you want to, just don't overdo it. Soon as you start feeling tired, rest. So that's the way I did it. I didn't ask anybody.

MP: Suppose you had a problem and you called your doctor, and they said that he's out of town for a week, who would be your second choice?

Informant: Well, I'd ask my sister, because she is a nurse.

. . . . . .

Informant: I felt good when I was about four or five months pregnant. I didn't even feel pregnant. And I was talking with this girlfriend -- she's due on the 25th, about two days before I am -- I was talking to her about things you should do and things you should not and she said her doctor says do anything you're used to doing normally.

MP: Do you ask you own doctor?

Informant: Oh, yeah, I asked my doctor when I came back to Vancouver . . .

MP: If you have a question about what you should or shouldn't do, do you talk it over with this girlfriend, or do you ask your doctor?

Informant: . . . Oh, I usually ask my doctor eventually.

. . . . . .

Informant: I write down all the questions that I have. He (the doctor) teases me about being so organized. And he gave me an excellent book to read . . . that relieves him of having to tell me all these things. All I do is question him about the things I wonder about.

In the discharge of their duties, however, many doctors can not spare the time and/or do not wish to offer moral support to their patients. Some women feel that the doctor is perfunctory in his duties and find this disappointing.

Informant: I'm sort of disappointed. Maybe this is what you get from going to a general practitioner and not an obstetrician. Like he always asks me, "Is there anything that you'd like to ask me?" and I just say, "No." Because really, ah, I mean, I don't know what to ask him. What is there to ask him? . . . And it's sort of disappointing because unless you took these classes and did a lot of reading on your own from books that you would get -- Really, my doctor has told me nothing.

Indeed, during pregnancy, physical care and emotional support come from separate sources in our society. (See Chapter V) Few doctors have the time to care for more than immediate physical needs of their patients and do not seek to become more involved in their personal lives than is necessary to fulfill this function. Many women express some hostility for the fact that doctors and nurses are so unconcerned about what is to them one of the most

important events in their lives; while from the other point of view, medicine as it is practiced in large urban areas seeks to routinize recurring events such as occur in pregnancy in order to give uniformly high performance in the technical sense, leaving the patient's emotional needs to others. So while the patient is dependent upon her doctor, this dependence is not mutual.

Who can a pregnant woman look to for support? The person with whom she has primary daily contact in most cases is her husband. The husbands of women in my sample offered a varying range of support from none at all to a full and eager desire to share the pregnancy experience with their wives. Most of the women, however, found that their husbands shared many of the same anxieties about impending parenthood, and that therefore it was necessary to look beyond the home for help.

Likewise, mothers, aunts, and others of ascending generations might be considered ill-equipped to provide support because in the first place, they may be unavailable or because they are thought to be "old fashioned."

It is possible that, because of North American neo-local residence rules, nuclear family living groups, and high mobility, the need for moral support during this critical time in life might be left unfulfilled if friends and other peers were not so free and easy when communicating their personal experiences during pregnancy and thereby permitting frequent opportunities to ventilate feelings. I feel strongly that this is why most people find this activity not only satisfying, but also very necessary, as it provides mutual support among the conversants that is unavailable through any other means.

Also, prenatal classes, which are an adjunct to the medical profession, help to fill this need by bringing women together for the purpose of discussing subjects of mutual concern.

Thus, women who have their babies in our culture experience a dilemma. On the one hand they are well informed and given the best physical care available, a situation which should lead to greater self-confidence. Yet, their extreme dependence on the medical profession and on hospitals, combined with their lack of personal experience in this area, takes away the sense that reproduction is a natural, normal function and lends to the whole experience an impersonal quality and intensifies the sense of fear. It is essential, therefore, that friends and others be permitted the liberty of discussing things which might otherwise be considered too personal for open conversation, to help to compensate for this loneliness.

Notably, professionals in the area of childbirth education have noticed an increase in the number of couples who want to have their babies at home, away from the institutionalized hospital setting, where rules and the necessity for sanitary conditions isolate the mother from her husband, family, and friends during delivery and the days immediately thereafter. The presence of this trend indicates that some people are seeking new alternative means of assuring moral support during this life crisis.

For pregnancy is inevitably a life crisis on a personal scale; only the focal point of this crisis is culturally determined. While this is more true of women having first babies who

are facing the unknown, it also applies to second and subsequent experiences, since each experience is unique.

Informants frequently report that friends and strangers are unusually solicitous during the final phases of pregnancy, and the question, "How are you keeping?" is frequently asked. This question is in fact specific to pregnant women, replacing the usual "How are you?" that is asked of everyone else. Non-verbal gestures of respect are also common, such as providing a seat in crowded places, opening the window to provide fresh air, providing refreshments, and other acts of catering. In fact, a new fad attempts to capitalize on these customs. Two New York designers have begun manufacturing a specially-shaped pillow, called the Pwf, which can be worn by non-pregnant women to simulate the look of pregnancy, and thus to reap the rewards of pregnancy without its consequences. Yet, in real life, many find these special attentions amusing, as they are unnecessary gestures to someone who is "feeling just fine". I asked one man why he was always so solicitous of the comfort of pregnant women and he replied that it made him feel better to know he had done something helpful, indicating that he knows that some sort of help is needed and tries to provide it in his own way.

People in our culture are aware that a woman who is about to have a baby is experiencing a crisis, for not only do they readily provide moral support, but they also unconsciously practice a special protective measure. This is an informal taboo on the word "pain" when talking to a pregnant woman about her

impending labour and delivery, a subject which frequently dominates her thoughts and conversation during the final weeks of pregnancy. Frequently, milder synonyms such as "discomfort" or "ache" are euphemistically substituted, but the word pain itself is conspicuously absent from the talk I both overheard and took part in. Yet, in our language, one meaning of the word pain has a special connection with childbirth: Webster's New International (1945) defines pains (plural) as "the throes or travail of childbirth; labor . . ." The pain of childbirth is a recurring theme in our literature and folklore and is probably ingrained in our assumptions. Indeed, most women (even if not all) do experience some degree of pain during labour. Still, we do not say this word to a woman who is about to have a baby, nor does she herself say it aloud, at least in public.

One reason why this is so may be that everyone in our culture fears pain and seeks medical aid to prevent and relieve it. Indeed, intense pain is not generally encountered in everyday life, except in the context of misfortune. Yet as birth is both inevitable and inescapable, one must face up to the possibility that it might be an intensely painful experience. The taboo on using the word shows that these are thoughts which one keeps secret, or shares only with a confidante. It is not a subject to be spoken of lightly. Apparently, the word pain powerfully symbolizes the whole range of emotionally charged ideas; by avoiding the word itself, one is spared the anxiety of bringing a private conflict out into public view. Rather,

the public denial of this fear reflects the attitude, "Ignore it and it will go away."

By the same token, tactful persons avoid the use of the word in the presence of a pregnant woman so as not to risk arousing emotions that they themselves are not prepared to handle. People in our culture seem to know, intuitively, that just as one does not talk about death to a person who is critically ill, one also would be irresponsible to mention pain to someone who is already worried about it.

A second reason stems from this. The fear that one will not be able to act in a dignified or socially acceptable manner during the stress of labour is a troublesome thought to someone about to experience it for the first time.

Informant: You don't know what to expect and you don't know how you'll react.

. . . . . .

Informant: This is what scares me, that I don't want to make an idiot of myself. I realize that people take things differently. Some people can take more pain* than others. And sometimes what you think is painful is not painful to the next. (* The informant's oblique use of the word pain occurred after about 50 minutes of talk, during which we had become remarkably frank and truthful. It was as if she was confiding in me.)

Thirdly, current approaches to childbirth place major emphasis upon the more positive elements of emotional fulfillment in the act of giving birth, thus de-emphasizing any pain involved. Proponents of "natural childbirth" in its varied forms, have been enthusiastic in support of various methods for overcoming

fear and tension, which contribute to pain, and the basic assumptions of this way of thinking have become well known, thus challenging one of our assumptions concerning childbirth. Yet, only experience can confirm or deny these beliefs. By drawing the emphasis away from pain, the word itself has fallen into a sort of disrepute; for instance, in the vocabulary of terms in current use by laymen, what used to be called a labour pain has been replaced by the word "contraction", a term which describes the action of the uterine muscles, rather than its reaction on the nervous system.

One informant was noticeably different in her response to the idea of pain. Early in our talk, she herself quite openly volunteered her feelings about pain and her possible reactions to it. One major reason for her openness lies in her family situation. She is one of seven sisters from a closely-knit Italian family, three of whom had already had children and had shared their experiences with her during frequent visits and phone calls. She had had the opportunity to verbalize her fears and receive the acceptance and support of those who meant something to her.

On the other hand, another informant avoided talking about her worries to a close relative:

Informant: I really don't like to tell her (sister-in-law) too much about myself because she was a registered nurse, and she had an obstetrician and she feels that I should have one. She's one of these people who feels that if you're going to have a baby you should go to a baby doctor. I don't know, she's always telling me about bad things, never anything good . . . When first I got pregnant, I had a pain in my side and she'd say, "Oh, you

might have a pregnancy in the tube, and have to go to the hospital and have it removed or something." It's never anything good. It's always all the bad things . . .

MP: So you don't talk much about it because you're afraid she's going to . . .

Informant: -- tell me bad things, which I know she will. She never tells me good things; they are always bad things.

Once I realized that this taboo exists, I became aware of the lengths to which some persons will go to avoid the word pain, even where its use would not only have been otherwise appropriate, but also would have conveyed the meaning more accurately than the synonyms which were substituted. Prenatal class instructors rarely, if ever, use the word when talking about labour. One highly-skilled teacher with many years experience, however, did use the word to describe a particularly critical stage in labour, but only after she had carefully won the trust of her students. When I questioned her after class, she said that, though she had not given it much conscious thought, pain was in fact a word she shied away from in her classes. She felt that others did likewise. This was confirmed by another teacher, who uses the word only in carefully guarded contexts and instructs her fellow teachers to do likewise.

Yet, though the word is absent, the idea is still conveyed by the frequent use of such phrases as "strong contractions", "hard labour," "toss and moan", by referring to drugs as "pain killers", and by teaching that certain methods of breathing and body positioning can relieve "discomfort" and "tension". In other words, it is proper to talk of labour as

hard work, a time of great stress, as requiring endurance and intelligent management, and so on, but to refer directly to suffering is too threatening.

The way that people act intuitively to avoid this delicate issue is one example which reinforces my belief that there is a definable communication code to deal with pregnancy in our culture, and that its parameters are well understood. People receive no instructions about how to act in this area, yet they "know" what to do; behavior by and toward pregnant women is not random, but conforms to a pattern. This can only come from grasping the underlying assumptions from which the behavior arises. This understanding shapes the kind of special behavior which passes between pregnant women and others.

Hence, clues as to the nature of these underlying factors can be gained from the content of the conversations that pregnant women have among themselves and with others. Three basic generalizations can be made in this regard:

1) Talk centers on <u>having</u> the baby, not on the baby itself;

2) There is a preponderant concern with physical well-being, with birth itself, and with the complications which commonly occur even during "normal" pregnancies, and

3) These concerns are inveriably interpreted through knowledge of physiology and medical procedures, the only body of belief that is considered relevant.

So much talk about the physical aspects of pregnancy suggests that our assumptions about pregnancy stem from beliefs

about birth itself and its relationship to the biological function of women.

Birth, the source of life, can also be the cause of death, and in our culture we rely upon medical practice to mediate this source of tension and resolve it in favour of life. Low maternal and infant mortality attest to the success of this solution. Death in childbirth we believe to be completely avoidable, and if it does occur, it is the result of poor medical management and is a senseless tragedy -- a scandal perhaps. So too with infant death or damage at birth.

Hence, fear of death plays no significant role in our assumptions about pregnancy and birth, for we have resolved its basic life-death aspects.

Still, even despite the successful reliance upon the science and technology of medicine, birth remains a crisis in our culture.

I suggest that this is because it brings together the physical realities of procreation with the profound mysteries of life itself, a duality which science has not resolved. A pregnant woman, a giver of life, is in touch with this phenomenon, and hence symbolizes the power of nature, over which no one has control.

In the middle class sector of our culture, this set of circumstances gives rise to indulgent behavior toward pregnant women (including, for instance, the protective device of avoiding the word "pain"), which are signs of respect, not just for

the woman herself, but for the symbolic nature of her pregnant condition.

Other forms of behavior which relate to this are many. Occasionally, it is stated overtly, as in the case of a general practitioner who told me that there is a "magic" (his word) about a pregnant woman which causes him to feel awe in her presence. And the sentimental notion that "a woman is never more beautiful than when she is pregnant" persists, even though the "fat" image of a pregnant woman runs counter to other standards of attractiveness in the culture.

Several informants told me that some men feel sexually attracted to pregnant women, as well, though statements of this nature may also be considered by some to be funny or ridiculous, as a pregnant woman is considered by some to be in a separate category sexually.

Laughter or ridicule, as in the above case, is in fact expressive of another frequent response to pregnant women -- hostility -- which is usually mildly expressed through humour, but which is occasionally expressed openly in anger and insult. Examples: A pregnant woman dressed in shorts was approached by a middle aged man who sneered and said: "Don't you look cute"; or, a man makes a point of admiring the slimness of his wife's friends in front of her.

Hostility logically stems from the threat posed by the power implicit in the metaphor of woman as life-giver. One can predict that hostility is expressed by 1) men who do not possess

adequate compensatory expressions of maleness, 2) women who are physiologically unable to bear children or who are single and wish to be married and have a family, and 3) to a much lesser extent, other non-pregnant women in situations which arouse jealousy, i.e., when a pregnant woman is getting all the attention.

Thus, culturally transmitted feelings about the function of women as givers of life shapes the behavior, both verbal and non-verbal, that people exhibit towards pregnant women. Though certain specific behaviors are learned through repeated contact in appropriate situations, it can still be argued that a person facing a social situation involving pregnant women for the first time will have an intuitive feel for it, or will at least know that some special behavior is called for, and will probably act appropriately.

V. CONCLUSIONS

In this essay, I have discussed pregnancy as the focus of a particular type of communication in our culture, a process by which women learn to orient themselves to the physical and social realities of pregnancy and motherhood by sharing these experiences with others.

Within this general framework, five relevant groups can be distinguished within which communication takes place. Each group involves distinct types of relationships, and forms of behavior. One is based upon obligation, another on choice, and the third on exigency, a fourth on recognition, and a fifth on commercial profit.

Obligation -- Her husband, parents, in-laws, best friends, and other kin types (see Chapter III) form a group defined by obligation. These persons have a right to be the first to know about her pregnancy, to receive unsolicited reports on her health and welfare, and in the opinion of some, to be consulted on such matters as naming. The obligation is mutual, for it is this group to whom she has the right to look for assistance financially if need be, for special care (i.e., help with housework and other chores), home nursing (i.e., post-natal care), and for emotional support. Relationships within this group are based on the exchange of affect.

Choice -- By contrast, a second group is comprised of peers, within whom the relationships are primarily based on

the exchange of shared experiences. In this group are friends and acquaintances, as well as sisters, who have themselves been or who are now pregnant and who are therefore willing to talk about their own experiences. Between such individuals, a mutual feedback of information permits the participants to orient themselves regarding the experience and to assess how their own experience fits into the universal phenomenon of childbearing. Among this group may be friends known before the pregnancy, as well as persons met at prenatal classes who share in common nothing more than the pregnancy; of course, since best friends and sisters may also be in this category, there is obviously some overlapping with the previous group.

Exigency -- Medical personnel -- doctors, nurses, and prenatal class teachers -- comprise the third group, defined by the physical exigencies arising from pregnancy. Their relationship to a pregnant woman is based on exchange of knowledge and information needed to insure the physical well-being of mother and child. She goes to these persons seeking information and care, and they respond by offering a service based on the accepted body of medical knowledge. In this group, therefore, the communication is seemingly one-sided, with the woman always taking and the doctor, nurse, or teacher always giving. However, this exchange is balanced with the payment of a fee for the service. Thus, the exchange in this group is more impersonal than in the other two groups.

This factor explains why, although there may be overlapping between persons in this group and the choice group --

i.e., a friend may also be a nurse -- or with persons in the obligation group -- i.e., a father may also be a doctor , -- it is nevertheless true that when overlapping occurs in this area, the person involved does not serve both functions at once. That is, he or she either serves in a professional or a personal capacity, not both. Under these circumstances, in fact, such a person is almost certain to opt for the personal relationship, for if a father is also a doctor, he will, of course bring special knowledge to the relationship, but rarely would he attempt to exercise it, leaving this function instead to non-kin. This is perfectly consistent with the notion that medical personnel must not become personally involved with patients. By the same token, pregnant women have to look to persons in the other groups for the support and confirmation they need.

Thus, true overlapping between this group and the other two is not possible; it may merely touch them:

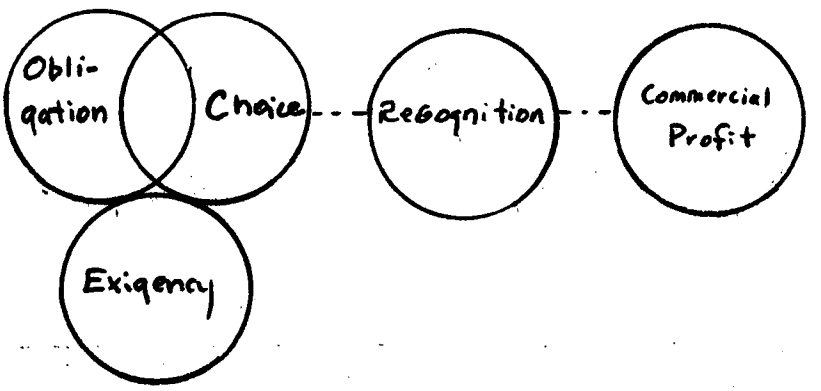

FIGURE 2 Five spheres of communication during pregnancy and their relationship to each other.

The two remaining categories -- recognition and commercial profit -- involve fleeting contacts which leave no lasting effect. Recognition by strangers of a woman's pregnant condition may or may not evoke special behavior on her behalf. For instance, other women may smile in a special "knowing" way when eye contact is made, or strangers may offer courtesies which would not be extended to non-pregnant women, such as offering a seat on a bus. Thus, recognition, while of no lasting consequence, plays a role in defining pregnancy as a special condition.

Commercial profit -- is made from pregnant women by stores which sell maternity and infant wear, and by insurance companies which stand to gain by providing additional coverage to prospective parents. Should a pregnant woman receive special attention from these organizations, it is probably motivited by profit incentives.

Therefore, it is the first three of these categories -- obligation, choice, and exigency -- which impinge most directly on the life of a pregnant woman.

I have distinguished between these groups on the basis of three dimensions: participants, content of exchange, and function. In a diagram, the parameters look like this:

Group	Obligation ⟶	Choice ⟶	Exigency
Participants:	Kin ⟶	Best Friends ⟶	Friends ⟶ Medical Personnel
Content of Exchange:	Affect ⟶	Experience ⟶	Information
Function:	Support ⟶	Orientation ⟶	Physical care

FIGURE 3 Parameters which distinguish between spheres of communication during pregnancy.

From this, it is evident that each of the dimensions forms a continuum (indicated by the arrows) going from personal to impersonal, from closeness to distance. It is possible, therefore, to use this diagram to map relationships on the basis of any or all of the dimensions, and to assess the relationship a person is likely to have with a woman accordingly. On the basis of this continuum, it is readily apparent why behavior which is appropriate to some relationships is inappropriate to others and so on -- why, for instance, the closer the friend, the more direct to obligation she may be asked to take, or why a nurse can offer a different sort of comfort than a good friend can.

Pregnant women in our society thus can function within a communication network which is potentially extensive and potentially capable of answering a variety of needs. From this point of view, the power of the network is its ability to unite the uniqueness of each individual experience with the universal phenomenon of procreation.

APPENDIX

QUESTIONNAIRE

1. When did you announce your pregnancy to others?

2. Who was the first person you told?

   Who was next?

3. Do some people have a right to know before others? Who and Why?

4. What did people say when you told them? If you can remember, what words did they use to express their feelings?

5. Are married women expected to become pregnant?

6. Did anyone question you about your plans to have a family? Who?

   Were these persons also curious about your methods of birth control? Who?

7. What sort of questions did people ask?

8. Did you feel any pressure to conform to someone else's expectations in this regard?

9. Were you more willing to discuss these subjects with some people and not with others? Who and why?

10. Is anyone urging you to limit the size of your family? Why?

Thank you very much.

GENERAL INFORMATION

Age: _____
Number of children: _____
Number of pregnancies: _____

Year of marriage: _____
Education: _____
Occupation: _____
Are you working now: _____
Do you plan to return to work after you have the baby? _____

Husband's occupation: _____
Husband's education: _____

Your ethnic affiliation: _____
Husband's ethnic affiliation: _____

Approximate income (combined, if you work, too):

Under $5,000
$5,000 to $10,000
$10,000 to $15,000
$15,000 to $20,000
Over $20,000

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