

Donor Conception: The perspective of fathers where donor sperm has assisted conception

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ABSTRACT

This study explored the lived experiences of men, diagnosed as infertile, who had become fathers through the use of donated sperm since the lifting of donor anonymity in 2005. The extant literature suggests that both infertility and parenthood via Donor Conception (DC) are associated with psychological distress. Research however, has strongly biased towards the experiences of women. Few studies have investigated either how men make sense of becoming a recipient father, or the psychological impact of lifting donor anonymity. This qualitative study drew upon information gathered from semi-structured interviews with eight recipient fathers. Interviews were analysed using Interpretative Phenomenological Analysis (IPA). Three super-ordinate themes were identified. '*The me that couldn't be and who I have become*', depicted the complex and recursive nature of the psychological challenges of both infertility and DC. It portrayed the difficult road from infertility to becoming a parent, resulting in a reconstruction of the meaning of 'fatherhood'. '*The safety of silence; the triumph of talk*', described how men felt both isolated and silenced regarding infertility and DC. The reparative value of talking to non-judgemental others was highlighted. All the men believed it was important to disclose the children's DC origins to them, despite the feared repercussions. '*The strangers in my family*', illustrated the ways in which professionals, the donor, and the child itself, could all be experienced as intruders into the men's lives and minds. The lifting of donor anonymity seemed to place additional burdens on recipient fathers. Initial bonding seemed particularly difficult with sons, but strengthened over time. These findings are considered in relation to the literature and suggestions for further research offered. Clinical implications are discussed, confirming the importance of including men throughout the DC process and recommending that support groups and psychological therapy be offered independently from the fertility clinic setting.

CONTENTS

1. INTRODUCTION	7
1.1. Overview	7
1.2. Literature Search Criteria	7
1.3. Infertility	8
1.3.1. Definition	8
1.3.2. Prevalence	9
1.4. Biological, Social and Psychological Aspects of MFI	9
1.4.1. The Biological Basis of MFI	9
1.4.2. The Biological, Social and Cultural Context of Infertility	10
1.4.3. The Psychological Impact of Infertility	12
1.4.4. Psychological Models of Infertility	14
1.4.5. Seeking Psychological Support for Infertility	15
1.5. Treatment for Infertility	16
1.5.1. Historical and Socio-Political Context of Infertility Treatments	16
1.5.2. Medical Treatment Options	17
1.6. Donor Conception	17
1.6.1. Definition	17
1.6.2. The History of DC	18
1.6.3. Prevalence	18
1.6.4. Another Man's Sperm: A Socio-Cultural Backdrop	18
1.6.5. The Psychological Impact and Experience of DC	19
1.6.6. Donor Anonymity: A Changing Landscape	21
1.6.7. Disclosing and Discussing	22
1.7. Rationale for the Current Study	26
1.8. Research Aims	27
2. METHODOLOGY AND METHOD	28
2.1. Ontological and Epistemological Position	28
2.2. Rationale for a Qualitative Methodology	29
2.2.1. Extending Current Understanding	29
2.2.2. Epistemological Considerations	29
2.3. Interpretative Phenomenological Analysis (IPA)	30
2.3.1. The Theory Behind IPA	30

2.3.2.	How these Ideas have been Implemented in the Current Study	31
2.3.3.	Justification for IPA Over Alternative Qualitative Methodologies	32
2.4.	Participants	33
2.4.1.	Inclusion and Exclusion Criteria	33
2.4.2.	Recruitment Procedure	33
2.4.3.	Service Context.....	34
2.4.4.	The Sample	35
2.5.	Ethical Considerations	36
2.5.1.	Consent.....	36
2.5.2.	Managing Potential Participant Distress.....	36
2.5.3.	Ensuring Anonymity	36
2.6.	Data Collection	36
2.6.1.	Semi-Structured Interviews	36
2.7.	Data Analysis.....	38
2.7.1.	Transcription	38
2.7.2.	Stages of Analysis.....	39
2.9.	Reflection on My Position in the Research	41
2.9.1.	Reflexive Practice.....	41
2.9.2.	The Impact of Being a Female Interviewer	42
2.9.3.	Research versus Therapy	43
2.9.4.	Personal Statement.....	43
3.	RESULTS	45
3.1.	The Me That Couldn't Be and Who I Have Become	46
3.1.1.	The Loss of the Ideal and Unborn Self	46
3.1.2.	The Long Road to 'Fatherhood'	51
3.1.3.	Re-Constructing 'Fatherhood'	53
3.2.	The Safety of Silence; the Triumph of Talk.....	56
3.2.1.	Silent and Silenced.....	56
3.2.2.	Finding a Voice.....	58
3.2.3.	Whose Business is it?	60
3.3.	The Strangers in My Family	62
3.3.1.	"Social Services for Foetuses"	62
3.3.2.	Strangers who Lurk in the Shadows.....	64

3.3.3. The ‘Father’ in My Child	66
4. DISCUSSION	71
4.1. Addressing the Research Questions	71
4.2.1. How do DC Fathers Make Sense of their Infertility?	71
4.2.2. What are the Experiences of Men Becoming Fathers Through DC?	74
4.2.3. What are DC Fathers’ Experiences of Disclosing and Talking about MFI and DC to their Child, Family, Friends and Professionals?	77
4.2.4. The Impact of Lifting Donor Anonymity on DC Fathers’ Experiences	82
4.4. Implications and Recommendations	84
4.4.1. Implications for Clinical Practice	84
4.4.2. Recommendations for Further Research	86
4.5. Quality Issues: A Critical Reflection	87
4.5.1. The Paper Should Have a Clear Focus	87
4.5.2. The Paper Will Have Strong Data	88
4.5.3. The Paper Should Be Rigorous	88
4.5.4. The Analysis Should Be Interpretative Not Just Descriptive	89
4.5.5. The Analysis Should Be Pointing to Both Convergence and Divergence	90
4.6. Methodological Limitations	90
4.6.2. Sampling	90
4.6.3. Interviews	90
4.6.4. Choice of Analysis	91
4.7. Personal Reflections	92
4.8. Summary and Conclusions	94
REFERENCES	95
APPENDICES	110

1. INTRODUCTION

1.1. Overview

In 2005 the anonymity of sperm and egg donors was lifted. This study explores the experiences of men diagnosed with Male Factor Infertility (MFI), who have become fathers via the use of donated sperm since that time. A literature review aims to contextualise the topic and provide a rationale for the study.

The inability to procreate can raise a profound range of psycho-social concerns for the men and women in this position. These issues are considered with respect to infertility more broadly and in relation to MFI specifically. Some psychological models of the impact of infertility are identified and critically discussed.

This chapter then focuses on Donor Conception (DC), as one of the leading 'treatments' for helping couples conceive after a diagnosis of irreversible MFI and considers this within a socio-political context. Research suggests that there is distress associated with both infertility and treatment for both women and men, which may impact on their psychological well-being and relationships. Despite this, men have been significantly under-represented in the psychological research into both infertility and DC. This chapter highlights what is known about men's experiences and identifies some of the gaps in knowledge which this research attempts to address.

Finally, the research aims and questions are set out.

1.2. Literature Search Criteria

Electronic databases were used to explore the literature: PSYCINFO (EBSCO interface); CINAHL (EBSCO interface); and Google Scholar. A table of search terms is included in Appendix 1 including combinations of terms. These fell into the following categories: masculinities; infertility; assisted reproduction.

Searches were filtered by research methodology and gender but not organised by date.

Relevant information and current literature was also gleaned whilst attending specialist conferences, lectures, debates and through joining the MEN-INFERTILITY-ART list, an international specialist on-line academic community for research in male infertility. Further relevant articles, chapters and books were obtained through citations in the literature and via conversations with professionals in the field of infertility and DC.

1.3. Infertility

1.3.1. Definition

Definitions of ‘infertility’ lack uniformity (Gurunath, Pandian, Anderson & Bhattacharya, 2011) and seem to present a confusing admixture of bio-medical, psycho-social and behavioural paradigms. The International Committee for Monitoring Assisted Reproductive Technology and the World Health Organization classify infertility as “a *disease* of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse” (Zegers-Hochschild *et al.*, 2009, p.1522, my emphasis). The Human Fertilization and Embryology Authority (HFEA, 2004) meanwhile dropped the reference to disease and define infertility as the failure to conceive after one year of unprotected sex; whilst the National Institute of Clinical Excellence (NICE, 2004) guidelines extend this to two years.

It could be argued that this results in a medical diagnosis with implications for the beginning of medical investigation and treatment, but based on behavioural criteria, which in themselves mask socio-political assumptions. It supposes a) a hetero-sexual couple, b) who are having regular sex (although how regular is unspecified) and that c) ‘unprotected sex’ involves intra-vaginal ejaculation. The discrepancy between timeframes in HFEA and NICE guidelines is also significant. The longer NICE lead-in time allows for a greater period for conception to happen ‘naturally’, and also has financial implications for signalling the start of NHS investigations and treatment. This adds a financial and political aspect to diagnosis.

Greil, Slauson-Blevins and McQuillan (2010) present 'infertility' as a social construct negotiated by "sufferers", professionals and the media. They conclude however, that infertility is typically portrayed by researchers as "a medical condition with psychological consequences rather than a socially constructed reality" (p.140). They suggest that "no matter how medical practitioners may define infertility, couples do not define themselves as infertile or present for treatment unless they embrace parenthood as a desired social role" (p.141). They go on to point out that infertility is not something that happens solely to the individual but also to the couple and wider family and social network. They suggest it is useful to disentangle it from other medical conditions as unlike these, infertility is not signalled by the "presence of pathological symptoms, but the absence of a desired state" (p.141). Koropatnick, Daniluk and Pattinson (1993) refer to this as a 'non-event transition'. Yet once diagnosed, further investigation quickly becomes medicalized and gender-specific (Greil *et al.*, 2010).

1.3.2. Prevalence

The HFEA (2010) estimated that one in seven couples experience 'infertility' at some point. Figures suggest that 30% of couples presenting with difficulties in conceiving have problems that are attributable to MFI. A further 30% of couples have difficulties related to Female Factor Infertility (FFI) and in 40% of presenting couples problems appear to be joint or unexplained (Miles, Keitel, Jackson, Harris & Licciardi, 2009).

According to Mason (1993, p.3): "men are shadowy figures when it comes to infertility". She describes how MFI is not publically discussed, contributing to a widespread mis-perception that MFI is rare, despite the even distribution between male and female contributions to couple infertility.

1.4. Biological, Social and Psychological Aspects of MFI

1.4.1. The Biological Basis of MFI

There are a number of medical conditions that affect the quantity, quality or motility of sperm and may lead to sub-fertility. With time, these men may still be

able to achieve fertilisation, either ‘naturally’ or through a variety of fertility treatments. More rarely, men may be diagnosed as ‘infertile’, such as in instances of azoospermia, where no sperm are produced. Although there are some medical and surgical procedures to try and correct these conditions, in the absence of these working, these men are unable to achieve fertilisation. Further information about these biological conditions can be found in Appendix 2.

This study is of men presenting with conditions of infertility that have been irreversible.

1.4.2. The Biological, Social and Cultural Context of Infertility

Veevers (1980) suggests that having children is a social expectation, irrespective of racial, religious, ethnic, sexual or social class divisions. Both social pressures and individual goals to procreate, which may seem like personal choices, sit on the back of what Dawkins (1989) describes as powerful biological imperatives: the need to ensure survival of the species by replicating our genes. It is therefore unsurprising that a diagnosis of infertility is experienced by many as a profound ‘failure’ and may be culturally condemned, perhaps as a judgment from God or a sign of inadequacy, rather than a purely private loss.

In some cultures the social consequences of infertility can be devastating (Cousineau & Domar, 2007) and may lead to ostracism, violence and social stigma (Rutstein & Shah, 2004). Fear of judgment may contribute to a reluctance to openly admit to infertility, hence Domar and Seibel’s (1997) description of infertile couples as one of “the most neglected and silent minorities” (p.29).

1.4.2.1. *Gender in infertility*

There is a common mythology that everything to do with both the desire and capacity or incapacity to have and raise children is the province of women (Mason, 1993). A Canadian study of public attitudes towards infertility (Miall, 1994) indicated that people believed that women *wanted* children more than men. This public perception may have little foundation in the actual experience

of men, though this remains to be adequately researched. Twenty years on, Hadley and Hanley's (2011) research suggests that men also desire children and the experience of being a biological parent.

Historically, in the absence of scientific understanding, failure to conceive in heterosexual couples was always assumed to be a woman's 'fault' (Abbey, Andrews & Halman, 1992). These narratives pervade stories and mythologies through the ages (Cousineau & Domar, 2007; Powell, 2001) where childlessness was not linked causally to men. This belief has continued to dominate thinking so profoundly that as recently as 1993, Snowden and Snowden commented that fertility clinics typically completed an exhaustive battery of tests to exclude female factors before investigating men, despite the considerably greater ease of testing men.

1.4.2.2. *Virility: The conflation of masculinity, sexual potency and fertility*

The definition of "virility" combines masculine characteristics of strength, forcefulness and vigour with high sexual drive and potency and a capacity for procreation (Collins English Dictionary, 2013). This construct leads to the perception that "'Fatherhood' is...an expression of 'manliness'...exemplified by the ability to impregnate" (Crawshaw, 2011, p.5; Dyer, Abrahams, Mokoena & van der Spuy, 2004). Metaphorically, sperm are fantasized as "heroic warriors" on a perilous mission to impregnate the passive ovum (Konrad, 1998, p.648; Martin, 1991). It has been suggested that metaphors such as this are "understood in everyday life as an analogue to the attracting and meeting of men and women in social life and sexual relationships" (Wagner, Elejabarrieta, & Lahnsteiner, 1995, p.677). This works to merge notions of fertility and fatherhood with sexual potency. Humphrey (1977) found that childless men tended to equate 'fatherhood' with masculine identity whereas women's perceptions of 'motherhood' were associated with contentment and the achievement of life goals. Mason (1993) posited that 'manliness' was more closely associated with impregnating a woman than being a 'father'. Within popular television shows, 'infertile' men are commonly ridiculed through derogatory terms such as: "Jaffa" (a seedless orange) in *Only Fools & Horses* (Sullivan, 1986) and he's "firing blanks" in *Scrubs* (Celeboglu, 2006). These

discourses create powerfully negative constructs around MFI and are also sometimes responsible for conflating fertility and 'masculinity'. Gannon, Glover and Abel (2004) explored social constructs of male infertility by carrying out a discourse analysis on broadsheet newspaper articles. Media reports reinforced an idealised, hegemonic view of masculinity characterised by dominance, strength, invulnerability, insatiable sexuality and control, and MFI was conflated with impotence. They concluded that men had available to them a limited and stereotyped range of constructs with regards to their bodies and health.

Inhorn and Birenbaum-Carmeli, (2008, p.181) suggested that the "conflation with impotency and emasculation" has contributed to MFI remaining unspoken about and "deeply hidden", leading to men feeling isolated and stigmatized (Gannon *et al.*, 2004).

1.4.3. The Psychological Impact of Infertility

A number of studies have identified infertility as a source of immense psychological pain for both men and women, that can lead to 'depression', 'anxiety', low self-esteem, anger, guilt, frustration, powerlessness, jealousy and isolation (Baluch, Nasser, & Aghsa, 1998; Folkvord, Odegaard & Sundby, 2005; Greil, 1997).

Some older research suggests women tend to be more distressed about infertility than men (Freeman, Boxer, Rickels, Turek, & Mastroianni, 1985; Greil, Leitko & Porter, 1988; Wright *et al.*, 1991). Collins, Freeman and Boxer (1992) and more recently Wischmann (2013) dispute this however, proposing that men and women are equally affected by the unfulfilled wish for a child but may express their distress in different ways. They suggest that men tend to internalise their feelings, whilst women are more likely to talk directly. This contributes to the mythology that psychologically, infertility is a 'woman's problem' and consequently to research in this area being heavily focussed on women, leaving men profoundly under-represented (Bents, 1985; Crawshaw 2011; Keylor & Apfel, 2010; Malik & Couldson, 2008; Wischmann, 2013). As a result, comparatively little is known about the psychological impact of infertility on men.

1.4.3.2. *Men's experiences of infertility*

The research that has been undertaken has suggested that men experiencing infertility describe feelings of 'guilt', 'depression', 'anxiety' and lower levels of sexual functioning (Hadley & Hanley, 2011; Peterson, Gold & Feingold, 2007). A quantitative study of 357 men in infertile couples, conducted by Smith *et al.*, (2009), suggested where there was MFI, men reported lower sexual satisfaction and personal quality of life compared with men in couples where infertility was due to other causes. They concluded that MFI is an "important, clinically significant predictor of sexual and personal strain, independent of age, race, religion, household income [or] educational level" (p.2512).

Research has suggested that the discovery of MFI may be experienced as a significant attack on men's sense of manhood and masculinity (Gardino, Rodriguez & Campo-Engelstein, 2011; Inhorn & Birenbaum-Carmeli, 2010), resulting in a dissonance between the 'preferred' and 'felt' social identity leading to feelings of stigma and shame (Crawshaw, 2011; Nachtigall, Tschann, Quirogo, Pitcher & Becker, 1997). This may also partially account for findings that infertile men report reduced sexual functioning and satisfaction (Peterson, Gold and Feingold, 2007; Smith *et al.*, 2009). In a longitudinal study of distress in sub-fertile men, Glover, Gannon, Sherr and Abel (1996) suggested that 'loss' is a more powerful concept for women than for men, whilst men are more prone to feeling 'threat'. They concluded that MFI resulted in low mood, reduced life-satisfaction and self-blame which persisted 18 months following diagnosis. Distress may also be experienced around not being able to continue the 'family line' (Culley & Hudson, 2009). Jaffe and Diamond (2010) conclude that the impact of MFI on men is far-reaching and should not be underestimated.

1.4.3.3. *Real men don't talk*

Boys learn early on that 'feelings' are the realm of girls and are dissuaded from talking about their emotions, and nurturing play, instead being "encouraged to show stoicism, physical strength, aggression & bravado" (Timimi, 2011, p.87). These messages permeate every sphere of life. Health systems are no exception. Courtenay (2000) suggests "medical researchers, [and]

psychologists...have [all contributed] to cultural portrayals of men as healthy and women as the sicker gender and to the 'invisibility' of men's poor health status." (p.8). Banks (2001) found that men knew less about health issues and sought help when ill less often than women. There is also support for the thesis that men who endorse dominant customs of masculinity seek medical treatment and emotional support less readily (Courtenay, 2000).

Malik and Couldson (2008) conducted a study using data from an infertility online support forum to explore the impact of infertility on men. They concluded that men are socialised to contain "negative emotions and difficulties" (p. 29) associated with infertility. A paper by Wischmann (2013) supported this claim, that men experience more difficulty in expressing their distress about infertility and treatment than their female partners. This is in keeping with literature and social discourses suggesting that 'real men' neither talk about their feelings, nor ask for help (Addis & Mahalik, 2003; Mansfield, Addis, & Mahalik, 2003).

Greil *et al.* (2010) conclude that it is "not only women who reproduce, who undergo medicalization and who experience stigma" (p.14) and that more research needs to be done exploring the psychological impact of MFI on men.

1.4.4. Psychological Models of Infertility

In trying to make sense of the psychological responses to involuntary childlessness, some general theoretical frameworks have been adapted and applied to infertility.

1.4.4.1. *Lifecycle models*

Nowoweiski (2012) draws upon Erikson's (1950) psycho-social developmental stage model to account for adverse psychological reactions to infertility. She posits that infertility prevents adults from achieving the key developmental milestone of parenthood, thus failing to renew life and continue the human life cycle, which Applegarth (1999) suggests is a form of 'immortality'. Franz and White (2006) criticise Erikson's model for being based too heavily on identity and neglecting issues around intimacy and interpersonal attachment.

Carter and McGoldrick (1980) proposed that families as well as individuals have lifecycles and stages. At each stage families need to re-organise in order to adapt to the change. Procreation and parenting are central features of the adulthood stages. Infertility disrupts this expected cycle, possibly leading to a sense of loss. The family life-cycle model has been criticised as reflecting and reinforcing a stereotypical and patriarchal view of two-parent, heterosexual families where failure to conform may lead to an increased sense of being 'abnormal' (Rice, 1994).

1.4.4.2. *Grief models*

The discovery of infertility can mark multiple and significant losses of: life-goals; self-confidence; social status and the biological child they imagined having. Menning (1980) adapted Kübler-Ross's (1969) generic stages of grief model: shock; denial; anger; bargaining and acceptance, to explain the reactions of individuals and couples to infertility. Unruh and McGrath (1985) asserted that Menning's model assumes a linear progression towards an ending of mourning and an acceptance of the loss. They argue that the mourning of infertility typically does not follow this pattern, but has an ongoing and recursive nature, being re-awakened at different points in life, such as treatment failures or when peers procreate. They propose a 'Chronic Infertility-Specific Grief Model' that captures the on-going nature of mourning for infertile individuals and couples.

Burns and Covington (1999) drew upon the 'keening syndrome' in an attempt to understand the different overt reactions of men and women to infertility. This refers to a traditional Irish custom of mourning whereby women collectively prepare the dead in the middle of a room, with unconcealed cries of grief, whilst the men sit on the outskirts, watching in silence, becoming the "forgotten mourners" (p.8). They suggest that when it comes to infertility, typically "women weep, and men watch" (p.8).

1.4.5. Seeking Psychological Support for Infertility

Greil *et al.* (2010) suggest men experiencing infertility may benefit greatly from psychological support. Boivin (1997) found that whilst the majority of infertile couples expressed an interest in psychological counselling, few took up the offer

and those who did were predominantly women. Research on the efficacy of counselling support on reducing infertility-related psychological distress has yielded mixed results. Stewart *et al.*, (1992), Domar *et al.*, (2000) and Boivin (2003) found that support groups were effective in reducing distress, while a meta-analysis by Hämmerli, Znoj & Barth (2009) suggested that psychological interventions did not significantly improve 'depression', 'anxiety' or 'mental distress'. They concluded however that longer-term interventions of six or more sessions were of greater benefit.

Glover *et al.* (1994) found that men attending fertility clinics were reluctant to seek psychological support and therefore medical consultations offered an important opportunity to address psychological distress.

1.5. Treatment for Infertility

1.5.1. Historical and Socio-Political Context of Infertility Treatments

Treatments have reflected the changing paradigms for understanding involuntary childlessness and are shaped by their socio-cultural context (Greil *et al.*, 2010). They "have evolved over time, [as] have [the] social, cultural, legal and ethical responses to them" (Inhorn & Birenbaum-Carmeli, 2008, p.177).

Issues around gender identity are deeply embedded in the process of treating infertility (Inhorn & Birenbaum-Carmeli, 2008). Throsby and Gill's (2004) research explored men's experiences of infertility and the process of going through unsuccessful treatment, noting the "predominance of hegemonic masculine culture in mediating the meaning of In Vitro Fertilisation for both men and women" (p.330). One key dimension that differentiates the 'treatment' of MFI from any other 'medical' condition is that the majority of interventions available are directed to another person (i.e. a woman) (Daniels, Lewis & Gillett, 1995).

1.5.2. Medical Treatment Options

Since the first baby was conceived via In Vitro Fertilisation (IVF) in 1978, there has been a growing range of Assisted Reproductive Technologies (ARTs) on offer to couples with fertility problems. According to the International Committee for Monitoring Assisted Reproductive Technology (Zegers-Hochschild *et al.*, 2009), more than 3 million children worldwide have been born as a result of ARTs, many of which can be used in the cases of sub-fertility, where men produce sperm but their function is impaired. These include Gamete Intra Fallopian Transfer (GIFT), Intra-Uterine Insemination (IUI), IVF and Intra-Cytoplasmic Sperm Injection (ICSI). These facilitate fertilisation by reducing the barriers to meeting of sperm and egg.

For those with azoospermia, ARTs using men's own gametes are not an option. There are a number of surgical and medical treatments designed to cure some of the causes of male infertility. All those are described in Appendix 3.

Where these fail, Donor Conception (DC) using IVF or IUI with third-party donated sperm are currently the only options available for couples who want to conceive a baby. Sometimes DC may involve the use of both donated eggs and sperm, either because both parties' fertility is compromised, or because the couple elect to have equal biological status to their offspring. DC is also a route by which single women and lesbian couples can conceive.

Conception via donor sperm is the form of treatment being considered in this study and will be the focus of the remainder of this chapter.

1.6. Donor Conception

1.6.1. Definition

Donor Insemination (DI) is a practice by which a "woman's ovum is fertilized by a sperm donated by a known or unknown man who is not the sexual partner or husband of the woman. Conception does not take place through sexual intercourse" (Ehrensaft, 2000, p.373) but either via IVF or IUI. Berger (1980, p.38) makes the point that DC "bypasses" the male partner completely.

It has now become common practice to use the term Donor Conception (DC) rather than DI, a terminological shift introduced to account for the use of donated eggs as well as sperm. However, its use may also reflect sensitivity to sexual connotations of 'insemination' and a clear identification that the infertility is attributable to the male partner, whereas the term DC conceals the source of the infertility. Hereafter the term DC will be used.

1.6.2. The History of DC

The first recorded child born by DC was conceived through insemination of a woman by an American University Medical Professor in 1909 (Daniels, 1998). It was first officially offered within the NHS in 1968 (Irvine & Templeton, 1994).

1.6.3. Prevalence

Culley and Hudson (2009) reported that 25,000 children had been recorded as having been conceived using DC between 1991 and 2009. In 2012 the Human Fertilization and Embryology Authority (HFEA) reported that in 2010 alone, 2,481 cycles of IVF or IUI using donor sperm were carried out, resulting in 1176 births.

1.6.4. Another Man's Sperm: A Socio-Cultural Backdrop

Gamete donation has aroused intense controversy (Blyth & Landau, 2004). In some cultures it has been considered to "transgress the established boundaries of biological and genetic procreation between two individuals" (Culley & Hudson, 2009, p.250).

Catholicism officially opposes conception via third party gametes, on the basis that procreation should be an act of 'love' between a married couple (The Congregation for the Doctrine of the Faith, 1987). Within Judaism there is a moral duty to have children and as a result infertility treatment in general is sanctioned. With regards to DC, Progressive rabbis are more accepting whilst Orthodox rabbis forbid its use (Hirsh, 1998). Within Islam, DC was forbidden until the 1990s. Since then there has been divergence. Sunni Muslims have continued to prohibit DC whilst Shi'ite Muslims have condoned its use (Inhorn,

2006). Culley and Hudson (2009) conducted a study exploring 'public' understandings of gamete donation within the British South Asian community. They concluded that using donor sperm was considered more 'risky' and stigmatising than donor eggs as it retained more sexual connotations and the "introduction of [third party] sperm into the (married) female body was equivalent to adultery" (p.256), herein transgressing cultural and religious customs.

1.6.5. The Psychological Impact and Experience of DC

The decision to undergo DC involves men and women concluding that the desire to give birth to a child is more important to the couple than either remaining childless or considering adoption. Blaser, Maloigne-Katz and Gigon (1988) found evidence that the decision to pursue DC was often driven by the female partner. This inevitably impacts on men's feelings and sense of control. In a mixed methods study carried out by Daniels *et al.* (1995) on couples' decision-making with regards to DC, it was found that in families where the child is genetically related to one parent and not the other, the non-biological parent had some difficulties in relating to the child, experiencing feelings of inequality, inadequacy and jealousy.

Golombok, Cook, Bish and Murray (1995) and Golombok, *et al.*, (1996) carried out a mixed-methods pan-Western European study of 111 DC families created through the sperm donation, with children aged between four and eight years. They concluded that the presence or absence of a genetic link between father and child was less important to family relationships than a strong desire to have children. They also found that there was no difference in the strength of marital relationships between DC couples and naturally-conceiving couples, and no evidence of impairment in the emotional and behavioural development, attachment or self-esteem of DC children. They noted that mothers who had conceived via donated sperm showed greater warmth and involvement with their children than mothers with a naturally-conceived child. It is common for many new fathers to experience a sense of exclusion from the intimacy of the early mother-baby dyad (Diamond, 1986; Fägerskiöld, 2008). It may be anticipated that if recipient mothers do have an enhanced attachment to their baby who is

genetically linked to them but not their partner, DC fathers might feel additionally excluded and marginalised from the relationship between mother and baby.

1.6.5.1. *Being the recipient father*

It is likely that having a child by the use of another man's sperm will provoke a complex and powerful range of feelings and fantasies (Ehrensaft, 2000). It has been suggested that some men may feel less able to bond with and 'father' children that are not genetically linked to them (Brewaeys, 2001; Culley & Hudson, 2009). Brewaeys (2001) suggests that this may be particularly true where there are 'unresolved' feelings about being infertile. This finding has been supported in other research (Daniels *et al.*, 1995; Nachtigall *et al.*, 1997).

Sperm donation is achieved by a man masturbating and collecting his ejaculate. The process necessarily involves sexual arousal in the donor. This may stimulate fantasies in both the recipient mother and father of sexual betrayal, adultery and thoughts about impregnation by a more 'potent', 'successful' and 'fertile' man (Grace, Daniels & Gillett, 2008). Feelings of stigma and shame for the individual and couple may be heightened within some cultures and religions where DC is seen as an actual act of adultery (Culley & Hudson, 2009).

For the recipient father, social stigma and personal anxieties about DC may reinforce pre-existing feelings of emasculation associated with infertility and may be further compounded by dominant social discourses that encourage suppression of feelings and vulnerability in men. These factors may make it difficult for men to share and disclose their feelings and experiences.

Ehrensaft (2000) offers psychoanalytic interpretations on the impact of infertility and DC on men. She suggests that talking about the donor within men's families acts as a continual reminder that his bloodline is over and that "his baby may someday not love him because he did not make her" (p.393).

Carmeli and Birenbaum-Carmeli (1994) reported that men felt marginalised during the DC treatment process, as their partners became the focus of

treatment. This feeling is exacerbated by female-centric clinics (Mason, 1993) where men are referred to under their female partner's name (Crawshaw, 2012).

1.6.6. Donor Anonymity: A Changing Landscape

Prior to 1990, the strong medical recommendation to couples was to keep DC a secret both from the child and others (RCOG, 1987). In 1990 the Warnock Committee proposed a partial lift on donor anonymity on the grounds that "secrets in families were unhealthy and that DC people were entitled to some information about their origins" (Blyth & Frith, 2008, p.76). However, they considered that knowing the donor's actual identity may unsettle "the integrity of family relationships" (p.75) thereby suggesting that DC children be registered at birth and given non-identifying information after the age of 18. On the basis of this the Human Fertilisation and Embryology Act 1990 was implemented in 1991 and a register of DC births was kept.

Since then, changes in social, political and medical thinking have resulted in legislative alterations (Blyth & Frith, 2008) and in 2005 the UK parliament voted to lift the anonymity of future donors with effect from the 1st April that year. This entitles donor-conceived adults to identify their donor and any potential half-siblings.

This created a situation whereby donor-conceived adults have the legal right to identify their donor, whilst recipient parents are not legally obliged to inform children of their DC origins. There is no reference to the donor on the child's birth certificate.

A number of concerns were raised about the decision to lift anonymity. Winston (2006) predicted that far fewer people would be prepared to donate. A survey by the British Broadcasting Corporation (BBC, 2006) found that almost 70% of UK fertility clinics claimed to have either insufficient or no access to supplies of donor sperm. It was forecast that enabling children to seek out donors after the age of eighteen might dissuade recipient parents from disclosing to their children "because of the fear...of rejection in favour of an identifiable biological parent" (House of Commons Science and Technology Select Committee, 2005, para, 157). In studies pre-2005, donor anonymity was

cited as a contributing reason for parents not disclosing to their child (Daniels *et al.*, 1995). In contrast, Blyth and Frith (2008) and Crawshaw (2008) found no evidence that lifting donor anonymity had reduced parental disclosure. Clearly that this is an area which merits further study.

1.6.7. Disclosing and Discussing

The issue of disclosure to the child and others is a fraught topic and one that couples may well differ over (Daniels *et al.*, 1995). The most contentious and arguably important subject within this area is the matter of whether or not to disclose to the child (Brewaeys, 2001). It has been a litigious area where opinions and advice have evolved over time. Historically, medical professionals advocated total secrecy within families, advising parents that “under no circumstances should they, or need they, ever tell the child the method of conception – in fact they should forget about it themselves.” (Bloom, 1957, p.207). Professional opinion has transformed, and most medical and mental health professionals and support groups now advocate disclosure (Montuschi, 2006). This follows research outlining the numerous advantages of openness and honesty and a sense that “secrecy...may affect family relationships negatively and undermine the relationship of trust between parents and children.” (Brewaeys, 2001, p.38). Despite this, research suggests that although the number of parents telling their children about their DC conception may have been growing (Crawshaw, 2008; Freeman, Jadv, Kramer, & Golombok, 2009), “the majority of children conceived in this way remain unaware that the person they know as their father is not a genetic parent” (Golombok *et al.*, 2011, p.230). This has been demonstrated internationally (Gottlieb, Lalos & Lindblad, 2000; Nachtigall, Becker, Quiroga & Tschann, 1998). There are limited follow-up studies of DC offspring, though a longitudinal study examining parent-child interactions in twenty-six DC families, suggested that, at age 18, only two of the DC children were aware of their origins (Owen & Golombok, 2009).

Salter-Ling, Hunter and Glover (2001) carried out a quantitative study looking at the relationship between the parental experience of DC and the intention to tell their child. They found men and women not planning to tell their child about

DC reported higher levels of distress and greater anxiety about the thought of telling. In The UK the Donor Conception Network offers information and workshops to support parents in telling and talking to their children (Montuschi, 2006).

Nachtigall *et al.* (1997), in a quantitative study comparing characteristics of disclosing and non-disclosing families, found secrecy not to negatively impact on family functioning. By contrast, other authors have found evidence that non-disclosure may cause psychological damage to the child and undermine trust and honesty within families (Feingold, 2011). Brewaeys (2001), in a meta-study noted secrecy within families associated with DC did affect the father-child attachment relationship negatively, particularly when fathers had inadequately grieved the genetic child they would not have. Lycett, Daniels, Curson and Golombok (2004) found evidence of more positive parent-child relationships in disclosing than non-disclosing families. Berger (1980) suggested total secrecy prevents the 'working-through' of conflicts between parents.

It would seem informing offspring at a younger age of their DC origins has benefits for their psychological adjustment (Golombok *et al.*, 2011), whilst those who discover their DC origins accidentally, or later in life, appear to show increased rates of anger, feelings of betrayal, and distrust (Jadva, Freeman, Kramer & Golombok, 2009). Golombok *et al.* (2011) recommend children are told in pre-school years. This information can then become part of their story early on (Montuschi, 2006). Hunter, Salter-Ling & Glover (2000) and Burns and Pettit (2002) found parents who told their child at an early age felt it somewhat easier to do than those who delayed. They also identified men tended to be more worried than women that telling would threaten the relationship between them and their child. MacDougall, Becker, Scheib and Nachtigall's (2007) study described parents' desire to choose the 'right time' to tell. They described parents choosing one of two disclosure strategies: 'seed-planting', whereby children are told as young as possible, often around the age of three so that they "always knew" (p.524); and the 'right-time' strategy, where disclosure is viewed as a singular event which should take place when the

child has the cognitive skills to understand the information but before the onset of adolescence, around the age of ten.

The lifting of donor anonymity has enabled DC adults to trace any half-siblings from the same donor. This has clear implications for if and when a family choose to disclose DC. Complications arise in families where more than one child has been born using the same donor. The timing of disclosure and the choice to pursue the donor may differ between siblings.

Feingold (2011) outlines reasons given by parents for non-disclosure, which include: fears that disclosure may break the DC child's attachment to the non-genetically-linked parent, leading to rejection; beliefs that disclosure may cause identity confusion in the child; attempts to protect a sense of being a 'normal' family for both parents and children; and anxieties over social stigma and alienation. Other studies confirm that recipient fathers experience worry about disclosure, fearing it may lead to rejection by the DC child (Blake, Casey, Readings, Jadvá & Golombok, 2010; Rumball & Adair, 1999). Hunter *et al.*'s (2000) study with eighty-three DC parents who had disclosed to their children suggested the experience of telling can be painful and difficult. This was mirrored by MacDougall *et al.* (2007) who found that although men were concerned about disclosure, they experienced positive feelings of relief once it was done.

1.6.7.1. Gender differences in talking

There is some evidence that men and women within DC couples differ in their opinions about the importance of maintaining confidentiality, and that fathers tend to be more secretive over DC conception than women (Brewaeys, Golombok, Naaktgeboren, Bruyn & Hall, 1997). Daniels and Taylor (1993) suggested that DC carried a stigma and was often shrouded in secrecy.

Little research has been carried out around how couples negotiate the disclosure of DC. Research in 1995 by Daniels *et al.* and followed-up in 2009 by Daniels, Gillett and Grace, found gender differences in preferences around confidentiality. They identified that women would often accommodate their husband's wishes when it came to disclosure and were keen to protect their

male partners from feelings of rejection and anxiety. Blake *et al.* (2010) reported mothers as the main disclosers of DC to children. Mahlstedt, LaBounty and Kennedy (2010) identified that out of eighty-five adult DC offspring, only thirteen reported their fathers' being present at point of disclosure.

Another under-researched area is how couples discuss and disclose DC to friends, family, colleagues and wider social networks. Daniels *et al.* (2009) found that in 59% of cases where DC had not been disclosed to the child, at least one other person had been told about the conception. They conclude that there is a significant chance of off-spring learning about their origins from another source. Importantly, Taylor, (2007) and Lund, Sejbaek, Christensen and Schmidt (2009) suggest that receipt of social support is associated with more positive psychological adjustment and lower levels of depression and anxiety in recipient parents. Peterson *et al.* (2007) and Crawshaw (2011) suggest there are gender differences in how people discuss and share issues of infertility and treatment with social networks. Hammarberg, Baker and Fisher (2010) found men were more likely to keep DC a secret from friends and family than women. This may be understandable as research suggests that when men do share these experiences, they feel that they receive little social support from peers (Lund *et al.*, 2009). Crawshaw (2011) suggests further exploration of men's experience of social disclosure is warranted.

1.6.7.2. Psychological support for DC fathers

Prior to DC treatment recipients are required to attend at least one counselling session at the fertility clinic. Covington and Burns (2006) reported a reluctance to have pre-treatment counselling which they attributed, in part, to a stigma around counselling and mental health.

Importantly, research suggests men may feel more comfortable and willing to explore their emotions 'openly', when participating in online support groups rather than face-to-face groups (Malik & Couldson, 2008; Mickelson, 1997; White & Dorman, 2001). This is consistent with other findings suggesting men may be more secretive about both their infertility and DC than women and more

reluctant to discuss their feelings and experiences. One hypothesis to account for this is that disclosing feelings of distress or vulnerability, and admitting to infertility and DC fatherhood might all exacerbate a sense of failing to live up to stereotypical constructions of 'successful' or 'real' manliness.

Keylor and Apfel (2010) and Raphael-Leff (2003) suggest, at least some form of psychotherapy is vital in helping couples and individuals make sense of the psychological intricacies implicated in infertility and treatments and the attack on what Raphael-Leff (2003) calls "generative identity" (p.45).

1.7. Rationale for the Current Study

Extensive literature has supported the idea that infertility and related treatments have immense psychological implications for individuals, couples and families, yet men are consistently under-represented in research in this field (Crawshaw, 2011). Work by Blaser *et al.* (1988) suggested that DC did not pose a psychological threat to men and they considered this group to be at low risk of experiencing psychological difficulties. By contrast, Salter-Ling, Hunter and Glover (2001) found high levels of stress associated with both MFI and DC in men. The discrepancies in these findings may reflect a greater willingness to disclose feelings over the intervening period, or at least a greater alertness to men's distress amongst researchers. Other studies have indicated men experience equal levels of distress to women, but feel less able to seek support both socially and professionally (Brucker & McKenry, 2004; Collins *et al.*, 1992; Malik & Couldson, 2008). Hunter *et al.* (2000) suggested "concerns about the impact of DC on relationships and men's reactions to not being able to be a biological father, need to be explored before, as well as during and after treatment" (p.162).

This study aims to elucidate men's experiences and signal how clinical psychologists may be better able to creatively engage and support men going through this process. This may have benefits for not only the men, but also indirectly for their relationships with their partner, child and wider social networks (Raphael-Leff, 2013).

There is a dearth of research exploring men's personal experiences of DC and their patterns of talking and telling to a spectrum of people, including their child. Numerous authors have suggested that this warrants further exploration (Crawshaw, 2011; Malik & Coulson, 2008). A literature review was unable to locate research exploring the impact of the lifting of donor anonymity on recipient fathers' experiences.

1.8. Research Aims

The current study aims to address some of the shortfalls in the literature by exploring the experiences of men who have been diagnosed as infertile and then gone on to have a child through the use of donated sperm since the lifting of donor anonymity.

The research is interested in exploring the following questions:

- 1) How do DC fathers make sense of their infertility?
- 2) What are the experiences of men becoming fathers through DC?
- 3) What are DC fathers' experiences of disclosing and talking about infertility and donor conception to their child, family, friends and professionals?
- 4) What has been the impact of the lifting of donor anonymity on DC fathers' experiences?

Due to the exploratory nature of the study, there are no hypotheses.

2. METHODOLOGY AND METHOD

The following section will provide a rationale for the chosen methodology, including: my epistemological position; a description of Interpretative Phenomenological Analysis (IPA); and why this was used over other methodologies. It will then outline the method: how participants were recruited; how data was collected and analysed; and ethical considerations. Lastly I will reflect upon my own position within the research.

2.1. Ontological and Epistemological Position

Underlying all research, the implicit and explicit beliefs and assumptions about the world held by the researcher influence the research questions, methodology, analysis and interpretation of findings. Willig (2008) suggests that clarity with regard to the researcher's: *ontological* position, of "what there is to know" (Harper, 2012, p.87, *sic*); and *epistemological* position of "what it is possible to know" (Harper, 2012, p. 87) is essential if research methods and methodologies are to be consistent with the underlying assumptions in the research questions.

Ontological and epistemological positions lie on a continuum from: naive realism, assuming a *true* reality that can be uncovered and observed; to radical relativism, arguing that there is no objective *reality* outside that which is constructed through discourses and paradigms (Willig, 2008).

I approached this study from a critical realist ontological position. This holds that there are real entities, but that these can only be indirectly and partially understood (Nightingale & Cromby, 1999) via language. This research assumes lived experience is phenomenologically real, but that neither participant nor researcher can know all the factors that have shaped this experience such as early experience, family and cultural beliefs or "the history of the concept itself" (Harper, 2012, p.88).

This research also takes a contextual constructionist epistemological position: that knowledge production and meaning-making "does not develop in a social vacuum but is rigorously situated within a socio-historical and cultural milieu of meanings and relationships" (Jaeger & Rosnow, 1988, p.66). These factors

influence the development over time of both researcher's and participant's understandings, beliefs and knowledge about the area of study. The interview process itself, however, also involves a co-construction of meanings and interpretations that affect the data and its later analysis (Yardley, 2000).

2.2. Rationale for a Qualitative Methodology.

I will outline the reasons why a qualitative methodology was felt to be more appropriate than a quantitative methodology for this study.

2.2.1. Extending Current Understanding

This study aims to explore men's subjective, lived experiences of infertility and DC fatherhood. As cited in the introduction, literature has tended to bias towards an exploration of women's experiences of infertility whilst the voices of men have gone largely unheard (Hadley & Hanley, 2011; Wischmann, 2013). Willig (2008) recommends the use of qualitative methodologies to allow for in-depth exploration, where little is known about a subject and Ashworth (2003, p.24) suggests qualitative research allows a "hearing for the voices of the excluded".

Qualitative analysis enables a wider and deeper understanding of phenomena, allowing for unanticipated findings and is suitable for obtaining phenomenological information (Barker, Pistrang & Elliot, 2002).

2.2.2. Epistemological Considerations

Quantitative methodologies are derived from positivist epistemological positions which seek to find objective, value free 'truths' assumed to exist in the world (Barker *et al.* 2002). Qualitative analysis, on the other hand, allows for the "proper awareness of the diverse experiences of individuals" (Ashworth, 2003, p.24). This study does not aim to identify one 'truth' about how DC fathers see the world, but instead to critically examine a range of subjective experiences, which it is hoped will generate new understandings. Qualitative research views the researcher as a significant party within the research process and findings (Frost, 2011; Yardley, 2000) and considers narrative accounts to be situationally and contextually dependent. The deployment of qualitative methodology and

analysis reflects the critical-realist, context-constructionist assumptions of the current research.

Support for the use of qualitative methodologies in infertility research is offered by Crawshaw (2011, p.2). She argues these approaches are “better at capturing nuance, ambiguity and dynamic changes across time and context...pay[ing] attention to the immediate and wider social context of people’s lives; the influence of health care settings and professionals within them; and wider political meanings of infertility and parenthood.”

Qualitative research has grown in use and popularity (Yardley, 2000). It covers a wide range of methodologies with varying theoretical and epistemological underpinnings. This study will use Interpretative Phenomenological Analysis, one of the more recent methodologies developed by Jonathan Smith in 1995.

2.3. Interpretative Phenomenological Analysis (IPA)

This section will outline: what IPA is; its theoretical underpinnings; why it is appropriate for use in this study; and how these ideas have been incorporated into the method.

2.3.1. The Theory Behind IPA

IPA is “a qualitative research approach committed to the examination of how people make sense of their major life experiences.” (Smith, Flowers & Larkin, 2009, p.1). It is guided by three theoretical ideas: *phenomenology*; *hermeneutics*; and *idiography*. These will be considered in turn. Phenomenology is an umbrella term for a philosophical movement developed by Edmund Husserl, who was interested in the study of lived experience in its own terms (Finlay, 2011). It is hinged on the notion that experience is accessible through language. Husserl believed it possible to identify and “bracket off” or “reduce” one’s own experiences and assumptions in order to gain access to the lived experience of another. Finlay (2011) documents how philosophers such as Heidegger and Sartre, who followed on from Husserl’s work, argued that this reduction is impossible, as we are inextricably linked to our pre-understandings and context. The closest one can get to experience is through *interpretation*.

Hermeneutics is the theory of interpretation and is interested in how we make meaning from experience (Finlay, 2011).

Within IPA, the researcher is expected to engage in a 'double hermeneutic' (Smith & Osborn, 2003), being aware that they are themselves interpreting the participant's interpretations of their experience. The researcher is urged to engage in constant reflexivity, in order to remain vigilant to their own preconceptions and attempt to 'bracket' these off, allowing for a greater receptivity to the new and unique experiences of the participant (Finlay, 2011). Smith, Flowers and Larkin (2009, p.37) suggest that "without the phenomenology, there would be nothing to interpret; without the hermeneutics the phenomenology would not be seen".

IPA is ideographic in that it is interested in the *particular* experience of individuals in a certain context at a certain point in time. It attempts to make very tentative generalisations only after a comprehensive and detailed analysis of the individual (Smith, Flowers & Larkin, 2009). Warnock (1987, cited in Smith 2004, p.42) suggests that "delving deeper into the particular also takes us closer to the universal".

The current study is interested in exploring the lived experience of DC fathers and how they have made sense of their experiences of MFI and DC. IPA is increasingly being used in health related psychological research (Smith, 2011) to explore 'illness' experience. IPA has also been frequently used to explore the perceptual processes involved in people going through infertility, assisted reproduction and DC (Blyth, 2012; Phillips, Elander & Montague, 2013; Turner & Coyle, 2000; Schilling & Conrad, 2001). With this in mind, IPA was identified to be the most appropriate methodology for addressing this study's research questions.

2.3.2. How these Ideas have been Implemented in the Current Study

Phenomenological accounts of men's experiences have been elicited through the use of semi-structured interviews.

Hermeneutic considerations, encouraging awareness of the researcher's own preconceptions and interpretations, were addressed at every stage of the research, through the use of a reflexive journal (Appendix 4); reflexive IPA meetings with peers; and supervision.

In line with IPA's idiographic requirements, the sampling framework for this study focussed on the experiences of a small and relatively homogeneous sample of purposively selected men at a particular moment in time (Smith, Flowers & Larkin, 2009). Smith, Flowers and Larkin (2009) recommend between four to ten participants for professional doctorate theses.

2.3.3. Justification for IPA Over Alternative Qualitative Methodologies

IPA was considered the most appropriate methodology for exploring this topic. Three other widely used qualitative methodologies that were contemplated will be outlined: Thematic Analysis; Discourse Analysis; and Grounded Theory. Reasons will be given for why these were eschewed in favour of IPA.

Thematic Analysis (TA) was considered and disregarded, as it deploys larger sample sizes with less focus on the phenomenological aspects of the data (Hefferon & Gil-Rodriguez, 2011). Unlike IPA, TA does not place emphasis on reflexivity, nor on the impact of the researcher's assumptions and experience on interpretation of the data. It felt key to consider how my own ideas on infertility and DC impacted my interpretation of men's narratives.

Discourse Analysis (DA) and IPA are both interested in language, but whilst IPA uses language to understand how participants make sense of their experience, DA uses linguistics to consider how people construct these experiences. DA is sceptical about the claims of IPA that experience can be accessed through language. DA holds that language constructs the reality rather than accesses it (Willig, 2008). Whilst IPA acknowledges that we can never access an unmediated account of lived experience, it does imply that we can learn something of the meaning-making of people in particular situations and get "experience close" (Smith, 2011, p.10). IPA is in alignment with my critical-realist position insofar as it assumes that language gives access to experience, albeit indirectly, through the interpretative lenses of both the speaker and the listener.

There is significant overlap between Grounded Theory (GT) and IPA, but the former is interested in developing theoretical accounts which describe social processes, and is more widely used in psychosocial research (Smith, Flowers & Larkin, 2009). It draws on larger sample sizes within a heterogeneous and stratified sample to do this. In contrast, IPA attempts to offer “a more detailed and nuanced analysis of the lived experience of a small number of participants with an emphasis on the convergence and divergence between participants” (Smith, Flowers & Larkin, 2009, p. 202). IPA was felt to be more in keeping with the psychological aims of the study

2.4. Participants

2.4.1. Inclusion and Exclusion Criteria

The literature suggested that the recruitment of men in the area of infertility is often difficult (Lund *et al.*, 2009; Webb & Daniluk, 1999). A balance was needed between maintaining homogeneity between participants whilst not keeping the inclusion criteria so narrow that it prevented sufficient recruitment. Inclusion criteria were: men who had been diagnosed as ‘infertile’; who had gone on to conceive a child through the use of donated sperm; and where conception occurred after the 2005 anonymity laws changed. One man who expressed an interest in participating in the study, whose partner was eight and a half months pregnant with their first DC child was also keen to participate and was included. The possible implications of this are considered in Section 4.6.3.

Participants who were non-English speaking were excluded from the study, due to the nuances of language possibly being missed during interview and translation and to sustain homogeneity. Country of origin was not an exclusion criterion and participants were included who lived outside of the UK.

2.4.2. Recruitment Procedure

Senior members of a DC charity were contacted via telephone and email and sent a copy of the research proposal. They welcomed involvement in the research and consented for me to recruit from their membership (Appendix 5).

A Participant Information Sheet (PIS) was designed (Appendix 6). This explained that the aims of the research were to increase psychological understanding of men's perspectives of DC fatherhood, with a view to improving support services. The PIS set out that participation would involve being interviewed by the researcher for up to an hour and a half at a location and time convenient to them. Woods (1986) suggests that offering some control to participants is essential in building rapport. Anonymity was assured. My contact details were included and potential participants invited to contact me via e-mail or telephone, if they were interested in participating, or for more information.

Participants were recruited through the DC charity in the following ways: an advert, outlining the research and seeking volunteer participants was twice posted on monthly e-bulletins and circulated to all members (Appendix 7); I attended an annual DC charity meeting and issued the PIS to attendees; in addition, I contacted the facilitator of a regional support group for men, who subsequently distributed the PIS at groups; I also attended the 2011 Fertility Show and handed-out the PIS on the DC charity's stall.

The men who contacted me were sent an e-mail thanking them for their interest and arranging when and where the interview would take place. Two participants who lived outside of the UK were interviewed on video Skype. The impact of this is considered in section 4.6.3.

2.4.3. Service Context

The DC charity is the UK's main charitable group dedicated to supporting families considering, and having undergone, DC. They have a membership of approximately 1600 families both nationally and internationally; advocate the disclosure of DC to children; and offer disclosure and discussion workshops for parents of children of different ages and support groups for people at every stage of DC. The researcher acknowledges that the sample of men will not be representative of all men who have experienced DC, but will reflect a spectrum of views of a group who have opted to engage in support networks and volunteered to share their views in this research study.

2.4.4. The Sample

A total of nine men expressed an interest in participating in the research. One man, whose children were born prior to the lifting of donor anonymity agreed to participate in a pilot study. The remaining eight men were all interviewed as participants in this research. They ranged in age from early 30s to late 40s. All the men identified as heterosexual; had been diagnosed infertile; and had been in relationships with partners who had conceived a child through the use of donor sperm. Anonymised details of all these men are provided in Table 1. Seven of the eight men were still in the same couple relationship. One man was separated from his partner and described himself as still very actively engaged in parenting. One man had not yet become a father and his partner was imminently due to deliver their first baby. He was the only participant with a 'known' donor. All participants were aware that, from age eighteen, their children would have the legal right to identify their donor.

Table 1: Participant information

Participant Alias	Rel'ship status	No. of Children	Age of Children	Gender of Children	Interview Location	Cause of MFI
Dave	Married	2	5, 2	2 x M	Work	Undescended testes
Graham	Married	1	6	1 x M	Home	Hypogonadism
Jed	Married	3	7, 5, 2	3 x F	Skype	Azoospermia
Josh	Separated	2	7,6	2 x M	Cafe	Twisted testicle
Dylan	Married	2	4 months	1 x M 1 x F	Home	Hyperthyroidism
William	Married	2	2, 2months	1 x M 1 x F	Home	Azoospermia
Gary	Married	1	4	1 x M	Home	Undescended testes
Sam	Married	unborn	unborn	unborn	Skype	Azoospermia

2.5. Ethical Considerations

Ethical approval was gained from the University of East London's ethics committee (Appendix 8) and from the DC charity.

2.5.1. Consent

All participants were told that they had the right to withdraw up to two weeks after the interview, after which point the interviewer had the right to use their anonymised transcripts. Participants were required to complete a consent form (Appendix 9) prior to the interview, seeking consent for: participation; audio recording; transcription of the interview data and inclusion of anonymised material in the thesis and possible publication.

2.5.2. Managing Potential Participant Distress

Due to the sensitive nature of the issues being discussed during the interviews it was possible that participants might become distressed. It was made clear that if participants wished to discontinue the interview they were free to do so. After completion of the interview there was a period of debriefing to reflect on their experience of the interview. Participants were given contact details of relevant support groups (Appendix 10).

2.5.3. Ensuring Anonymity

In order to ensure anonymity, participants, their partners and children were allocated an alias and all identifying references removed or changed. Identifying materials were stored separately from transcriptions in a secure location. Identifying data was kept on a computer and password protected.

2.6. Data Collection

2.6.1. Semi-Structured Interviews

2.6.1.1. *Interview Schedule*

My interview schedule (Appendix 11) was informed by: IPA literature (Smith, Flowers & Larkin, 2009); discussions with my supervisor; and via a pilot

interview. Kvale and Brinkmann, (2009) suggest pilot interviews can be valuable in constructing schedules. My pilot interviewee provided useful feedback on both the interview questions and style.

My schedule included eight questions and additional prompts intended to address the research questions. The starting question was intentionally broad to allow the participant to set the parameters for the subject (Smith, Flowers & Larkin, 2009) and was the only one which remained exactly the same throughout all eight interviews. The schedule was memorised and used flexibly to allow the order and flow of the interview to develop naturally to facilitate exploration of novel issues.

2.6.1.2. Interview procedure

Participants selected the location of interviews. Five men requested the interviews at their home; one at a work office; one in a public meeting space; and three over Skype. The three held over Skype were with men who either lived outside of London or England. With the participants who requested we met in private locations, such as their home or office space, I ensured my personal safety by informing a third party of my location and instructing them to call me one and a half hours into the meeting. This was explained to the participant at the start.

Prior to the interview, participants were given the opportunity to ask questions. This contributed to building rapport which is essential in achieving useful data (Kvale & Brinkmann, 2009). I explained that although there were some areas I wished to cover, the conversation would be fluid and led by their experiences. After this point the audio recorder was turned on and placed between us. For the participants whose interviews were conducted over video Skype, verbal consent was sought for recording.

I conducted interviews in a conversational and relaxed style in order to build rapport and to prevent the interview being experienced as interrogative. Following the interview, participants were again given the opportunity to ask questions and were encouraged to contact me following the interview for any further information or questions. Participants were asked whether they would

like information on the research findings. All of the men requested this and were sent executive summaries of the thesis.

Interview duration ranged from 53 to 84 minutes, with an average length of 67 minutes.

Following each interview, I noted my reflections in my research journal (Appendix 12).

2.7. Data Analysis

Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin, 2009) was used to analyse the data.

2.7.1. Transcription

There are a range of transcription techniques used within research, ranging in detail from a simple account of what was said to the detailed inclusion of complex information on pitch, intonation and speed as employed in the Jefferson scheme (Atkinson & Heritage, 1984).

IPA is interested in the content of conversations with some acknowledgement of linguistic techniques used by speakers (Smith, Flowers & Larkin, 2009). In line with IPA's requirements, recordings were transcribed verbatim with some indication of pauses, stresses or non-verbal cues. (Appendix 13: coding system; Appendix 14: extract from Dylan's transcript). I was mindful that transcribing itself was a filtering process that necessarily involved my interpretation. During transcriptions I kept notes of passing thoughts and assumptions in my reflexive journal, which may have been impacting on my *hearing* and transcribing of the data (Appendix 15). This was in an attempt to 'bracket off' my experiences from what was being said by the participant.

When formatting the transcript, I numbered each page and line for easy referral. I also created large margins on the right and left of the page, to allow for notes on exploratory coding and emerging themes.

2.7.2. Stages of Analysis

Smith, Flowers and Larkin (2009) have offered flexible guidelines on carrying out analysis. In keeping with IPA's idiographic commitments, thorough and painstaking examination and analysis of each case was carried out before conducting cross-case analysis.

2.7.2.1. *Initial encounter with the text*

Following transcription, I read through the text several times to immerse myself in the data and build up an impression of the overall structure. The first reading was done in conjunction with listening to the recording and reminding myself of the reflections I had made following the interview itself, in an attempt to remain open to new ideas.

2.7.2.2. *Initial exploratory coding*

The most time-consuming stage of analysis required detailed line-by line examination of the text. I divided the exploratory coding into three areas: *descriptive*; *linguistic*; and *conceptual* (Smith, Flowers & Larkin, 2009) in an attempt to unpick and make sense of the meaning the participant may have been making of their experiences.

'Descriptive coding' operates at the most basic level, focussing on the content of what was said and the topic of discussion (Smith, Flowers & Larkin, 2009).

'Linguistic coding' focussed on the use of language and non-verbal cues, considering how these might emphasise or contradict the content of the verbal narrative (Smith, Flowers & Larkin, 2009), and to deepen my sense of the participants' experience. I highlighted instances of: pauses, laughter, stutters, pronoun use, metaphor, tone, and tenses. I reflected on how my presence may have been impacting on what and *how* things were said, or not.

'Conceptual coding' represents interpretative observations (Smith, Flowers & Larkin, 2009). I began to unpick the meaning behind the words used and subjects discussed, and searched for consistencies and contradictions

throughout the text. Peer supervision aided me in ensuring that my interpretations were grounded in the data.

2.7.2.3. *Developing emergent themes*

My initial exploratory comments were used to identify emerging themes. This required a focus on discrete sections of the interview whilst moving between other parts of the text and the interview as a whole. Smith, Flowers and Larkin (2009, p.92) comment that this represents the hermeneutic circle “where the part is interpreted in relation to the whole; the whole is interpreted in relation to the part”. They go on to suggest the “main task of turning notes into themes involves an attempt to produce a concise and pithy statement of what was important in the...piece of transcript.” I created a list of emergent themes with supporting quotes (Appendix 16a).

2.7.2.4. *Abstracting themes*

Once the initial themes had been identified I began clustering themes that I felt were related (Appendix 16b). In line with Smith, Flowers and Larkin’s (2009) guidance, this was achieved through: *abstraction* (discovering patterns between sub-ordinate themes and grouping them together); *subsumption* (elevating a subordinate emerging theme to a super-ordinate theme which encapsulates a set of related ideas); *polarization* (identifying contrasting ideas that may be describing different facets of the same phenomena); *contextualisation* (embedding the themes within personal, cultural and temporal narratives); *numeration* (the regularity with which an emerging theme is supported within the transcript); and *function* (making sense of what is being said in relation to how the participant wishes to present themselves and their narrative within the interview, and to the interviewer).

This required organising and clustering themes on a mind-map to create a visual representation (Appendix 17).

2.7.2.5. Moving to the next case

I completed the above steps for each case before moving onto the next. I attempted to approach each new transcript afresh as far as possible. I was aware however that within the hermeneutic circle my “fore-understandings” had altered (Smith, Flowers & Larkin, 2009, p.100).

2.7.2.5. Cross-case patterns

Once a table and a mind-map of themes had been created for each participant, I collated them and searched for similarities and differences between themes. At this point, there were an inordinately large number of themes and I spent a long time clustering and re-clustering them to create a higher level of abstraction. This led to the creation of a master mind-map (Appendix 18) followed by a master theme table (Appendix 19) with quotations from each transcript grounding themes in the data.

Although there are no prescriptive rules offered in the literature on the number of eventual super-ordinate themes needed, research has been criticised for insufficient abstraction of emerging themes, resulting in the research remaining at a descriptive rather than interpretative level (Hefferon & Gil-Rodriguez, 2011). Smith, Flowers and Larkin (2009) recommend around three higher order, super-ordinate themes, encompassing two to four sub-ordinate themes each.

2.9. Reflection on My Position in the Research

2.9.1. Reflexive Practice

In line with IPA’s hermeneutic commitments, I kept a reflexive journal at every stage of the research process. Prior to carrying out the analysis, six trainees involved in IPA research, set up a reflexive group. We were each interviewed in an attempt to tease out our implicit preconceptions, prejudices and vested interests in our research and the blind spots these may have created. These were audio-recorded and reflections later noted in my journal (Appendix 4). For example in the pre-interview IPA reflexive group, it became apparent that I held

a pre-conception that men would rather not disclose the DC to their children. By making the assumption explicit, I tried to then 'bracket' this, in order to allow me to be receptive to different and contradictory narratives.

2.9.2. The Impact of Being a Female Interviewer

The epistemological and methodological position of the research places fundamental importance on the interaction between interviewer and interviewee in co-constructing meaning (Yardley, 2000). It therefore felt important to consider how my gender, as well as other demographic characteristics, such as my age and ethnicity impacted on the research, both during interviews and analysis.

Research has identified gender-of-interviewer effects in qualitative research with men (Catania *et al.*, 1986; Fuchs, 2009; Sallee & Harris, 2011). Catania *et al.*, (1996) suggest that matching on gender, particularly with topics related to sexuality, yields better results, whilst Fuchs, (2009, p.37) suggested this depends on "the existence of gender-related social stereotypes" and where individual men position themselves in relation to this. Salle and Harris (2011) concluded men may produce more thoughtful, introspective reflections with female interviewers as "they [do] not feel the need to live up to masculine expectations." (p.426). Due to the sensitive nature of this research, it seemed probable that my gender would have some effect but that this would vary across the sample. For me, these differences provoked and consolidated the need for a questioning, reflexive and critical perspective throughout. I raised the issue of my age and gender at an IPA reflexive group (Appendix 4), and was questioned about the possible impact of this on interviews and analysis. I identified a presupposition of mine: that men would be less capable of, and feel less able to identify and talk openly about their emotional experiences than women. My experiences of talking to the men challenged, and in some cases disproved this assumption, as many of the men spoke with great openness, self-awareness and honesty about both their joyful and distressing feelings.

2.9.3. Research versus Therapy

It felt important to reflect upon the differences between research and therapeutic interviews, and the experiences and tensions with this. Core therapeutic skills, such as Rogers' (1951) ideas on empathy, genuineness, and unconditional positive regard were valuable in building rapport and eliciting exploratory information on participant's experiences. Moving accounts from participants, disclosing intimate and distressing experiences that I was aware they were still struggling to emotionally process, made it tempting to want to relate to the men as a therapist rather than researcher. However I was mindful that the research interview is not and should not be viewed as therapy and that 'therapeutic' responses and attempts would have been 'unethical' given the nature of the meeting and aims of the research (Coyle, 1998). I aired this tension in an IPA reflexive meeting (Appendix 4). As I advanced further into the research, I became more confident in encouraging men to open up about areas that were sensitive, as I realised that I could still contain this within the research framework without leaving the men feeling too distressed.

2.9.4. Personal Statement

IPA recognises that any knowledge produced in research is a co-creation between the researcher and researched (Larkin, Watts & Clifton, 2006) and that "the beliefs and behaviours of the researcher are part of the empirical evidence for (or against) the claims advanced in the results of research" (Harding, 1987, p.9). In line with Elliott, Fischer and Rennie's (1999) recommendations, this section attempts to make explicit to the reader a picture of who I am and some of the factors that affected how I approached this research (Yardley, 2000).

I am a White, British, heterosexual woman in my late twenties, without children. I have lived in London my whole life. My personal interest in this area stems from my experience of growing up as an only child, being acutely aware of my parents' struggles with infertility and their efforts to have more children. I am also at a point in my life when fertility and thoughts about having children are increasingly in the foreground, both for myself and for my male and female friends.

Studying male infertility rather than female infertility felt emotionally one step further away from me as a woman. I have noticed that female friends talk more openly about parenthood and their worries about fertility than my male friends. I was struck by the paucity of research with men in this field and felt curious as to why this was. This motivated me to explore the subject further and contribute to redressing the imbalance in this area.

My education and training, in conjunction with personal beliefs and frameworks, have guided me to approach research and theories on human behaviour with a critical mind. I am interested in how socio-political factors influence personal experience and behaviour. I am also drawn towards psychoanalytic ideas for understanding parent-child relationships and 'attachments', which are at the heart of my interest in this topic. The subjects of infertility and assisted reproduction often arouse strong feelings and spark heated debate across many spheres: relational, social, ethical, moral, religious, political and legal. Thus, my assumptions at the start of this research were that these elements may be represented in DC men's narratives about themselves, their personal experiences and decisions about disclosure. In identifying this supposition, I aimed to hold it to one side to allow for men's own narratives to surface.

3. RESULTS

The following chapter outlines the Interpretative Phenomenological Analysis performed on the eight interviews. It is acknowledged that the interpretations offered are one possible account of these men's experiences. Other researchers might well have extracted different themes. Whilst this account does not comprehensively cover all aspects of the men's narratives in the interviews, interrelated themes have been selected to address the research questions and also to capture the significant areas of commonality in their descriptions. It is unsurprising that within these themes there are areas of convergence and divergence. In line with the ideographic commitments of the study, individual as well as shared experiences will be considered.

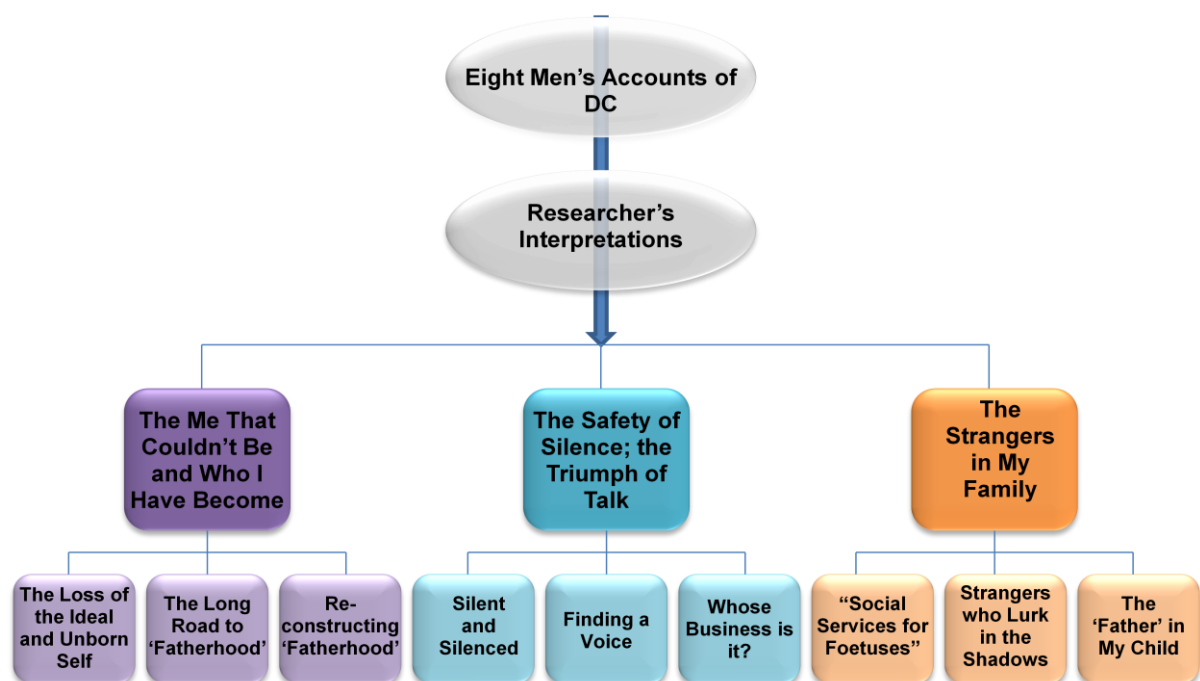


Figure 1: The super-ordinate and sub-ordinate themes arrived at through the interpretative lenses of participants and researcher.

In order to evidence each theme I have selected a limited number of representative or illuminating extracts. The location of theme in the men's transcripts is indicated at the end of the quote in the format (page: line). Where

other men have had similar or contrasting experiences, descriptive extracts are included in a supplementary table (Appendix 20).

3.1. The Me That Couldn't Be and Who I Have Become

This super-ordinate theme refers to the experience of the men on discovery of their infertility: the losses and grieving this entailed; the journey towards DC fatherhood that ensued; and the changes they have undergone in their construction of themselves and what it means to be a father.

3.1.1. The Loss of the Ideal and Unborn Self

All the men, with the exception of Dave, expressed powerful emotional reactions following the diagnosis of infertility. To a greater or lesser extent, all the men commented on feeling an attack on their sense of manhood and the loss of an 'ideal' self and an imagined future. The same seven referred to a feeling of "bereavement" for the biological child they would never have. Infertility, in this way, was experienced as marking a kind of ending of themselves as well as of their family line that resulted in deep distress and an increased awareness of their own mortality.

Concerns about not being a "real" (Josh, 22:842) or "true" (Gary, 16:535) man seemed most acute for Dylan and Gary, who experienced developmental delays at puberty, leading to investigations which highlighted conditions associated with infertility.

Dylan: all my kind of peers were growing and becoming men if you like, [pause] and because all of that was delayed in me [pause] I think perhaps I became...there was something in my head that was kind of thinking: "uh you're not really quite right" [...] there was something in the back of my head that said: "you're not a proper man, kind of thing, you're [pause] you're missing a piece" (4:112)

Dylan: you just think he's 14, he's growing a beard and I want to [he theatrically gestures a beard and we both laugh] and so you feel really left out (5:164)

In the extracts above Dylan constructs his sense of what constitutes being a 'real man' and the ingredients needed to achieve this, which he felt he lacked.

The emphasis on “growing” and “delayed” stresses the discrepancy between him and his peers and a sense that he was deviating from ‘normal’ development. The self-critical voice “in the back of [his] head” conjures a sense of a bullying and ‘omni-potent’ peer in his mind. Dylan sometimes used self-deprecating humour when talking about sensitive topics. This perhaps worked to distract from his feeling of embarrassment and distress and engage me in his story so that I laughed with him not at him.

Gary too had concerns, at the age of fourteen, that he may experience difficulties with fertility after the discovery of two un-descended testes. He described it:

Gary: ...like being in the zoo kind of thing. All the junior doctors all crowded round (14:473)

Gary began to build an internal sense of himself as a “freak” (15:493) who transgressed normal development. The repetition of “all” emphasised his perception that his condition was rare and his humiliation at everybody being called in to look at him. He later goes on to say:

Gary: as a man, as a bloke, everyone wants to be able to feel they can have children, and if you can't have children then I think there's...there's definitely a feeling of “oh you're not a [stutters] a true man” (16:535)

Gary's shift from “man” to “bloke” suggested he held a sense of a continuum of ‘manliness’, with the embedded assumption that he was not at the ‘hegemonic masculine’ end. His stuttering towards the end of the extract may have represented his embarrassment in vocalising this perception of himself, seeing it as something shameful.

Similarly, for Josh, a “seed” (Josh, 6:232) of doubt was sewn regarding his fertility after experiencing a strangulated testicle aged twenty-one, which caused him to question his masculinity. For Josh, as well as for Dylan and Gary, this “seed” of doubt both about their ability to procreate in the future and about themselves as a ‘real man’ may have been re-awakened at the point of a definitive diagnosis later in life when they were beginning to embark on starting

a family and were surrounded by friends who were having children and demonstrating their masculinity and 'virility'.

Dave, whose infertility was also suspected at age fourteen, after discovery of un-descended testes, referred to a feeling of an "*extended adolescence*" (6:177) and to how doubts about his fertility and masculinity contributed to a lack of self-confidence, particularly between ages seventeen and twenty-seven:

Dave: I was quite an unconfident person erm and [...] wondered sometimes whether [...] that might have had something to do with it (6:183)

Josh suspected he may have difficulties creating a child naturally following a strangulated testicle in his early 20s.

Josh: I think I [pause] probably felt [...] less of a man...I did feel less of a man. (9:325)

Josh too positions himself on this continuum of 'manliness' on which he sees his status as having been diminished.

For William, Jed, Graham, and Sam, the discovery came unexpectedly in adulthood. They described the impact more as a "*dent*" (William, 24:846) to their sense of masculinity. Their concerns seemed to relate more to the guilt about denying their partner and parents by failing "*essentially [to] do what you're put on earth to do*" (William, 24:848):

Sam: I think the biggest issue for me was the fact that just not being able to get Yasmin pregnant, there was a massive amount of guilt um but I think it's the virility thing, I think it's how much of a man you are and on a very basic biological level of spreading your seed, continuing your er genetic line. (8:249-255)

He, as with all the men, seemed to have internalised a social discourse conflating virility and fertility which may have impacted on his confidence in his masculine identity.

My first question at the start of each interview was asking them how it was they came to be a father. It is interesting that all the men grounded their stories

around an assertion that they knew they “*always wanted to be a dad*” (Josh, 1:7).

Graham talked a number of times about the imagined future that had been unfairly stripped from him:

Graham: “that future you thought you were going to have, that’s not going to be you, and you might have had...I had a picture of myself I guess in the future for a long time...I have a sort of picture...I’ve planned my life ahead and how things would happen and suddenly that’s not going to be anymore, it’s going to be something else.” (6:188)

Graham shifts from talking in the second person “*you*”, creating a sense of generality, to claiming the personal nature of this loss by using, and stressing, the first person “*I*” in the second line. Graham spoke frequently of his career successes and, I felt, portrayed himself as someone who liked to be in control and had a life plan, which up until that point he had commanded over. Temporal shifts from “*had*” to “*have*” suggested that, despite having a DC child, this was still something he was trying to make sense of and adjust to.

All of the men, other than Dave, spoke of feeling “*devastated*” (Jed, 3:103) and of deep emotional despair.

Graham repeatedly referred to “*profound*” existential concerns around the end of his genetic line.

Graham: it’s still quite a profound thing that you think um you know it’s entirely the end of the genetics (3:82)

This seemed to make him more acutely aware of his own mortality, questioning:

Graham: what is the point in going on? (4:130)

This may have reflected both his very low mood and the fantasy of suicide: the ultimate way of controlling one’s life.

Dylan used the metaphor:

Dylan: it pulls the life out of you (11:392)

I felt this symbolised not only the painfulness of coming to terms with infertility but also the loss of the potential life that he would not be able to create.

Sam and William spoke of the loss of their 'unborn self':

Sam: letting go of that kid I had in my mind's eye, that was basically a little replica of me but a female version. (3:84)

Sam's evocative description perhaps typifies the essence of 'reproductive' failures: the inability to duplicate one's self and genes. Interestingly Sam selected his brother as the donor, as perhaps this provided the greatest chance of *holding onto* this fantasy.

William: I haven't suffered yet, touch wood, a bereavement but it was a real sense of loss, for me, cos you know, I like, I love kids [...] and the thought of having my own children was very important to me [...] and then to have that snatched away [pause] from me was, yeah I would term it a bereavement. (4:135)

William talked as if he was not entitled to claim the loss of his biological child as a 'real' bereavement. As he explored this however, emphasising his love and longing for kids, he justified (through his injection of "you know") his right to describe his experience in this way. He described

William: ...undirected anger cos there was no one...it was no one's fault. (5:175)

He recounted his frustration and the difficulty in grieving someone who never existed and where there was no-one to blame.

Dave tended to identify emotionality and distress in other people, particularly his partner, more than within himself. He described the discovery of infertility in adulthood as "not a massive deal" (3:72) for him, but talked repeatedly about his wife's feelings:

Dave: she went through a kind of period of kind of like ehm grieving if you will for the fact that any children we had wouldn't be kind of like biologically mine (3:77)

Whilst Dave explained that the discovery of infertility in puberty had given him time to come to terms with the prospect of being infertile, I also thought it possible that he may have displaced some of his own loss onto his partner and allowed her to deal with feelings on his behalf. He later expressed his own need to “*come to terms with it all*” (13:370).

3.1.2. The Long Road to ‘Fatherhood

All the men described the arduous process of tests, treatments, endless waiting, raised hopes and repeated disappointments involved in the route from first diagnosis to becoming a father. Typically, William talked about the:

William: five years of worry and decision making (29:1021).

Following the discovery of infertility, each spoke of their ‘journey’ to fatherhood conjuring powerful metaphors of “*roads*”, “*bridges*”, and “*dead ends*”, giving a sense that this was a tortuous, unnatural, and winding “*path*”, travelled both alone and with others:

Sam: we had a clear direction of where we wanted to go to have a family and then suddenly we found ourselves going, sometimes in circles, sometimes get to a dead end, um and we had to deal with new bridges, new roads, finding...and that was what the donor conception, part of it, that’s what it gave us, that suddenly there was a road, but it look a lot longer (11:360-368)

Sam: I don’t know how many times I built that bridge, I kept trying to build it, it kept falling down (18:588)

In the first extract, Sam gives the impression that he and his partner had a joint plan for how their lives would unfold. The ensuing list of metaphors then paints a vivid picture of just how difficult, frustrating and strenuous their journey to the end goal of being parents was. In the second extract, Sam shifts to talk about trying to repair the broken path in the first person, giving the impression it was something he was doing alone.

In each of the interviews there was an oscillation between the sense of this being a lonely personal journey and one experienced in the context of the couple relationship and wider familial and social networks.

Dylan, Graham, Sam, Josh and William each talked about initially experiencing the infertility as their loss: one which they felt their partner neither understood, nor had entitlement to mourn.

Graham: my partner was saying that she um was having a tough a time as I was, and I kept thinking God well you're not, I know which shoes I would like to be in, I would rather be the fertile one, you know and have a partner that was infertile (2:69)

For some this initial resentment of their partner's expressed grief was replaced by a greater appreciation of what they too had lost.

Dylan: I kind of thought it's my problem, I'll be the one upset but of course it affected her as well (6:211)

A repeated pattern in each of the interviews was a clear, 'flashbulb' memory of the discovery of infertility, whether in adolescence or adulthood. Other than Dave and Graham, all participants described this in minute detail.

Jed: "I was driving home and it was about 2 hours away the doctors office in a fairly rural area at the time [...] and it was winter and it was icy and snowy and I remember pulling off into this parking lot next to the river which was the central attraction to this small park and just cried. I was just terribly devastated" (3:93)

Josh, Dylan, Sam, Jed and William described the crystal clarity of diagnosis being followed by a period of fragmented recollection, which some described as a period of numb 'inertia'; a sense of "walk[ing] around in a daze" (Josh, 10:386), on "autopilot" (Sam, 13:435), neither looking for, nor finding solutions. Josh describes:

Josh: "you kind of switch yourself off emotionally from the whole experience" (10:386)

This was represented in the interviews through disjointed narratives and gaps in memory, and as such remained in stark contrast to the fluency of the rest of the interview:

Sam: would it have been 2000? I am trying to think now, yeah it would have been 2011, so we got pregnant, [...] erm no so it was 2010, when did I find out? I found out and then we started our

treatment [pause] oh this is such a blur, it's quite scary actually (493-498)

Josh, Jed, Graham, Sam and Dylan described that their wives, still determined to have their own biological child “*pretty much took over*” (Sam, 13:455) and became “*pushy*” (Graham 2:58) about pursuing DC. Dave however described his own “*pragmatism*” as guiding their decision:

Dave: “it was the only option if Louise was going to have a natural birth and absolutely that’s what she wanted and I wanted her to have it as well, ehm there was no other option, if she wanted to biologically have a child, she was going to have to do it [laughs] with someone else’s sperm” (3:87)

Dave’s “*pragmatism*” (4:97) and laughter possibly acted as a defence against the “*icky[ness]*” (11:302) of DC as he later described it.

I was struck how most men spoke about the importance of both pragmatism and ‘positivity’ as ways of coping with distress in a ‘manly’ way.

Graham: It wasn’t all negative, mostly positive feeling generally mostly positive, I’m not going to say things like I didn’t feel angry, isolated, or confused. I actually felt fairly positive (3:102-106)

Graham sandwiches his negative feelings between declarations of positivity. This may have been an important coping strategy for him, as it was for other men. Later, Graham talks of his hopes to raise his son to be “*strong and positive*” (15:518), perhaps fusing notions of strength and positivity as masculine qualities that he would like to pass on.

3.1.3. Re-Constructing ‘Fatherhood’

Becoming a father through DC had, for many of the men, involved a gradual re-construction of their sense of ‘fatherhood’ in general and the development of a more robust self. Identification of themselves as ‘real’ dads went hand-in-hand with their increasing love for their DC children. Joy and gratitude co-existed alongside ambivalence and recurring grief for the loss of the imagined genetic family.

Jed described the need to “*grieve for your own loss*” (16:618) before embarking on “*building a family*” He spoke of the importance of his own genetic heritage in making him who he was but expressed a need to relinquish this so as not to pass on a: “*sense of loss to my daughters*” (4:137).

Some of the men talked about their drive to be involved in ‘making the baby’ in other ways. This seemed particularly true for Dylan, who was heavily involved at each step of the IVF process. He described:

Dylan: giving injections and stuff like that. It was kind of exciting when we were in the middle of doing it....um and the kind of physicality of having to give Leila an injection and stuff [mimes thrusting injection] it was kind of like: “it’s happening!” (18:626)

His thrusting gesture and enthusiastic tone indicated something exciting, comparable to sexual intercourse, about administering hormone drugs to his partner. Making a spreadsheet to select the donor became a nightly, shared activity that helped him feel involved in the process. Although the amount of their involvement varied, all the men described being involved in the selection of a donor.

The decision to pursue DC treatment and subsequently become a father via this route seemed to result in a re-construction of their sense of what it meant to be a ‘father’. There emerged a greater focus on being a “*daddy on the ground*” (Jed, 15:589) rather than the ‘doing’ of the act that causes a child to be conceived.

At the beginning of the interview Josh referred to parenthood as:

Josh: that’s something I wanted to do or rather wanted to be. (1:10-11)

His correction from “do” to “be” is perhaps illustrative of this active shift in what constitutes fatherhood. He later says:

Josh: That’s actually not being a father just because you’ve gone out there and given your sperm, that’s not...that just proves that you can do the act or whatever. Being a father is picking them up

from school, feeding them. Just being there. That's being a father isn't it? (22:845-851)

I felt that the question posed at the end of the second extract acted as a way of seeking my approval for this construction. Relevantly for Josh, his own father had been absent during his childhood, possibly explaining the importance he placed on being present in his children's daily lives and formative years.

All of the men listed activities they thought fatherhood entailed including telling children to “*put their shoes on*” (Graham, 20:707) or “*teach[ing] him how to say hello*”. (Gary, 31:1023). Jed refers to how:

Jed: genetically they may not be linked to me but I'm their daddy and “go to bed now” (24:923-924)

All of the men, other than Sam, whose baby had not yet been born, described the joy of having a “*brilliant*” and “*normal*” family life. Gary, William and Josh spoke of their children as the ones they were ‘meant’ to have. William and Gary maintained they would not change their infertility as:

Gary: if we had had our own children, we wouldn't have Tommy (6:175)

All the men, except Dave, expressed simultaneous feelings of joy and gratitude for the family they had attained alongside ambivalence and recurring grief over losing their biological, imagined family.

Graham: the way we think about that, um erm is grateful, relieved grateful, happy, [...] that's how we generally felt about it...but initially it's quite hard to use the word donor.

Amy: Why do you think that was hard for you at that point?

Graham: I think because it was a lot of rawness still that you carry around” (25:885-898)

The metaphor of a “*raw*” wound was used both by Dylan and Graham. The extract suggests that even once ‘fatherhood’ had been achieved, the enduring loss of infertility is held onto and recurs. Graham spoke of his alarm and discomfort when his wife unexpectedly brought the donor into conversations, or

offered tributes to him in significant moments, such as mentioning him on father's day.

3.2. The Safety of Silence; the Triumph of Talk

The men in the study all made reference to ways in which they felt silenced by society, clinics, family, friends and sometimes partners. For some silence felt like a hiding place, while others wanted to talk but felt that their efforts to disclose fell on 'deaf ears'. There was a ubiquitous fear that telling their children about their DC origins might at some point lead to rejection. Nonetheless, all believed it was important and better to be open and honest. Some had found relief through talking with friends, family, support groups or through therapy. Their opinions differed over to whom it was appropriate to disclose the DC, raising the question 'whose business is this?'.

3.2.1. Silent and Silenced

Some of the men spoke of their difficulty in talking about both infertility and the DC.

Sam referred to a social conspiracy, whereby "*the system is set up [...] as women being the problem*" (34:1158) in order to conceal and protect men. He suggests that this "*makes it easier for men to back out*" (34:1170).

Many of the men commented on how female-centric clinics, where only their wives were the named patients, left them feeling excluded and an unnecessary piece of the "*puzzle*" (Sam, 25:985).

Graham: the consultant writes to your partner, the consultant writes to my wife. And I'm actually admitted to the clinic under her name [...] You don't ever get referred as a man. (8:278)

As in Section 3.1.1., Graham, in the first line, shifts between speaking in the second person to the first, claiming ownership of the experience but also commenting on a practice that he thinks is unjust and silencing of men in general. By contrast, he also suggests that it might be a welcome and safe hiding place for some men, who:

Graham: ... probably quite like sitting in the waiting room and it being under the wife's name (9:307)

Josh commented on how some medical professionals encouraged him to keep the DC a secret:

Josh: "If I were you I would have this procedure then forget it ever happened" (25:947)

William, who worked in journalism, described how scarce and skewed the media coverage of MFI and DC was. He thought this contributed to a lack of public understanding and exacerbated men's feelings of isolation.

William: male infertility is relatively sort of um obscure and rare in its coverage, in being talked about (23:805)

Both Sam and Josh described difficulties in being able to express and share their experiences of both infertility and DC to friends and family. They spoke of indirect ways they had disclosed to friends and how this had not been heard.

Sam experienced particular difficulty in gaining emotional support from male friends who encouraged him to "keep that to [him]self" (21:717). He explained:

Sam: Yasmin did a cycle ride, [...] to raise money for the National Gamete Trust um and [...] this is again an insight into the way that men deal with the situation, everybody knows why she did that, it was really obvious, [...] but whenever we met up with blokes in particular they would ask about the bike ride, "how's the bike ride", which is a way of asking, how is the fertility treatment going basically (23:802-813)

Josh: [I] put this play on [...] and friends came along and saw it and I kind of thought [...], it was me coming out to everybody [laughs] but then loads of people didn't think "that's Josh". (20:774-780)

He described how difficult he found it to tell even close friends, lest they would "reject [...] or [...] think badly of [him]" (21:974).

Gary identified discourses dissuading men from talking about emotion appearing in adolescence:

Gary: 14 year old at an all boy's school [laughs] never say that sort of thing, no, you probably wouldn't have a little shoulder, it would be "oh there he is" [laughs] no I definitely didn't [...] you would have been called "Jaffa" you know, seedless sort of thing [...] People never really spoke at school like that anyway you know you talk about football (16:510-529)

From adolescence, Gary seemed to have internalised a narrative that boys talk about football not feelings, and a belief that male friends would ridicule him and not offer support. He cut short the saying 'a shoulder (to cry on)' perhaps symbolising his continuing difficulty with showing or talking about vulnerability.

I sensed great internal conflict for Gary. On one hand was his desire to be open and a belief that keeping it "*all bottled up*" (26:873") could lead him to feeling "*bitter*" (6:173). On the other hand he found it difficult to talk. Gary was the only father who had not yet made a firm decision to tell his son about his DC origins. He worried that the disclosure would damage the emerging and developing bond between them and had an urge to maintain the illusion that he was his son's biological father.

Gary: I'd feel really heartbroken if I have to say "you're not mine" as such. "you are mine, but you're not mine" it's, it's total opposites, you know very difficult (22:712)

He seemed uncertain about whether he felt he could claim his son as his own. His use of the word "*if*", suggested his indecision over whether to disclose. The words "*have to*" implied it was something he would feel forced into. His anguish over this conflict is vividly portrayed, and may also reflect his experience of a step-mother who had treated him "*differently*" (19:618) from her biological children.

3.2.2. Finding a Voice

All of the men described the dangers of secrecy and of suppressing emotions - for themselves, their families and for other men experiencing MFI and DC. All the men spoke of the benefits of talking in spite of the initial trepidation of doing so. They suggested that talking and openness had helped them come to terms with their infertility and DC, and helped repair their damaged sense of self.

Dylan spoke of talking as painful but reparative:

Dylan: I just didn't want to have to talk about it, just [pause] cos it reminded me of...that it was real I suppose [pause] um and I suppose that it was probably talking to Leila that you, as time goes on, you feel a little bit less [pause] like it's a raw wound kind of thing...maybe you grieve a little bit and then it becomes something you are naturally more comfortable talking about (11:381-393)

In the extract above, Dylan repeatedly stopped short of using the word 'infertility', suggesting that this is still processing. His omissions and substitutions with "it" indicated that he may still have difficulty talking about it. Dylan created distance from the painfulness of the experience by shifting from the first person "I" to the second person "you", making the process feel less personal and more universal.

All the men described the benefits of being given space to talk. Throughout the interview William repeatedly spoke of the value of being offered an "*emotional sounding board*" (18:643) by friends, family and counsellors.

Infertility and DC support groups also provided the opportunity to hear other men's voices and experiences. This helped to "*normalise*" (Dave, 27:785) their experiences and reduce the sense of stigma.

Dave: that's been massively helpful, [...] obviously met people who were thinking about doing it you know, just random, just normal people that were doing it and you know it wasn't anything weird if you know what I mean [...] I just think it is great that er they're out there banging the drum and normalising it a little bit. (27:772-788)

Dave's use of words like "*random*" and "*normal*" demonstrated his relief to me and himself that by association, neither his family nor what they were doing was abnormal or aberrant.

Sam and William both spoke of the value of talking to counsellors who were independent from the tangled emotional relationships in their families and social networks:

Sam: There was no way we could we could have got, gone down this road without that support and without just getting all of this stuff

out, all these...all the emotion, all the guilt, all the [pause] stress, all the anger, and um you can't do that with friends [pause] or family [...] the last thing I wanted was for someone to turn round and tell me it would be all okay [pause] it wasn't okay. (17:557-563)

For Sam, talking to the counsellor acted as a vent for releasing painful feelings, enabling movement and growth. At the point of discovering his infertility he particularly valued having a space to talk and work things out for himself, in an arena free from guilt and without practical suggestions or false reassurance.

Jed, Sam, Dave and Josh spoke of the importance of 'breaking the silence' around MFI and DC at wider societal levels in order to reduce stigma and increase public awareness. These men engaged in and advocated social action as an active attempt to gain some mastery over their experiences, reaching out to "help dads who are going through this" (Sam, 28:955).

Jed: I have actually published a small piece about some of the controversies that come up, you know about evaluating reactions to it (26:1033-1040)

This activity may also have been a way of intellectualising distress to create emotional distance. Sam and Jed explicitly noted the desire to enable a more open and public debate about male infertility and DC as their primary motivation for volunteering in the current study:

Sam: I would much rather a very open and honest conversation about men's health happened more um which is why when I found out about what you were doing I thought it was amazing. (14:470-474)

3.2.3. Whose Business is it?

Another recurring theme centred on *who* was told about the infertility and DC and how this was negotiated. This included decisions around disclosure and discussion with their DC children.

Complexity arose when trying to decide the 'right' time to tell their children about their DC origins. Though the men wanted to tell their children as early as possible, weaving it into their story, they felt a need and urge to 'protect' their

children from conversations around reproduction, sex and the uncomfortable topics of the 'birds and the bees'.

Dave: he was probably about 18 months [pause] erm so it, [pause] that's a little bit weird, cos it contains [pause] it contains words like sperm and stuff which you do think like if somebody random came into my house they'd think, "what are these people teaching their children?" (18:505-512)

Dave seems mindful of an imagined judgemental gaze that others may cast on him. He felt tension between trying to do the right thing by his son and a worry that the conversations he was initiating might be perceived as inappropriate.

William too spoke of his uncertainty about the 'right' time to tell his children:

William: I think we just have to sort of choose our moment really [...] when they're old enough to realise what we are telling them but not so old that they're like "why didn't you tell me earlier?" (13:453-454).

The need to identify the ideal time suggested that telling was imagined to create potential challenges and negative responses.

Josh spoke of how his children were making sense of the information:

Josh: they're kind of like growing into it, the older they get. I can remember actually this book [...] it was all about this girl [...] I read it to my two boys and Zack, my eldest, got it, he really understood it. Chris went "what do you mean they haven't got the same jeans? [...] why would they be wearing the same jeans?" Took it very literal and fell asleep. Zack and I burst into tears and then we had, then we had just a really really lovely moment cos he was sort of understanding. (19:719-737)

For Josh, his son's realisation did not signal rejection, but an intense moment of closeness. The humour in his account of Chris's misunderstanding, juxtaposed with the poignancy of Zack's sobering realisation, perhaps highlighting the different relationship he has with each of them. This mirrored Josh's description of feeling increasingly attached to his boys as they got older.

Dylan, Dave and Jed spoke about who they thought had 'rights' over this information and the sharing of it. Dylan noted that there was a point in which he and his partner had to relinquish control of the information, which became the property of their children:

Dylan: I guess at some point the information stops being ours and starts being theirs (28:961-963)

Many of the men spoke about who 'deserved' to know, suggesting there was a filtering process in how the information was shared:

Dave: they're not important enough in my life that they need to know [...] I don't feel anybody has a kind of right to know this (16:460)

All of the men, other than William and Josh used variations on the phrase: "*it's private, not secret*". This gave me the impression that whilst men believed it was appropriate to talk about the DC, there were limits to what, when, where and to whom disclosure should take place. The men did not elaborate on the parameters of this or how this issue was negotiated with their partners.

3.3. The Strangers in My Family

This super-ordinate theme refers to the men's experiences of the DC process and the various ways in which this involved 'strangers' intruding into their lives. These included: the medical and counselling professionals who were seen to act as creators or barriers to them becoming parents; and the spectre of the donor who had entered their family lives at the point of conception, along with imagined half siblings from the same sperm donor. These were feared entering their lives and enticing their child away. The lifting of donor anonymity added another layer of complexity to this process. Other intrusions came in the form of conscious and unconscious phantasies of the different 'fathers' they perceived and related to in their child.

3.3.1. "Social Services for Foetuses"

Several of the men experienced the compulsory pre-DC counselling session as more akin to an "*examination*" (Gary, 28:949), rating their suitability to "*go ahead*

and have a family" (Graham, 40:1423). They described the experiences as a "hurdle" to get past, rather than a supportive space to consider hopes and concerns.

Dylan: It wasn't framed in that way, it was actually framed as "come and talk to us". And I went: right this is an exam; we need to prep for this [...] It just comes across as a bit like social services for foetuses (34:1169-1194)

Dylan's lack of trust in the offer of a supportive space was very clear.

The necessity to involve medical and counselling professionals in the building of their family was also noted as an intrusion. Whilst many of the men expressed gratitude for their intervention, some nonetheless found it uncomfortable:

Dave: Thinking about somebody else's sperms being um [pause] um put...then not massively weird [we both smile] [pause] yeah not something that you want to do every day, let's put it like that, but it's done in a very clinical environment er and so that helps yeah, I think that helps. It's like you're going for some like kind of procedure, so that helps definitely (10:288-297)

Dave stammered at the start of the extract, perhaps implying his unease at talking about the method of conception. The repetition of "helps" suggests it may have been disturbing to witness the procedure. He emphasized how the clinical environment and medicalization worked to disembodify the male donor and de-sexualise the experience.

Jed also described gratitude for the clinical environment that created personal and emotional distance and made the process more bearable:

Jed: there was a male doctor involved in the fertility treatments, what did I think about that? You know...to cut right down to it, here is this guy who is going to get my wife pregnant and I'm not you know? [it] is very clinical very professional, and there are times that you want that distance, you want that to be...it wasn't impersonal but you want it to be very...this is professional this is a procedure, this is what we do (31:1219-1235)

Earlier in the interview, Jed had talked about his sense of failure in being unable to fulfil his duty as a man in continuing on the family line. It seemed as though the point

of artificial insemination acted as an uncomfortable reminder of what he had been unable to do, and a repeated attack on his sense of masculine pride.

3.3.2. Strangers who Lurk in the Shadows

The donor and any other half-siblings that might have been born into other families from the same sperm donor were imagined in the faces of strangers on the street.

The lifting of donor anonymity meant that the chance for both the donors and any half siblings to gain contact and literally, rather than just symbolically, enter into their family, becomes a very real possibility. For the majority of the men this represented a source of threat. Some were able to be more welcoming of the possibility.

All of the men, excluding Dylan, expressed ambivalence towards the donor, with an implicit fear that the man who generously gave them their family, could, at some point, steal it away.

William: They have to [...] abstain, [...] it is a very [...] conscious decision to make and now that anonymity is lifted you know, they have to be aware that in 18 years time you might get a knock on the door saying hello, [...] I'm your genetic offspring, so it's not, it's not a small thing to do. So I um am full of admiration for anyone who would do that and I...feel you know nothing but sort of um gratitude, I suppose, in that uh, he has enabled me to have a family, but that's tempered, I suppose that's tempered by a slight, not...a wariness I suppose. I am aware of the fact that Jack and Lily might want to go and track him down and I don't know quite how I would feel about that. (31:1097-1118)

Through the process of DC, William's construction of the imagined donor and his motives for donating shifted. From the fantasy of the "student" who would "*hop down to the clinic for a quid and then off they go*" (31:1092) to a person whose actions are considered and motivations altruistic. The emphasis he put on the words "full", "nothing" and "gratitude", rings a note of enforced positivity and contrast to the more tentative language towards the end of the extract. This

suggested his ambivalence towards the donor, of simultaneous gratitude and envy.

The donor is constructed by Jed as an unfamiliar outsider who has the potential to enter into and meddle in his family life.

*Jed: we don't want some stranger interfering with our parenting
(23:882)*

Josh recognises that although he would prefer the donor to vanish from his and his son's lives, he recognised that this is not possible and acknowledged they will always be curious about him, as he is about his own, unknown father.

Josh: I was really glad for this guy just to give his sperm, go off and never ever be anything to do with us ever again and that's not actually the reality I don't think. (15:559-561)

Dylan aside, all the men described their latent fear and expectation that at some point, probably in adolescence, their DC child would reject them:

Gary: if you were having an argument you know and then he would say "you're not my real daddy" sort of thing and that would be awful [...] that's the number one isn't it, then you just have to walk out there...But that's looking at arguments when he's 14, 15, 16, [...] that's when it all comes out (22: 732-746)

I thought it relevant that Gary's fantasy was that his son would reject him in early adolescence, around the age of fourteen. This was, perhaps not coincidentally, also the time that Gary's un-descended testes were identified, leading to a set of procedures and decisions made by his step-mother which Gary remembers vividly and unfavourably. He also described feeling developmentally immature compared to his peers at this time. A combination of these factors may have led Gary to feeling a sense of powerless 'im-potence' aged fourteen. I wondered if Gary imagined his son becoming the 'omni-potent' adolescent he had not been himself, and thus a more rejecting and potentially threatening character.

Some of the men described a hyper-awareness of the appearance of other children around the same age, who they imagined might be related to their child and therefore a potential extension to their own family.

Graham: “we’ll be at the swimming pool or in the queue at Tesco’s and another sort of 6 year old is running around and he is the spitting image of Peter [sighs] and you think it’s a slim chance, but you do see some children, and there is something about them [...] we were at the museum yesterday and this child, and I almost walked up behind, to say “Peter”. Completely different clothes and everything, but the face, oh [sighs] oh! That could be a sibling.” (32:1131-1142)

Clearly thoughts about the donor and possible half siblings are frequently brought to mind in everyday situations. Graham described the repeated shock of seeing his child in the faces of strangers everywhere he goes. The difficulty of this is expressed through his sighs and exclamations “oh! oh”.

For Sam the situation was different. He noted a “*real difficulty with the anonymous donor*” (7:226) idea, as they represented shadowy strangers in his mind. It was partly because of his discomfort with selecting an unknown donor that he selected his brother. Consequently, this raised a different concern:

Sam: what if the kid runs [...] up to my brother and [goes] “you’re my daddy” (25:852).

Whilst selecting his brother as the donor increased the possibility that Sam and the DC child would share physical characteristics and a genetic line, he worried that this may lead to a blurring of roles and a painful sense of rejection if his brother were to be perceived as the ‘real’ father.

3.3.3. The ‘Father’ in My Child

This sub-ordinate theme refers to the different ‘fathers’ who were consciously and unconsciously fantasized and perceived within the donor-conceived child: the donor; the recipient father; the recipients’ father; and the sense of the adult man in their child. These were particularly evident in the men’s relationships with their DC sons, and seemed to affect their initial bonding.

A theme that felt present in many of the men’s accounts, particularly those with a DC son, were the fantasies of an imagined man, (i.e. the donor), in their boy. Before Dylan’s twins were born he pictured his wife giving birth to two loud ‘man-boys’:

Dylan: I don't know why but I envisaged them coming about as 5 years old or you know, kind of toddlers, kind of really loud, shrieky boy toddlers, that wanted to play football and do man things (26:922-925)

Dylan had already identified repeatedly throughout the interview that he had never really felt like a “proper man” (4:120). His premonition of two boys, of Oedipal age, rather than two babies, both the product of a man who “*had demonstrated that he was successful*” (15:528), may have felt like an intimidating and emasculating prospect. He reported:

Dylan: probably going back to the whole um my growth spurt, masculinity type thing um [pause] yeah, I dunno, I never felt like...and I'm not, I'm not an alpha male kind of uber masculine kind of guy and something in my head said that if you have 2 boys you need to be that kind of guy to [...] be a role model for them, (27:934-940)

He also worried that he would not be able to meet their masculine needs and might fail to gain their respect. Nonetheless, Dylan described his relief upon the realisation that his baby son was in fact tiny and totally dependent.

William noted the discrepancy between the ease with which he bonded with his daughter compared with his son. His son seemed to more clearly represent the donor, the man who had successfully impregnated his wife, thus was a painful reminder of what he hadn't been able to achieve, and a representation of a more ‘virile’ and ‘successful man’.

William: she didn't bond with Lily immediately whilst I did. [...] as soon as I picked her up I was you know, completely smitten with her and remain so [we laugh] [...]. So um and then with Jack [...] as soon as Jack was born, Claire was completely over the moon and was overjoyed. And I was overjoyed too [tut], but it's been less, it's been less, it's taken me longer to bond with him, and it's getting easier cos he's started smiling and cooing and all that malarkey but I suppose I look down at Jack and I do see, I see the donor which I find, I find, I find, I'm [stutter] finding harder than I thought I would find [pause] basically. (29:1031-1043)

William shared this towards the end of the interview, after subtle hints that bonding had been more difficult with Jack. The fondness and fluency with which

he spoke about Lily is juxtaposed with the difficulty of talking about Jack. He begins this extract by highlighting his wife's trouble in bonding with their daughter, perhaps serving to normalise his guilt. William struggled to speak about his ambivalent feelings towards his son, which felt scary and uncomfortably exposing. His stuttering and halting speech accentuated how difficult it was to say out loud. This was followed by a pause and then the word "basically", suggesting that he had managed to get out essentially what he may have been guiltily nursing. The spectre of the unsmiling face of the donor in his new-born son was clearly very unsettling for William. William's attachment and ability to bond with his son developed when he started smiling and engaging with his dad.

Throughout Josh's interview I noted that the imagined father in his sons seemed to shift through time from a blurring with his own father, the donor, and eventually himself. In the first extract Josh described his genetic father, who left when he was three:

Josh: [I] think he's got 5 other children from what I gather. He had his first child when he was 14 (15:583-584)

Josh's biological father has the same mystique as the donor, who may himself also have many other children. Josh reported him as having many children and as having started early in adolescence, suggesting he imagines him to be a highly 'fertile', 'omni-potent' man, unlike his own perception of having failed in these ways.

Josh: I knew I wanted to have a parent...I wanted to be a parent, but I didn't know, when our children were going to be born, how I would feel and actually when Zack, my eldest son, was born, I felt nothing for him at all; I felt no emotional attachment to this child at all. That scared me. [...] I think because Zack was 9 pounds 12 and he was a really big baby. Tanya, tried to have a natural birth at home and he was just too big to come out and so he had to come out through the sun roof! (11:411-428)

The slip on the first line perhaps unconsciously reveals his own desire to have a present father. The emphasis on Zack's size conjured an image of a large, strong, unmanageable, 'imposter' who was 'violating' his wife's body. Josh

seemed to experience his baby son as a threatening intruder in his family with whom he had difficulty bonding.

This feeling of initial coldness and lack of early attachment to the baby was echoed in the interviews with Dave and William. Josh later goes on to talk about how their relationship grew:

Josh: we're both Virgo and actually we're incredibly alike, incredibly alike, we really are, and you know clearly not genetically linked, obviously but we're like, we're just slightly soul-mates, you know the way we think, the way we....so maybe it's sort of discovering him, discovering about him (13:482)

Josh emphasizes how very similar he and his son are and how they are becoming 'soul-mates'. Josh is beginning to see Zack as a person in his own right, but also, perhaps, to notice the emergence of his own personality mirrored in him.

Gary and Dave also described their gradual and "slow burning" (Dave, 21:611) love for their child, which "has just sort of grown as they get older" (Dave, 22:644). They too spoke about seeing aspects of themselves as fathers beginning to emerge in their sons. Dave explained his pleasure in noticing physical similarities between his child and his own family.

Dave: It's nice, like for example, I've got really really brown eyes and Nick my first born has, and my mum has (12:340)

All of the men described an attempt to find a donor who shared similar characteristics with them. This may have been, in part, an attempt to encourage bonding. Gary explained:

Gary: cos when they were trying to match me with another donor, you know he's a really good looking boy and we're really happy, also something that people, as he was young, it was like "oh well he looks exactly like you" [...] I think even if it's normal children with both parents, the son or daughter looks like the father, and the father thinks "oh that's great, it's definitely mine" and gives you more chance to [pause] bond with the child. (6:200-210)

The thought that they had been successful in finding Gary's 'doppelgänger' in the sperm donor seemed to permit Gary greater acceptance and claim of compliments about his son, with the implicit suggestion that his son would look similar if he were genetically related to Gary. Gary also describes the joy of noticing his own character traits beginning to be mirrored in his son:

Gary: he says "hello" to people in the park, cos I say "hello" to people, so it's a classic case of er nurture or nature (12:400)

I sensed that for Gary, as for all the men, the gradual recognition of themselves in their children led to an increased sense of attachment.

4. DISCUSSION

In this chapter the three super-ordinate and nine sub-ordinate themes will be considered in relation to how they illuminate the research questions and compare with the extant research literature. Implications for further research and clinical practice are presented and issues of quality and rigour critically reflected upon. Methodological limitations and challenges are considered, closing with my personal reflections and conclusions.

4.1. Addressing the Research Questions

The current study was interested in exploring the experiences of men who had been diagnosed as infertile before having a child through the use of DC. In the following sections, I will consider each of the research questions, contextualising the findings within the literature. Figures inserted at the start of each section highlight which of the themes identified in the results, address each question.

4.2.1. How do DC Fathers Make Sense of their Infertility?

The results suggested the men made sense of their infertility in complex and diverse ways. What was common among them was that theirs was not a static position but changed over time. Components of all three super-ordinate themes contributed to an understanding of this question.

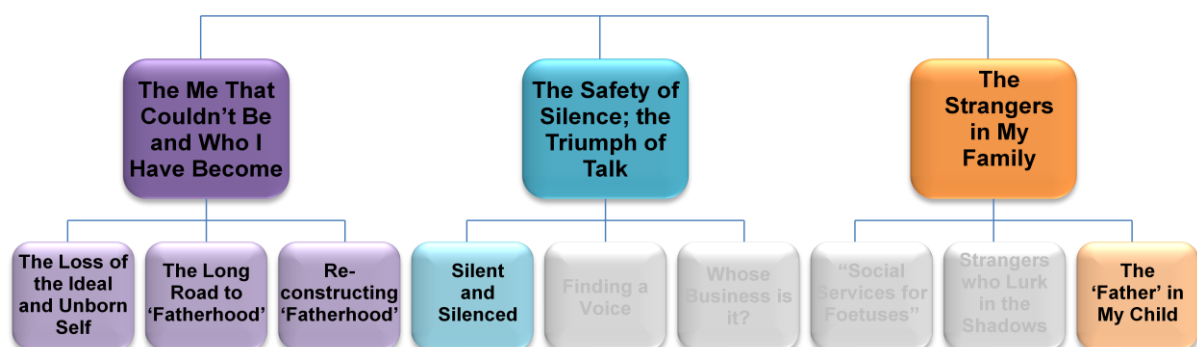


Figure 2: Super-ordinate and sub-ordinate themes relevant to how DC fathers made sense of their infertility.

For the majority of the men, the diagnosis of infertility was accompanied by an overwhelming sense of profound and multiple losses of: the imagined child they would not have; the end of their genetic line; and the idealised 'virile' self they had in their mind's eye. This was captured in the sub-ordinate theme: 'The Loss of the Ideal and Unborn Self'. These losses are what Koropatnick *et al.* (1993) refer to as 'non-event transitions'. The findings were at odds with the conclusions of Glover *et al.* (1996), who suggested that 'loss' may be a less pertinent concept for infertile men. The results supported Unruh and McGrath's (1985) 'Chronic Infertility-Specific Grief Model', where infertility was accompanied by a feeling of multiple, recurring losses.

In line with research, (Crawshaw, 2011; Inhorn & Birenbaum-Carmeli, 2010) most of the men felt the discovery an attack on their sense of being a 'complete' man, to a greater or lesser extent. Some had internalised social discourses conflating 'masculinity' and fertility, akin to that discussed by Gannon *et al.* (2004) leading the men to feel isolated and stigmatised. This was represented in sub-ordinate themes: 'Loss of the Ideal and Unborn Self' and 'Silent and Silenced'. Many described feeling they had failed in one of their primary goals as a man: to impregnate their partner and continue on the genetic line and family name. Crawshaw (2011) posited that this gives rise to discordance between men's 'preferred' and 'felt' social identities. The damage to men's self-esteem and masculine identity seemed considerably less far-reaching for those who discovered their infertility in adulthood at the point of trying to start a family, than for those whose first doubts arose in adolescence or early adulthood.

The point of discovery of infertility also affected how the men made sense of, and came to terms with the reality that they would not have their own biological children. Some had experienced delays in growth and development at puberty, at a time when they were cultivating a sense of their masculine identity and comparing themselves with their peers. For these men, confirmation of infertility, later in adulthood, when they were trying to start a family, may have re-awakened anxieties about being an "incomplete" man. These men also seemed to experience a greater sense of 'threat' when anticipating particularly their sons reaching puberty, imagining they would be more 'masculine' and 'virile' than

they had themselves felt. This issue was considered in the sub-ordinate theme: 'The 'Father' in My Child'.

Almost all the men described feelings around what I understood to be, the loss of the 'unborn self'. Dawkins (1989) spoke of the importance of procreation, in the individual's attempts to continue not only the species but specifically their own genetic makeup, leading to what Applegarth (1999) suggests is a form of 'immortality'. Raphael-Leff (2003) describes the diagnosis of infertility as akin to facing "genetic extinction" (p.41).

On learning of their infertility, the majority of the men described intense feelings of 'depression', 'powerlessness', 'anger' and 'guilt', consistent with the findings of Hadley and Hanley (2011) and Peterson *et al.* (2007). For some of the men, infertility had stirred existential questions about the meaning of life, provoking a heightened awareness of their own mortality. Importantly two men had questioned the point of 'going on' and described having had suicidal ideation. These feelings no longer seemed to be present at the time of interview. Alongside their low mood, thoughts about suicide may have represented a desire to re-gain control over their lives, whilst also representing a symbolic feeling of deathliness. Notably, it seemed these men particularly valued being in control. Lester and Yang (1992) reported a significant correlation between infertility and suicide rates in men aged between twenty-five and forty-four.

Smith *et al.* (2009) reported that the diagnosis of infertility and subsequent treatments impacted negatively on couples' sexual relationships. In this research men referred to the strain on their couple relationship, but did not discuss their sexual relationships. Consistent with the men in Hadley and Hanley's (2011) study, and contrary to Miall's (1994) findings, that women wanted children more than men, all the men described how they had always wanted to be a father. Research presented by Hadley at the British Sociological Association in London (April, 2013) indicated that men may be just as psychologically distressed by childlessness as women.

Each of the men described a process of gradually 'coming to terms' with their diagnosis of infertility. Diagnosis marked the beginning of a journey towards the

desired destination of fatherhood, but along a road they had neither anticipated nor wanted. The men described how they had held an image of their imagined futures and the 'milestones' they hoped they would reach, similar to those described by Nowoweiski (2012). The men recounted how the discovery of infertility had forced them to re-evaluate their expected life-journeys. This finding seemed consistent with the work of Carter and McGoldrick (1980), who suggested that the disrupted 'normal' family lifecycle results in psychological challenges and a need to adapt and readjust. There was an oscillation for all the men, though to differing degrees, between this being considered a solitary and lonely journey, which no one else could share or understand, and feeling that they were on a joint road where the losses and challenges were shared with their partner and decisions made together. What seemed present, however, was a sense of the men's developing mastery over this perceived adversity. As they made sense of and came to terms with their infertility, they re-constructed their ideas around what 'fatherhood' both meant and entailed, depicted in the sub-ordinate theme: 'Re-constructing 'Fatherhood''. Many described a simultaneous love and appreciation for the family that had been created and recurring loss for the genetic family that would not be, finding themselves in the seemingly oxymoronic position of being an 'infertile-parent'.

4.2.2. What are the Experiences of Men Becoming Fathers Through DC?

Aspects of all three super-ordinate themes addressed different facets of the men's experiences of becoming fathers through DC.

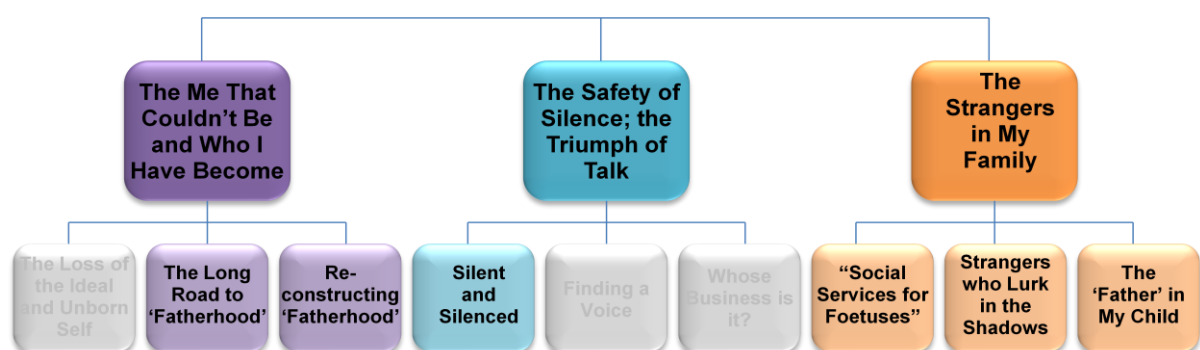


Figure 3: Super-ordinate and sub-ordinate themes relevant to the experience of men becoming fathers through DC

The men spoke of the need to relinquish their goal of biological parenthood before moving onto and embracing their role as DC fathers. As the men went down the road of DC, many consciously or unconsciously seemed to re-define their ideas about what it meant to be a 'father'. This is depicted in the subordinate theme: 'Re-constructing Fatherhood'. They moved from a position of wanting to create a baby with their own genes to an understanding of the importance of creating the 'person'; differentiating the 'doing' of the act of conception from the 'being' of the "daddy on the ground". As one man poignantly stated: "it takes a second to be a father, but a lifetime to be a daddy". There is substantial evidence that greater paternal involvement in childrearing is associated with benefits in cognitive, social and emotional development (Lamb, 2004). All the men were involved in some way with 'making the baby', whether through choosing a donor, administering hormone injections, or attending medical appointments as well as the birth. It seemed as though greater involvement acted as an important way for the men to enhance the ease of bonding with their child. In her paper, Ehrensaft (2000, p.390) describes how: "as we watch sperm transformed into men and men reduced to sperm, we witness both the construction and the destruction of the father". As the bond with their children grew and they began to see themselves reflected in their child's demeanour, so the imagined face and presence of the donor somewhat receded.

Despite the long and challenging journey to fatherhood, all the men spoke of their joy and relief at having a child and a family life which felt 'normal'. Some of the men referred to the feeling that they could not imagine loving or wanting biological children more than the children they had.

An apparently novel and unanticipated finding was the discrepancy between how the men experienced having a DC son as opposed to a daughter. For all but one of the seven men with sons, direct and indirect references suggested the bond and love for their sons took time to develop. For some, the idea of having a DC son felt a threat to their masculine identity. A few held fantasies that sons would be born as boisterous, 'omni-potent' and excessively masculine, and seemed to be concerned that they would not be a good enough 'role model'

as a father. They also seemed more aware of the presence of the donor in their sons, and this may have acted as a reminder of their own perceived 'inadequacies' as a man. It was not possible to identify literature that examined child-gender influence within DC families. However studies of child-gender preferences in naturally-conceived families suggest that men tend to 'favour' sons (Dahl & Moretti, 2008; Goldberg, 2009) and spend more time with sons than daughters (Manlove & Vernon-Feagans, 2002; Raley & Bianchi, 2006). Raley and Bianchi's (2006) review of literature examining child-gender preference suggests that many parents believe "fathers have special knowledge to impart to sons (e.g. how to be a man)" (p.408). Williamson, (1976) posits that this may be due to the desire for men to continue the family name through the son or a belief that having a son is a greater demonstration of masculinity. If one was to follow Williamson's argument, this presumably has implications for men who are not biologically related to their sons, where the presence of a son may be perceived as a signifier of greater 'masculinity' in the donor.

Importantly though, fathers' relationships with their children, particularly their sons, seemed to grow and improve as their child grew older, and the fathers began recognising in them their own character traits.

Golombok *et al.* (1996) carried out a pan-European study of family functioning and child development in families created by ART, including DC and IVF. They found that mothers of children conceived through ART showed greater warmth, emotional involvement and interacted more with their children than mothers whose children were conceived naturally. It is a common finding that men in naturally-conceived families can feel excluded from the intimate early mother-baby dyad (Fägerskiöld, 2008). There was no way of confirming or disconfirming whether the DC mothers had a particularly close bond with their children, but if they did, this might further exacerbate the men's feelings of exclusion.

In the men's accounts there seemed to be a 'flashbulb' memory of the moment of discovery of infertility, followed by a period of hazy 'inertia' where they felt they were 'drifting along'. There was a sense from the men that, in the majority of the cases, their female partners took the wheel in pursuing DC, and the men, initially reluctant, followed passively behind. This is in keeping with Blaser *et al.*'s

(1988) findings that in most instances, DC is initiated by the female partner. Despite the initial reticence of some men in this study to undergo DC, they all commented that they were pleased that the decision had been made and did not regret it.

4.2.3. What are DC Fathers' Experiences of Disclosing and Talking about MFI and DC to their Child, Family, Friends and Professionals?

The men's experiences of disclosing and discussing both the MFI and the DC were varied and highlighted a number of challenges. The super-ordinate themes: 'The Safety of Silence; the Triumph of Talk' and 'The Strangers in My Family', illuminated these.

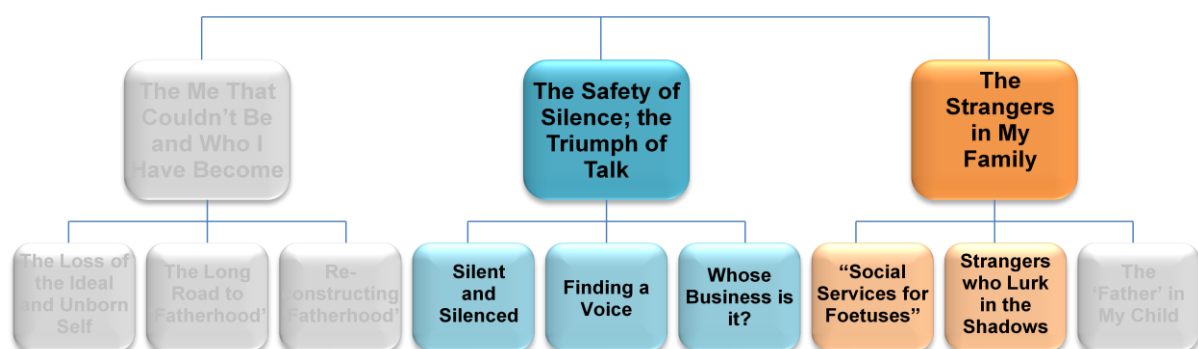


Figure 3: Super-ordinate and sub-ordinate themes relevant to DC fathers' experiences of telling and talking

Present in all the men's accounts was their initial sense that MFI and DC were 'rare' and 'abnormal', as they were seldom spoken about in public discourse. In line with Lee (2003) and Gannon *et al.* (2004), this may lead to increased feelings of shame and stigma and the belief that these are not issues to be discussed publically. This silencing worked to heighten men's senses of "isolation and desolation" (Lee, 2003, p.73). The super-ordinate theme: 'The Safety of Silence; the Triumph of Talk' illustrates that although talking had at times been painful and daunting, the men felt they had benefitted from having an emotional "sounding-board". Talking to: their child; their friends and family;

and professionals, including support groups, raised different challenges and are considered in turn.

4.2.3.1 Telling Their Child

All the men in the current study thought it was important for men to disclose and discuss the DC with their children, at least in principle. Only one man was still deliberating over whether or not they were going to tell, fearing it could irreparably change the family dynamics and his relationship with his child, as found by Feingold (2011). The high rate of intention to disclose in this sample may reflect an internalisation of more recent social narratives, advocating disclosure and discussion within families (Montuschi, 2006). Freeman *et al.* (2009), found evidence that more DC parents were disclosing to their children yet Golombok *et al.* (2011) suggested it still remains more common for DC parents to withhold the information about DC from their children. This research does not support the latter finding, though this may reflect a sampling bias, with men who were, by virtue of volunteering, more willing to talk.

In line with MacDougall *et al.*'s (2007) research, the men and their partners chose a mixture of disclosure strategies. Most had employed a 'seed-planting' approach, whereby they used storytelling to begin informing their children while they were pre-verbal, so that they 'always knew'. Others opted for a 'right-time' strategy, waiting until they felt their children were old enough to understand the information, but young enough that they did not feel they were 'keeping it' from them. There was anxiety around telling, regardless of the method chosen.

Parents who selected the 'seed-planting' strategy felt uncomfortable about talking about the 'birds and the bees' when their children were so young, and imagined that others would look unfavourably upon them for doing so.

Consistent with the existing research, all of the men feared that at some point, their children would use the information to reject them, claiming: 'you're not my real daddy' (Feingold, 2011; Hunter *et al.* 2000; Rumball & Adair, 1999). It could be argued that the lifting of donor anonymity added another layer of complexity to the men's choice about whether and when to tell their children about their DC origins. The theme: 'Strangers who Lurk in the Shadows' encapsulates the worry that the donor may at some point enter into their family. Many of the men

feared their children might want to seek the donor out, or that half-siblings might make contact. This undoubtedly increased the men's anxiety about telling. However, consistent with MacDougall *et al.*'s (2007) study, despite men's initial anxiety about disclosure, those who had told, all felt they had made the right choice and were relieved it had been done. Some felt increasing the amount the DC was discussed in their family actually reduced the chance that it may be used against them in the future.

4.2.3.2. *Talking with friends and family*

With regard to talking with friends and family men described initial anxiety, particularly around conversations with male friends from whom they feared humiliation or rejection. Disclosure to friends and family was often attempted but the men described sometimes feeling dismissed and discouraged from talking about their experiences and left alone with their worries. The sub-ordinate theme: 'Silent and Silenced' encapsulated the conflicting experiences of wanting to talk but sometimes feeling dissuaded from doing so by society and the responses of friends and family.

Lund *et al.* (2009) suggested that men's reluctance to confide in friends may result from a lack of support when they do so. This is in keeping with the experiences of some of the men in this study. Participating in charity fundraising events for DC and writing a play about the topic were just some creative ways the men found to 'come out' about their MFI and DC. They were often dismayed that this communication seemed to fall on 'deaf ears'. Lee (2003) states: "men willing to acknowledge male infertility and to 'come out of the closet' are few and far between" (p.73). By volunteering to participate in this study, it could be suggested that this self-selecting group represent a skewed sample unrepresentative of the majority of men experiencing MFI and DC. Nevertheless, the finding that men actively sought public disclosure and private discussion is at odds with pre-existing literature, suggesting that men prefer not to talk to friends and social networks about their infertility (Hammarberg *et al.*, 2010). Of the 112 infertile men in their study, over half reported that they had not disclosed to family or friends. The men in this study all commented that more open, public debate around MFI and DC would reduce associated taboos and stigma.

Despite talking being anticipated as potentially threatening and painful, all the men found talking to supportive and non-judgemental friends and family a welcome, helpful and reparative experience. This was captured in the sub-ordinate theme: 'Finding a Voice'.

Most of the men expressed how they and their partner were in agreement over how the DC and infertility was to be discussed, both with their children and with wider social circles. All the men spoke about the differentiation between the information being 'private' but not 'secret'. This was a distinction cited in Walker and Broderick's (1999) paper, who suggested that the word 'secrecy' was too emotionally laden. Whilst distinguishing these two constructs was useful for the men, it could be argued that it resulted in ambiguity around who should know; who had already been told; who this information remained private from; and who had the right to divulge and when. This may be a confusing and conflictual issue for children as well as parents and was demonstrated within the sub-ordinate theme: 'Whose Business is it?'.

4.2.3.3. Professionals and support groups

The men had mixed experiences of talking to professional services and support groups. Many felt by being referred to under their partner's name in female-centric medical services, they were rendered silent, forgotten and an unnecessary "piece in the puzzle". This added to a sense of stigma and isolation which was congruent with Courtney's (2000) assertion that through the unequal fixation on women's health, the medical professions render men's health invisible. Men commented on their frustration in being referred to under their partner's name when attending counselling sessions at clinics. This was noted by O'Donnell (2007, p.28), who described the importance of "making room for men in infertility counselling" and not approaching men as merely the husband of the 'patient'. These issues were considered under the theme: 'Silent and Silenced'. Findings reported in 1994 by Carmeli and Birenbaum-Carmeli and in 1993 by Mason, suggested that men felt excluded and sidelined from the process of DC by medical professionals. This practice persists, despite research demonstrating its negative impact on men's well-being (Wischmann, 2013). The men in the study who perceived that medical professionals viewed them as an

'equal' partner in the treatment, seemed to then find the process of going through the DC and bonding with their DC child easier. Most of the men commented on how being involved 'at every step' helped them 'come to terms' with their infertility and DC and strengthened their relationships with their partner and child.

The men's reports on the helpfulness of counselling and psychotherapeutic input were mixed. The obligatory session of counselling prior to DC treatment was perceived by the majority in this study as an 'examination' to test their paternal capabilities. This was felt to be unhelpful and the men did not feel able to openly discuss or voice any conflicting thoughts or worries about going through the procedure, for fear that they would be deemed 'unfit'. The timing, lack of clarity about the purpose of these sessions and the location in the fertility clinic, all contributed to this being a squandered opportunity for emotionally processing their feelings. Three of the men spoke openly about knowing they needed to 'manipulate' the session to 'pass the test' and allow them access to DC treatment. Covington and Burns (2006) attributed men's reluctance to have pre-treatment counselling to stigma around mental health. It is possible that this was true for the men in this study, although this seemed less relevant than not trusting the motives of the 'counselling'. This was described in the theme: 'Social Services for Foetuses', which is how one man framed the offer of counselling.

Other men voluntarily opted for therapy as they felt they needed a third party to help them individually, or as a couple to 'work-through' some of the difficult emotions such as envy, guilt, anger and loss. Two men in particular thought the support of a therapist had been essential in order for them and their partner to continue with the DC and build a loving relationship with their child. This is in keeping with Keylor and Apfel (2010) and Raphael-Leff's (2003) assertion that supportive therapy is important for individuals and couples experiencing infertility and embarking on treatments, particularly DC.

All the men spoke of benefitting from talking to other men and families perceived as sharing similar experiences. Hearing other men speaking out and sharing their stories of MFI and DC in support groups was invaluable in allowing the men to share their own stories. Most helpfully, the groups seemed to allow for the

more difficult and ambivalent views about pursuing DC to be expressed. Stewart *et al.* (1992) and Domar *et al.* (2000) also found that support groups were successful in reducing infertility-related distress.

4.2.3.4. *Breaking the silence at the societal level*

Many of the men felt strongly that the lack of public discourse around MFI and DC served to reinforce their own feelings of stigma, shame and isolation, and desired to take social action to break to the cycle of silence; reach out in support of other men; and normalise their own experiences. Men recounted trying to achieve this through: writing plays, articles and chapters; raising money and awareness through charity events; facilitating support groups; and offering to participate in the current research study. Granello (2000) suggests that men tend to 'intellectualise' their emotional experiences. Social action and academic writing may offer a legitimate forum for this. The phenomenon of trying to gain mastery over personal experiences of adversity, trauma or discrimination by drawing public attention to the issues is widespread, often expressed through social actions such as the setting up of charities or service-user led groups like The Hearing Voices Movement (Romme & Escher, 1989); political lobbying and fundraising events.

4.2.4. The Impact of Lifting Donor Anonymity on DC Fathers' Experiences

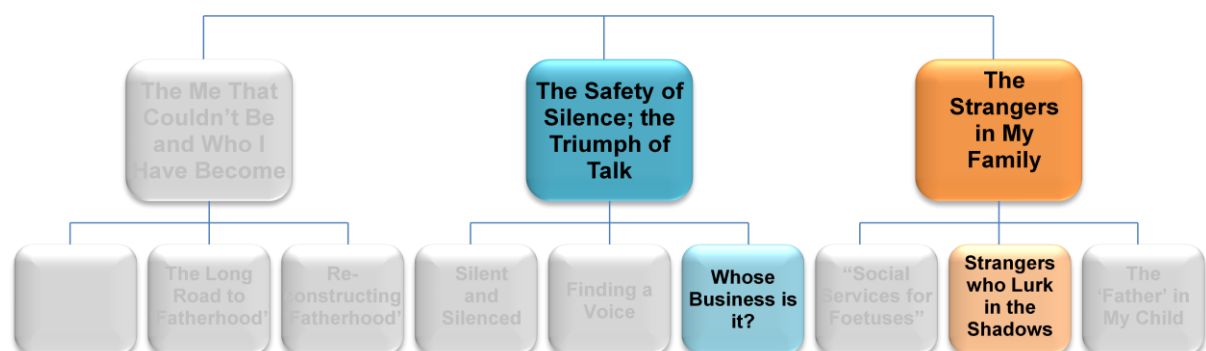


Figure 4: Super-ordinate and sub-ordinate themes relevant to the impact of lifting donor anonymity on DC fathers' experiences

The lifting of donor anonymity created the threat that the donor would enter into their own and their child's lives in a real way. The House of Commons Science and Technology Select Committee (2005) expressed concern that lifting anonymity might reduce the likelihood of disclosure to children. This research supports the findings of Blyth and Frith (2008) and Crawshaw (2008), who found no evidence that the lifting of donor anonymity had reduced parental disclosure. The men's worries about possible rejection following disclosure seemed to have been overridden by the desire for and belief in the importance of openness and honesty. Some men welcomed that their children may trace their donor and any half siblings.

An awareness of what donating entailed, such as abstinence from sexual intercourse, and the willingness of the donor to be identified, seemed to reassure the men that they were 'decent' people who had made the decision to donate thoughtfully. This seemed to matter to the men when thinking about the genetic inheritance of their children, and the possible prospect that one day, the donor could become part of their children's lives.

The men expressed feelings of profound gratitude towards the donors. This was coupled, however, with deep ambivalence. There was a sense of envy that the donor had been able to get their wife pregnant when they had not, and fearfulness that the man who had 'given' them their child could, at some point, enter into their life and be chosen by their child as their 'real' and 'preferred' father.

The lifting of donor anonymity raises the likely future identification of both the donor and any half siblings. One consequence of this seemed to be that the men in the study were preoccupied with fantasies of these as yet unknown but biologically-related strangers. This did not apply to the one participant whose donor was known to him. The other men imagined the donor as a shadowy figure, mirrored in the faces and actions of their children, and also in the appearance of other children and men encountered day-to-day. Although it is impossible to ascertain whether these men would have felt as strongly about this before the lifting of donor anonymity, it seems probable the legislative change intensified such preoccupations. There has been little exploration of the

fantasies of recipient fathers, however Keylor and Apfel (2010) did identify intrusive fantasies of the fertile donor in men who had become fathers through DC.

In spite of all the difficulties and emotional hurdles, the most enduring feeling conveyed by men of their experience of DC fatherhood was gratitude and wonder for the family they feared they would never have. With time, as their love for their child, and identity as a 'real' father grew, the DC aspect of their family seemed to fade in significance.

4.4. Implications and Recommendations

4.4.1. Implications for Clinical Practice

Becoming a parent involves difficult psychological, emotional and relationship challenges for everybody. DC parenthood undoubtedly adds additional layers of complexity.

Not all the men felt the need for therapy, but suggested they may have found it helpful if they had been unable to discuss issues with their partner or social network. For the men who had, the benefits had been striking. They expressed a preference for therapy that combined finding practical solutions with an open and supportive space to discuss feelings.

The results confirm the findings of Unruh and McGrath (1985), that 'grieving' for MFI is an ongoing and recursive challenge that is probably at its most vivid at the point of diagnosis. Men commented on the importance of recognising their feelings about infertility and 'grieving their loss' before proceeding with DC. Men will choose to do this in different ways. It would be helpful for them to have the option to access professional psychological therapy or counselling. More informal help via support groups, online forums and social media sites may offer a setting which is perceived to be less threatening. In addition, infertility clinics could usefully provide leaflets outlining some of the possible psychological reactions to MFI and signposting support agencies and other resources. Clinicians should be alerted to the powerful emotional reactions experienced by some men and for the possibility of suicidal feelings.

Many men described a period of dis-orientation and emotional numbness following diagnosis and explained that the drive for pursuing DC was often initiated by their partners. Providing opportunities for both individuals and couples to discuss and prepare for DC treatment would seem advisable. This would offer men an opportunity to voice their feelings and concerns and engage in both the decision making and treatment processes.

An interesting finding was that men often saw the obligatory pre-treatment counselling session as a 'therapy test' and found it unhelpful. The Human Fertilisation and Embryology Act (1990, 13:5) specified that "a woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment". If the pre-treatment counselling session ever influences the clinical decision to offer DC, I suggest it should be explicitly indicated in advance.

The timing, location and nature of the therapy offered all have consequences for how it is received and used. It is the recommendation of this study that counselling or therapy sessions be offered at a location separate from the fertility procedures. Many men saw the one session as tokenistic and unhelpful. I believe it may be helpful for there to be the offer of greater continuity of psychological support, not only before conception but during pregnancy, birth and early parenting. This is an area where clinical psychology has a strong role to play, in the development and delivery of perinatal psychology services for parents who seek early support. This time is increasingly being recognised as a golden opportunity for early intervention, and for strengthening parent-infant relationships, (Department of Health, 2011). Raphael-Leff (2013) concludes that where parents have not 'worked-through' and grieved for losses such as those associated with infertility, the DC child may be left with emotional trauma which she refers to as the 'presence of absence'. She cites this as another reason for the importance of offering psychological treatment.

In addition it was noted that female-centric clinics contributed to men feeling marginalised and excluded from the treatment process. Men who felt more involved throughout the DC reported benefits for them, their couple-relationship and their bonding with their child. I would recommend: identifying men as named

patients, alongside their partner; gender-neutral clinics; re-naming 'Mother and Baby' units as 'Parent and Baby units'; and providing male toilets to help empower and engage men.

For new recipient fathers, the intrusion of fantasies about the donor seemed to interfere with their early attachment to their babies. It may be helpful for clinicians to be alert to the possibility that some men may initially experience difficulty in bonding with their DC children, particularly their sons. Information should be available to couples and their GPs that low mood and difficulties in early bonding may not be uncommon. Men could be advised that they are not alone if they have these worries, and informed that they may fade as the relationship with their child develops. For the men in this study, many of these difficulties subsided once they began to recognise their own character traits in their children. Men should be encouraged to actively engage with their child to encourage this development. Workshops, support groups or counselling for new DC parents might also be helpful in addressing these concerns.

In this research, men who experienced early warnings of future infertility in adolescence, seemed to experience a greater impact on their sense of self-confidence, as compared with men for whom adult diagnosis came unexpectedly. This may indicate the value of emotional support being offered in adolescence to young people who are investigated for conditions associated with possible infertility.

All the men commented on the immense value of meeting with and talking to other men in similar situations. The DC charity offered a supportive and normalizing setting through on-line forums, support groups and meetings. It provided a community who celebrated their families. Men commented that they had had to find their own way to such networks and would have welcomed direction from medical services.

4.4.2. Recommendations for Further Research

One of the novel findings of this study was the impact of the child's gender on men's psychological experience of fatherhood and attachment. Contrary to previous findings with naturally-conceived families, men seemed to experience

having sons as a greater challenge. Further qualitative explorations with this as a focus might be beneficial. There was some suggestion that early bonding with sons improved over time. A qualitative, longitudinal study with DC fathers might elucidate whether the impact of gender differences changes with time.

Quantitative research may clarify how generalisable the findings were with regards to the impact of gender.

Experiences of death, illness and disability with DC children were touched on by two of the men in this study. There was no opportunity to explore the impact of this on the men and it may warrant further investigation.

A comparative study exploring the differences in psychological adaptation between infertile men who had become fathers via DC contrasted with fathers via adoption and where double donor gametes (egg and sperm) have been used to achieve fatherhood may also be useful.

4.5. Quality Issues: A Critical Reflection

Quality and rigour in this study will be considered in relation to guidelines set out by Smith (2011) and Yardley (2000) for assessing qualitative research and IPA in particular.

4.5.1. The Paper Should Have a Clear Focus

Smith (2011) recommends research questions and the lens of investigation focus on a particular aspect of the experience rather than a “broad reconnaissance” (p.24). The research questions covered four inter-linked areas of the experience of DC fatherhood: infertility; becoming a DC father; telling and talking; and the impact of the lifting of donor anonymity. Whilst it could be argued that the scope of the research was too broad for an IPA design, the pilot participant thought it was important to offer men the opportunity to discuss the context for becoming a DC father, importantly: “how it was they did not become a father” (Pilot participant). The men all grounded their description of DC fatherhood in their discovery of their infertility. In retrospect, it would have been possible to focus the research either on an exploration of the ways in which men felt lifting donor anonymity had impacted on their experiences of DC, or on

disclosing and discussing. This might have enabled a more thorough exploration of each facet.

4.5.2. The Paper Will Have Strong Data

Smith (2011) suggests that the achievement of 'strong data' requires "good interviewing" (p.24). This is clearly subjective yet I felt that the interviews generated rich and extensive information on the experience of the participating men. The process of conducting and recording a pilot interview enabled me to reflect on my research style and questioning, modifying this in subsequent interviews. As I gained experience conducting semi-structured research interviews within the IPA framework, I became more skilful at asking non-leading questions, allowing the men to describe their experiences more freely. I felt I was able to establish good rapport early, which contributed to men sharing personal and intimate experiences.

4.5.3. The Paper Should Be Rigorous

Yardley (2000, p. 221) posits that rigour involves "prolonged engagement with the topic...and immersion in the...data". My commitment has been demonstrated through: attending regular HFEA public debates; lectures; conferences and DC charity meetings; and meeting with other researchers in the area of infertility and DC. In addition to the many hours spent analysing the texts, I also attended IPA training workshops and set up an IPA peer supervision group.

According to Smith (2011), 'good' quality IPA should give an indication of the prevalence of each theme, adequately representing each of the participants. In order for the results section to move beyond a purely descriptive account of each person's experience of the phenomena, I selected three or four longer extracts to illustrate convergence and divergence within each theme, whilst also acknowledging other participants who may have had similar or differing experiences. I have tried to give each man an approximately equal voice throughout the analysis. Rigour is also demonstrated by the fact that the super-ordinate and almost all sub-ordinate themes were highly relevant for all the men.

A supplementary table of quotes provides extracts that evidence the prevalence of themes and each participant's perspective (Appendix 20).

In order to provide 'transparency and coherence' (Yardley, 2000), I have included an audit trail to show the process by which I arrived at my final themes. Using Dylan as an example, I have appended: a key to my coding system (Appendix 13); an extract of his analysed transcript (Appendix 14); my reflections following our interview (Appendix 12); a table of his emergent themes (Appendix 16); a visual mind-map of Dylan's themes (Appendix 17); and a mind-map of cross case themes (Appendix 18).

I have attempted to make it explicit that interpretations are personal and not objective 'truths'. I have aimed to contextualise the research with reference to my own position (Section 2.8) and have included an extract from my reflexive journal, kept throughout the research process (Appendix 4).

4.5.4. The Analysis Should Be Interpretative Not Just Descriptive

Whilst analysing the men's accounts I drew upon Smith's (2004) four 'layers of interpretation', moving between an 'empathic' description of the text and a more questioning and interrogative examination of accounts, searching for possible inferences beyond the words. At times I felt a tension when using IPA between a desire to 'give voice' to the men's experiences and stay closer to their words and the contradictory drive and expectation to scrutinise their meaning and build my own interpretations of what, and how, things were being said. Ricoeur (1970) calls this the 'hermeneutics of faith' versus the 'hermeneutics of suspicion'. Josselson (2004) suggests these two hermeneutic engagements have opposing epistemologies, positing: "one cannot both re-present and demystify" simultaneously (p.23). Smith (2004) believes that it is both possible and desirable to engage in both modes of hermeneutic understanding in order to weave a rich tapestry of lived experience, as long as the researcher is explicit about their shifting position. In line with Frost *et al.*'s (2010) observations about the importance of the researcher's position remaining transparent throughout the analysis and write-up, I have attempted to offer my interpretations tentatively, using a first person narrative to own my ideas, and highlighting

where these exceeded merely a description of the participant's account. I enjoyed exploring the intricate and complex relationship between what and how things were spoken about, and ways in which this helped to layer interpretations of possible meanings beyond the words.

4.5.5. The Analysis Should Be Pointing to Both Convergence and Divergence

My super-ordinate themes were intentionally broad to allow for converging and diverging accounts of the phenomena, which Smith (2011) cites as essential in capturing the nuance of each participant's experience. Whilst I have attempted to identify similarities between the men's account of their experiences, extracts from different participants were used to illustrate how each theme manifested in different ways for each man.

4.6. Methodological Limitations

4.6.2. Sampling

It is recommended that IPA studies should recruit a homogeneous sample, although Smith (2003) acknowledges that there is ambiguity over what constitutes homogeneity. This study used a purposive sample. The participants had all been diagnosed as infertile and their partners successfully conceived a child through DC. Participants differed, however with regards to age, number and gender of DC children; and ethnicity, which will certainly have impacted on each of their experiences. Whilst I have attempted to contextualise each participant in the results section, further research may usefully focus on a more narrowly defined sample, such as men with both a DC son and daughter.

4.6.3. Interviews

The information gleaned from the eight semi-structured interviews was influenced by the interview process as a 'social' interaction (Rapley, 2001). The context of the interviews as well as the unique interaction between me and each man will have impacted on what was said and not said. My gender, age, accent and so on, may have all contributed to opening up conversations and possibly closing them down. I noted that although topics around sex arose more

generally, these were frequently framed in a frivolous and light-hearted manner, and men did not discuss their sexual relationships with their partners, despite questions on the impact their experiences had had on their couple relationship. Catania *et al.* (1996) suggest individuals may find talking about topics of sexuality easier with interviewers of the same sex. Salle and Harris (2011), however, suggest conversations between female interviewers and male participants can facilitate exploration of more sensitive topic areas. I was struck by how much the men were prepared to share of their experiences and grateful for their openness.

Several participants lived outside of London and England. It was impractical to conduct the interview face-to-face and it was agreed that we would talk via video Skype. It was difficult to know the impact this had on the interviews but certainly it would have done so. On the one hand it felt as though the distance created by the computer screen and the geographical space perhaps offered protection and safety for both the men and me, allowing exploration of more sensitive areas. On the other hand, I wondered whether it interfered with engagement and rapport and disrupted more fluid and natural conversations, particularly when intermittent technical errors broke the connection.

Where interviews were held in men's homes, the background presence of their partners and children will have impacted on what was said. In some cases it felt as if men used this as a channel to communicate indirectly with their partners and children. The choice of an office environment for holding the interview seemed to correspond with a less 'emotionally charged' account. By contrast, a bustling café environment provided a relaxed informality that seemed to spill over into the interview.

4.6.4. Choice of Analysis

IPA assumes language can give some access to a 'real' internal experience of another (Willig, 2008). Conversely, discursive approaches, assume that meaning and experience are socially constructed through the use of language.

Frost (2011) advocates considered use of pluralism in qualitative research in order to provide a richer and multi-perspective account of phenomena. In some

of the sub-ordinate themes such as 'Silenced and Silent' and 'Re-constructing Fatherhood', it may have been advantageous to have looked beyond the men's words as indicative of an existing experience, and concentrate on the constructional aspects of their accounts and language. A Foucauldian Discourse Analysis, used additionally on these sub-ordinate themes, may have illuminated some of the processes by which this group, both as 'infertile men' and 'DC fathers', see themselves as positioned within society and the impact this has on how they construct their accounts.

4.7. Personal Reflections

I recognise "interpretation of the intended meanings of a text is an inherently relational activity, encapsulating both the desire to understand and the impulse to connect and respond" (Tappan, 1997, cited in Josselson, 2004, p.11). I wanted to give the men a voice yet add something helpful to move understanding forward and not just directly 'broadcast' their words. I initially felt overwhelmed by the quantity of data, the many possible themes, and my strong desire to produce a piece of work that would be both a meaningful and honest reflection of the men's experiences. I had to negotiate whether or not to seek the participants' feedback on my interpretations. On the one hand it felt important to remain transparent about my interpretations and 'verify' these with participants. On the other hand, the double hermeneutic commitment of IPA makes explicit that interpretations are arrived at through the unique lens of the researcher and takes for granted that participants would construct different interpretations. I sought guidance about this at the IPA workshop. I was advised to not share my interpretations with participants at the point that they were being formed, but that it may be advisable to share these with participants once the research had been completed and final interpretations established. As had been agreed at the point of interview, I sent an executive summary of the thesis to participants, welcoming their feedback or thoughts. I received replies from all of the men. All commented that they had valued participating and were in alignment with the findings of the study.

Following the decision to investigate men's experiences of infertility and DC, and prior to beginning recruitment, I was warned of the potential difficulties of recruiting men for such studies (Lund *et al.*, 2009). Given this, I was pleasantly surprised to encounter no problems with recruitment, in fact regrettably I had to turn men away who volunteered after I had reached my desired sample size. I wondered whether, contrary to common opinion, this reflected men's desire to 'break the silence' around MFI and DC.

I struggled with whether or not to comment on participants' ethnicity, religion or employment in either the participant table or in the analysis. I felt sure that including and considering the impact of these demographic variables on men's accounts of their experience would have led to more thorough and interesting interpretations. This was however pitted against my desire to protect the anonymity of the participants. The community of families who were members of the DC charity was relatively close and I made the decision that naming these variables may have revealed the identity of some participants. It was noteworthy that the majority of participants were White, British and Middle Class. This raised interesting questions about both the normative population of families that decide to embark on DC and on the sub-group who volunteer for research of this kind.

I appreciated the scope offered by IPA in being able to reflect on my influence over the research, feeling this was in keeping with my epistemological position and an interesting way of conducting research. Discussing my interpretations, challenges and concerns with peers and supervisors became a valuable way of developing my ideas and made it less of a solitary venture. I enjoyed the close readings and analysis of the texts and the enhanced understanding this facilitated.

I felt honoured to be invited into the men's homes and lives; to be privy to their personal experiences. I was moved by both the pain of their experiences and the growing adoration and hope they had for their family. Although engaging in the interview may have been quite an emotionally intense experience for some of the men, my sense at the time and through feedback I received from many of the men, suggested they found it both interesting and helpful.

4.8. Summary and Conclusions

The findings in this study have added to the body of understanding and brought some new insights into the experiences of donor recipient fathers.

Difficult feelings about both their infertility and the DC continued to intrude into awareness at different points and required ongoing emotional processing.

Contrary to previous findings, the men in this study welcomed opportunities to speak of their feelings and experiences both to those close to them, to other DC parents and to counselling professionals. Single session, pre-treatment counselling was found unhelpful. Access to counselling outside the fertility clinic setting, both pre DC, during pregnancy and parenthood would be helpful.

A novel finding was that the men seemed to experience greater difficulty in initial bonding with their sons, with whom fantasies about the donor seemed more invasive and threatening.

All the men considered it important to disclose to their child about their DC origins, but the lifting of donor anonymity added to fears of the future repercussion of telling. However difficult the journey, all the men in this study were glad that they had taken the opportunity that DC offered to become fathers.

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APPENDICES

Appendix 1:	Literature Search Criteria
Appendix 2:	Biological Conditions Resulting in MFI
Appendix 3:	Medical Treatments for Infertility
Appendix 4:	Reflexive Journal Extracts Following IPA Peer Support Meeting
Appendix 5:	Approval to Recruit from DC Charity
Appendix 6:	Participant Information Sheet (PIS)
Appendix 7:	Recruitment Advert Posted in the DC Charity's E-bulletin
Appendix 8:	UEL Ethics Confirmation
Appendix 9:	Participant Consent Form
Appendix 10:	Information Sheet Providing Details of Support Services
Appendix 11:	Interview Schedule
Appendix 12:	Reflexive Journal Extract Following an Interview
Appendix 13:	Coding System for Transcriptions and Results Extracts
Appendix 14:	Worked Example of IPA
Appendix 15:	Extract from Reflexive Journal whilst Transcribing
Appendix 16a:	Example of a Participant's Emerging Themes
Appendix 16b:	Example of a Participant's Clustered Themes
Appendix 17:	Example of a Participant's Mind-Map of Themes
Appendix 18:	Master Mind-Maps of Themes
Appendix 19:	Master Theme Table with Extracts Participants
Appendix 20:	Supplementary Quotes Evidencing each Theme
Appendix 21:	Change of Thesis Title Confirmation

Appendix 1: Literature Search Criteria

The following search engines were utilized to carry out a search of the literature:

(EBSCO) CINHALL

(EBSCO) PSYCHINFO

Google Scholar

The following search terms were used in different combinations:

Infertility

Men

Male

Masculinity

Fathers

Fatherhood

Sperm

Fertility

Infertility

Reproductive Technology

Assisted Reproductive Technologies

Reproductive Technology

Assisted Reproduction

Donor Conception

Donor Insemination

Sperm Donation

Appendix 2: Biological Conditions Resulting in MFI

Definitions have been taken from Haynes and Miller (2003) and the Glossary of Fertility, IVF and Embryology Terms (HFEA, 2009).

Asthenozoospermia

Poor sperm movement (motility)

Azoospermia

The total absence of sperm in the man's semen

Ejaculatory Duct Obstruction

One or both ejaculatory ducts are obstructed

Hypogonadism

Testicular failure.

Oligospermia

Reduction in the volume of semen

Oligoteratoasthenozoospermia

A combination of problems with sperm morphology, motility and volume

Oligozoospermia

Low sperm count – usually between 5-20 million sperm per millilitre.

Teratozoospermia

Abnormal sperm shape (morphology).

Varicocele

A varicose vein on the testicles. This may cause overheating of the testicle and prevent sperm production.

Appendix 3: Medical Treatments for Sub-fertility and Infertility

Definitions have been taken from Haynes and Miller (2003) and the *Glossary of Fertility, IVF and Embryology Terms* (HFEA, 2009).

Treatments to which assist conception used in instances of sub-fertility:

Assisted Reproductive Technologies (ARTs)

The collective name for all techniques used artificially to assist women to carry children, including IVF and ICSI.

Gamete Intra Fallopian Transfer (GIFT)

This technique involves the collection and mixing of sperm and eggs outside of the body which are transferred to the fallopian tube prior to fertilisation.

Intra-Cytoplasmic Sperm Injection (ICSI)

This involves a single sperm being injected directly into each egg outside of the body. Successful embryos are transferred back to the womb. This can be used when the male partner has few sperm or poor sperm motility

Intra-Uterine Insemination (IUI)

This involves the insemination of sperm into a woman's uterus. This can be done in a clinic or at home and many women can self-inseminate without medical assistance (Saffron, 2001).

IVF (In Vitro Fertilisation)

This is where multiple eggs and sperm are collected and mixed in a culture dish outside of the woman's body. Successful embryos are transferred to the woman's uterus.

Testicular Sperm Aspiration (TESA)

This sperm extraction technique involves the insertion of a needle into the lower region of the testes and the removal of a small piece of testicular tissue.

Testicular Sperm Extraction (TESE)

This sperm extraction technique involves the removal of a small piece of testis via an incision in the scrotum.

Treatments for male infertility where there is no viable sperm:

Donor Conception (DC)

Conception through the use of donated third-party gametes.

Embolization

Non-Surgical treatment for varicocele

Transurethral resection of the ejaculatory ducts

Surgery to treat ejaculatory duct obstruction

Varicocelectomy

Surgery to correct the varicocele

Appendix 4: Reflexive Journal Extracts Following an IPA Peer Support Meeting

Transcribed extract from the first reflexive IPA meeting, held prior to beginning interviewing, including peer questions and my responses.

Q: Why this topic?

A: So, I suppose for a number of reasons. My parents had lots of fertility problems and they were trying for a while and ...couldn't fall pregnant... and were going to go through IVF and just before they did, they fell pregnant with me. So I wasn't conceived via IVF but after me there were years and years and years during my childhood where they desperately wanted more children and couldn't, and I guess that feels like quite a significant part of mine and their lives. So they went through years of unsuccessful IVF and I remember it being a traumatic time in my parents' lives. On top of that I am interested in the psychology of families and 'parenthood' within the context of theories of attachment. I think fertility, infertility and donor conception surface a multitude of moral, religious, ethical dilemmas and they are topics which perhaps feel relevant to many people's lives. And men, I suppose I thought that the void in research in this field with men was really striking and I am drawn towards topics which are not heavily spoken about. I'm aware that in lots of emotional and psychological areas, men's voices are not heard and I think that is fascinating. I think there is also a general assumption which has been reinforced through my discussions with friends, that infertility is a lot less common in men than it is in women, which is not true.

Q: Is that a general assumption, or your assumption, or both?

A: Umm actually it *wasn't* really my assumption, I think I always assumed that infertility rates were pretty equal but it's something that has come up a lot following conversations that I had with friends and family, that male infertility is relatively rare and is something of a taboo to talk about. I also knew that, if a couple go for infertility treatment, following a diagnosis of male factor infertility, and they decide to opt for donor conception, *all* the letters are addressed to the

woman and the focus is almost entirely on her. It is one of the only areas in physical health where a problem in one personal is treated in another. I think that that raises interesting questions about the experiences of men who are then fathers.

Q: So what kind of issues do you think they are going to talk about?

A: I think I have an assumption that infertility is a problem, a really big problem and that it *will* impact the relationship they have with their child. That's an assumption. That it will be likely to impact the bonding between father and child. I have an assumption that men would rather not tell their children.

Q: So you listed a few things, like your parents struggle with infertility, your own struggle with fertility, attachment, and then I'm going to add in your training at UEL. Which of those things are going to have the *most* impact on the interpretation you make of the data?

A: I guess it's a difficult question to answer. Intuitively I would say my personal and family experiences but actually I think that it is very hard to untangle and distinguish between each of those components, which are inextricably linked and combined. I suppose the lens though which I see this research will be a melange of all of those things. For instance my interest in attachment theories coexists with my belief in the power of social discourses, which impose ideas for how men and women *are* or should be, and a belief that these ideas and discourses can be internalised.

Transcribed extract from the second reflexive IPA meeting, held in the middle of interviewing.

Q: Did you have any assumptions as a woman asking these questions to men? And also bearing in mind the context you are coming from?

A: I think it definitely impacts on the conversation, me being a youngish woman, talking to a man. There sometimes seemed to be a bit of sexual bravado in the language used. I was left wondering whether they may be trying to assert themselves as sexually 'virile'. I think I have been aware of trying to gauge men's reactions when they first see me. I don't know whether I am pre-empting

there being something, perhaps I have an assumption that they may find it easier to have these conversations with either an older woman, perhaps more of a maternal figure or a man.

Q: what are you pre-empting?

A: Um possibly that they might feel a bit uncomfortable talking to a woman of child-bearing age

Q: How might the conversations you have had so far be different if you were interviewing women?

A: I guess my assumption is that women are generally more emotionally literate. So my assumption is that it may be easier to talk about slightly more tricky issues. And I guess, I have reflected on how far I should go, how far I probe, when things come up that I sense may be a bit of a sore spot, I feel an internal tug between wanting to get to the heart of the experience, which would be useful for the research whilst also being aware that this is just an hour and lots of the men had built up successful defences and barriers, where they are used to saying that they were fine and no one questioning that. So I suppose I was aware of whether or not to question any further. And I guess I found myself being a bit braver as the interviews have gone on, which has been useful actually, hopefully on both sides, in that it allowed things to be voiced rather than continuing to silence things that feel uncomfortable and I have been pleasantly surprised with how honest and open the men have been. I guess it has led me to question my assumptions that men find expressing their emotions more difficult.

Q: so how do you think your personal experiences would impact on your assumptions?

A: I guess a belief that infertility can cause great pain and loss. And then thinking about myself, and how I would feel if my partner and I had a child who had been conceived using another woman's eggs, so was not genetically linked to me, would I feel left out? Honestly I think I would find that quite difficult. I needed to be aware that those are *my* assumptions and be conscious to not put that onto the men's accounts. For the men I have interviewed so far, some really

have found this difficult and some less so. For some it seems to feel like a very sensible *solution* to a problem.

Q: how have you reacted to that response, those that have found it a less difficult experience?

A: If I'm going to be honest, initially a bit surprised I think, that they weren't saying what I imagined they would. And then maybe after the pilot interview, I was more aware that this was *my* assumption and trying to be more actively receptive to a different story which then led me to feel quite hopeful. So maybe there was a shift in how I thought about infertility and donor conception. One man spoke very openly about how *awful* the process had been at the beginning but then, with time he expressed immense joy and real closeness to his children. He expressed huge gratitude towards the donor as well as feelings of suspicion and envy.

Q: so you had a belief that the donor could only ever really be seen as a threatening person

A: maybe, and I think that that *has* come up, to some degree, in all of the interviews but what has also been very present was utter gratitude. Their feelings have been neither all positive nor all negative, they have fluctuated. I suppose it has made me feel like it might be something I might more readily consider embarking on myself, if I needed to.

Appendix 5: Approval to Recruit from DC Charity

E-mail sent from the DC charity, confirming that I can begin recruitment through them

Dear Amy

I have now been in touch with [REDACTED] and [REDACTED] who are very happy to support your research, so you have clearance from us to go ahead. I will send you our forms separately so that you can see the standards we are working to, but please don't worry about completing them. [REDACTED] and [REDACTED] are quite satisfied with what you are doing.

I hope this is what you wanted to hear.

Best wishes

[REDACTED]

[REDACTED]

Practice Consultant

[REDACTED]

Appendix 6: Participant Information Sheet (PIS)

Donor Conception: The perspective of fathers with children younger than 7 where donor sperm has assisted conception

Invitation to the study

You are invited to take part in a research study. Before you decide to take part, it is important for you to understand why the research is being carried out and what it will involve. Please read the following information and then decide if you wish to take part.

Background to the study

When it comes to infertility and its treatment, much less concern and attention is paid to the feelings and experiences of men than women. This is also the case in research, where the views of men have been much less widely documented. There is evidence that many men find it hard to talk about their experiences and this may lead to men feeling isolated and unsupported. Nowadays couples are encouraged to tell their child about their origins. The lifting of donor anonymity in 2005 may add another layer of complexity to this. This study is interested in understanding more about men who have become fathers since 2005. It will aim to investigate how men share this information to their children and to other people in their lives, and how this has affected them.

Why should I take part?

By participating in this study, you will be providing important information that could help to increase the understanding of men's perspectives on donor conception. This information could guide services in developing more effective and appropriate ways to support men. The interview may also provide an opportunity to reflect on your own journey through this experience.

Who are we looking for?

We will be recruiting men who have created their family through donor conception with the donor sperm provided in the UK since 2005. We hope that men with a range of experiences will come forward. Whatever your experience, your time and participation would be much appreciated.

What will happen if I take part?

You will take part in an interview with the researcher, Amy Schofield. The interview will last approximately one and a half hours and will be arranged on a date and time that is convenient for you. The interviews will be held at a venue of your choice. The researcher is able to travel to anywhere in the UK. Alternatively interviews can be held at the University of East London and reasonable travel expenses will be reimbursed (either public transport costs or a mileage rate agreed by the University).

The interview will be digitally recorded and transcribed (typed into text) for analysis. In order to ensure your anonymity, transcribing will be done by the researcher and all identifying names

and other material will be removed or changed to protect confidentiality. Prior to participating in the study you will be asked to sign a consent form.

Will my confidentiality be respected?

Your involvement in the study will be kept confidential. Any information identifying you, such as your signed consent form, will be stored separately from the typed copy of your interview. All material will be stored in a locked cabinet. Comments that you make in the interview will be used in the write up of the research, however all identifying information such as names and places will be removed or changed. The recording will be erased at the end of the research. Anonymised transcripts will be erased after 5 years. Only the researcher and supervisors* of the project will have access to the tapes and transcripts. Your participation in the research will remain anonymous and transcriptions will be made available to you before analysis if requested.

What will happen to the results of the research study?

The results of the study will be written up and submitted as a research project as part of a Professional Doctorate in Clinical Psychology. The researcher will make the conclusions of this study available to relevant service providers, including the [REDACTED] in order to help them support men who are embarking on the process of donor conception and beyond. The researcher hopes to publish the findings in a peer reviewed journal. Nothing will be written that will personally identify you. Before publication, participants will be informed and offered an emailed copy of the study and the researcher would be interested in any comments or suggestions.

Has the research obtained ethical approval?

The research has obtained ethical approval from the University of East London's Ethics Committee and from the [REDACTED] research panel.

What if I change my mind and want to drop out of the study?

You are free to withdraw at any time and you will not be asked to give any reason. Should you withdraw after two weeks following the interview however, the researcher reserves the right to use your anonymised data in the write-up of the study and in any further analysis.

What do I do if I want to take part?

If you would be interested in taking part please contact Amy Schofield on:

E-mail: [REDACTED]

Telephone: [REDACTED]

I would be happy to answer any questions or talk further about the research. **Your participation would be greatly appreciated and could make a real difference to other men.**

Kind regards,

Amy Schofield (Principal Investigator)
Trainee Clinical Psychologist
University of East London

*Supervised by:
Dr Sharon Pettle (Clinical Psychologist, [REDACTED])
Dr Paula Magee (Clinical Psychologist, UEL)

**Appendix 7: Recruitment Advert Posted in the DC Charity's
E-bulletin**

A Call for Participants

**Donor Conception: The perspective of fathers with children younger than
7 where donor sperm has assisted conception**

When it comes to infertility and its treatment, much less concern and attention is paid to the feelings and experiences of men than women. This is also the case in research, where the views of men have been much less widely documented. There is evidence that many men find it hard to talk about their experiences and this may lead to men feeling isolated and unsupported. Nowadays couples are encouraged to tell their child about their origins. The lifting of donor anonymity in 2005 may add another layer of complexity to this. This study is interested in understanding more about the experiences of men who have become fathers since 2005, with the use of Donor Conception. It will aim to investigate how men share this information to their children and to other people in their lives, and how this has affected them.

We will be recruiting men who have created their family through donor conception with the donor sperm provided in the UK since 2005. We hope that men with a range of experiences will come forward. Whatever your experience, your time and participation would be much appreciated.

If you would be interested in taking part or for further information please contact Amy Schofield on:

E-mail: [REDACTED]

Telephone: [REDACTED]

Appendix 8: UEL Ethics Confirmation

SCHOOL OF PSYCHOLOGY

Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.

UEL
University of
East London
www.uel.ac.uk

School of Psychology Professional Doctorate Programmes

To Whom It May Concern:

This is to confirm that the Professional Doctorate candidate named in the attached ethics approval is conducting research as part of the requirements of the Professional Doctorate programme on which he/she is enrolled.

The Research Ethics Committee of the School of Psychology, University of East London, has approved this candidate's research ethics application and he/she is therefore covered by the University's indemnity insurance policy while conducting the research. This policy should normally cover for any untoward event. The University does not offer 'no fault' cover, so in the event of an untoward occurrence leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the candidate is a student of the University of East London, the University will act as the sponsor of his/her research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,



Dr. Mark Finn

Chair of the School of Psychology Ethics Sub-Committee

Stratford Campus, Water Lane, Stratford, London E15 4LZ
tel: +44 (0)20 8223 4966 fax: +44 (0)20 8223 4937
e-mail: mno.davies@uel.ac.uk web: www.uel.ac.uk/psychology



The University of East London has campuses at London Docklands and Stratford
If you have any special access or communication requirements for your visit, please let us know. MINICOM 020 8223 2853



Appendix 9: Participant Consent Form



Consent to participate in a research study

I have read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data in the write-up of the study and in any further analysis that may be conducted by the researcher.

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Researcher's Name (BLOCK CAPITALS)

.....

Researcher's Signature

.....

Date:

Appendix 10: Information Sheet for Support Groups



Support Groups – Contact details

Samaritans: Help-Line: 08457 90 90 90;
British Infertility Counseling Association (BICA) (Promotes high quality counseling services for people with fertility problems. Information line: 01372 451 626 Website: http://www.bica.net/
DI Dads (A supportive blog for DI dads) To subscribe: email di_dads-subscribe@yahoogroups.com
Fertility Connect (Website for couples experiencing infertility and a chat room for people to share experiences. There is also a facility for individuals to contact fertility nurse specialists and counsellors.) Website: http://www.fertilityconnect.com/
National Infertility Support and Information Group (NISIG) in Ireland. (Voluntary organization offering information and support to couples undergoing fertility treatment and donor conception. Help-Line: 1890 467 444 Email: nisig@eircom.net
ACebabes (A network of families following assisted conception offering contact and support. Website: acebabes@frib.freesevice.co.uk

Appendix 11: Interview Schedule

1. Can you tell me about how it was you came to be a father?
2. Zooming back to when you discovered you may not be able to have your own biological children, do you remember what that experience was like?
PROMPT: Can you remember the kind of thoughts that were going through your head?
3. How was it decided that DC was the route you were going to take?
PROMPT: How did you feel about that decision?
4. What was the process of going through the DC like for you?
PROMPT: what, if anything made this process easier?
PROMPT: What, if anything, made this process more difficult?
5. Did you discuss either the infertility or DC with your partner/friends/family?
PROMPT: If yes, what were the reasons for choosing to do this and how was it to tell and talk to these people?
PROMPT: If no, what were the reasons for choosing this?
6. Have you decided whether or not you are going to tell your children about their DC origins?
PROMPT: How was this agreed with your partner?
PROMPT: How did you feel about that decision?
PROMPT: If you have already told, what has that experience been like?
7. Do you have any thoughts about the lifting of donor anonymity?
8. Is there anything we haven't covered which you think is important?

Appendix 12: Reflexive Journal Extract Following an Interview

Reflection following Dylan's interview:

The interview was held at Dylan's house. It was an easy journey getting there and communication regarding the interview had been good prior to meeting which led me to look forward to it. Dylan was very welcoming as was his wife who spent the duration of the interview in the adjoining room. I was also aware that his babies were in the house and wondered the impact of having the interview with his family in such close proximity and whether this may make him feel more engaged with his identity as a father. I speculated over whether his wife would be able to hear our conversation and how this might impact on what was said or not said.

Dylan had an open and relaxed manner and I felt at ease. The interview felt as though it flowed naturally with Dylan providing rich, honest accounts of his experience. It seemed as though his intense emotional and practical involvement in the process had helped him in coming to terms with the infertility and feeling ownership over the twins as his own. I thought it interesting that he repeatedly brought up his feelings about being an inferior and lesser man, as I experienced him as typical of the men that I know and respect in my work and personal life. I wondered how my being female impacted on how he presented himself and whether he may have felt less comfortable speaking to a male interviewer, particularly with issues relating to his diminished sense of masculinity.

He seemed both emotionally connected, being able to talk about his continuing worries and loss in a frank and candid manner, whilst also expressing a sense of growth, repair and readjustment which I think was helped by the strength and 'togetherness' of their couple relationship. One phrase in particular stood out to me: "we were on the edge but we were on the edge together so it was okay". This made her physical presence at the interview feel particularly relevant.

I felt that Dylan sometimes used humour as a defence against some of the more painful and embarrassing feelings and memories, such as his late development in puberty and his fierce envy of his peers who seemed to be growing in 'height and beards!' This also worked to 'bring me on side' encouraging me to laugh with, not at him. I felt that despite the interview, at times, re-surfacing difficult and painful memories and feelings for Dylan, he took something of use in the process with regards to his own continuing processing and making sense of the infertility and DC: all of which had happened relatively recently and quickly.

Appendix 13: Coding System for Transcriptions and Results Extracts

[text in square brackets]	Actions or non-verbal cues thought relevant by researcher
text highlighted in pink	Linguistic devices identified by as relevant by researcher
text highlighted in green	Key passages thought relevant by the researcher to describe the experience
hand written text in pink ink	Interpretations of linguistic devices e.g. metaphor
hand-written text in black ink	Researchers comments and interpretations and emerging themes
text circled	Key words identified by researcher as particularly relevant
text italicised in transcript participant	Emphasis placed on word by participant
text underlined in results extract participant	Emphasis placed on word by participant
...	Discontinued sentence or point by participant
[...]	Text removed by researcher

Appendix 14: Worked Example of IPA

Emergent themes	Transcript (Dylan)	Exploratory Coding
	<p>1 R: so Dylan my first question and I appreciate</p> <p>2 that is probably quite a big one, but um I was</p> <p>3 interested in how it was you came to be a</p> <p>4 father?</p> <p>5 P: Certainly. Erm, so [pause] I suppose at some</p> <p>6 point Leila and I had decided that we wanted to</p> <p>7 have children, I think I always know I wanted to</p> <p>8 have children um but it wasn't until [pause]</p> <p>9 probably a couple of years ago, maybe 3 years</p> <p>10 ago that, [takes breath in] we made the decision,</p> <p>11 it just suddenly started feeling like something I</p> <p>12 wanted to happen pretty soon erm Leila is a few</p> <p>13 years older than me as well so I think from a</p> <p>14 biological point of view, she was thinking about it</p> <p>15 before I was perhaps, then of course it's much</p> <p>16 more important in terms of women and age. Um</p> <p>17 [pause] and then I guess a few things happened,</p> <p>18 friends started having babies, maybe some</p> <p>19 slightly older friends and went from feeling like it</p> <p>20 was something I wanted to do in the future to oh</p> <p>21 actually this could be really cool um and and it</p> <p>22 changed quite quickly</p> <p>23 R: Ok</p> <p>24 P: Um [pause] we started trying and [pause]</p> <p>25 nothing happened and its funny I always had</p> <p>26 [pause] something in the back of my mind</p> <p>27 [pause] possibly because my sister as I said has</p> <p>28 hyperthyroidism, and so do I she's known since</p> <p>29 the age of about 10 or 11 that she was going to</p> <p>30 have fertility problems and has [sniffs] And has</p> <p>31 kind of been told she will probably never have</p> <p>32 children and so something in the back of my mind</p> <p>33 that [sighs] said well you've got hyperthyroidism</p> <p>34 too even though there's not this established link</p> <p>35 maybe there could be something there um and</p>	<p><i>Desire for children</i></p> <p><i>normal life cycle - Right of passage</i></p> <p><i>men worry about infertility too</i></p> <p><i>link between MFI and other medical conditions</i></p> <p><i>shift in relationship - from 'lovers' to 'baby makers'?</i></p> <p><i>metaphor: indicating possible worry prior to trying.</i></p> <p><i>fertility explored in women not men</i></p> <p><i>he made will rather than doctor</i></p> <p><i>difficult to say?</i></p> <p><i>sharing grief with me?</i></p> <p><i>society's expectations / assumptions that would have a greater impact on woman's life?</i></p> <p><i>joint vs. individual decision</i></p> <p><i>we/I</i></p> <p><i>part of life plan</i></p> <p><i>Shift from idea of having children in future to present desire</i></p> <p><i>life cycle / normal milestones</i></p> <p><i>Biological pressures for women</i></p> <p><i>peers beginning to have children</i></p> <p><i>social comparison</i></p>

Emergent themes	Transcript (Dylan)	Exploratory Coding
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Taking
stock

Desire to
'make' baby -
not just
'have' one

feeling
judged

36 so we went to the doctor fairly quickly when
37 things weren't happening, um [pause] turns out
38 [pause] oh they did the normal battery of tests,
39 um and yeah it turns out that I am infertile
40 [R:right], um [pause] and so hence we then kind
41 of started...well we stopped for a while and then
42 kind of went and took stock and thought (shit), um
43 [pause] and then [pause] went through various
44 options and kind of carried on talking to people
45 and doctors and um reading a bit more and kind
46 of doing our own research but we still really
47 wanted to have children, um [pause] we also
48 really wanted to go through the process of being
49 pregnant, it sounds really weird, but we both did
50 um [sniffs] and kind of making, you know growing
51 the baby you know because it seems like an
52 important part of the experience. [R: mm] Um I
53 went through a period of [pause] feeling quite bad
54 about, or certainly I did I can't speak for Leila,
55 she may or may not have but kind of worrying
56 about saying are we bad people if we don't want
57 to adopt people, you know is it different to
58 wanting to have your own children? Um but came
59 to the conclusion that even if we did want to
60 adopt in the future, we definitely wanted to try um
61 using using donor sperm um and have a baby
62 that way.

63 R: mm. Ok. [pause] So can I zoom back a bit?
64 thinking about the battery of tests you had
65 and I guess the question mark in your mind,
66 having known your sister was having
67 problems. Would you mind elaborating a bit
68 on what that experience was like? Receiving
69 that information, what went through your
70 head?

disclosure of mst

lots of
pauses +
breaks -
↳ taking stock /
processing it.

"we" - joint venture
↳ repeat of "really"
suggests immediacy.

temporal ref: past tense

Idea that parenthood
entails creating +
growing baby

Guilt of not
adopting judgemental
gaze of
others.

↳ desire for people to
approve of his decisions.

Idea that
adopted person
may have lost
childhood
↳ already
formed
people.

Emergent themes	Transcript (Dylan)	Exploratory Coding
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loss	71 P: yeah...so it was [pause] well it was pretty 72 <u>devastating</u> really um and all these weird things 73 that you don't really think [pause] can affect you 74 <u>emotionally</u> started coming into play um 75 <u>[swallows]</u> one of them being my grandfather was 76 adopted [R: right] and never knew his biological 77 parents [R: I see] and so that side of my family, 78 my dad's side has got quite a short kind of 79 biological history um I'm the only male on that 80 side that could biologically carry on the Smith 81 name and it wasn't until I found out that actually 82 biologically I couldn't, I suddenly realized how 83 much I wanted to um [pause] and yeah so I 84 guess with my sister also having known for such 85 a long time it's funny because...we're actually 86 very close now, we didn't used to be when we 87 were younger, but having become adults we're 88 much closer and I always thought I kind of 89 wanted her to be...I never questioned whether I 90 would be able to have children [pause] up until 91 then, and I really thought I wanted her to be really 92 involved in my children's lives...you know...not to 93 kind of make up for it but just to share that 94 experience with her a bit, knowing that she 95 probably couldn't do. And then to find out that I 96 probably couldn't either was...it kind of added to 97 the blow [laughs and takes a sip of water].	<p>"denigration"</p> <p>unanticipated</p> <p>still emotionally impacted / affected / preparing to tell me.</p> <p>importance of continuing name / masculine expectations</p> <p>Failure of role as a man</p> <p>Denial leads to greater desire / yearning!</p> <p>Breaking family unit.</p> <p>contradiction (1:26) where suggests he did suspect although this was never voiced in family.</p> <p>Failure as a brother</p> <p>soften pain?</p> <p>in long term laughter / try to soften information for me / him</p> <p>defence from pain?</p> <p>difficult to talk about?</p> <p>conscious / unconscious questioning of infertility</p> <p>preparing me for something potentially unfavourable</p> <p>feels need to caveat what he is about to say.</p> <p>holds an internal perception of what is 'normal'</p>
Role of man → continue family name		
letting people down.		
male fertility not questioned		
Sense of failure		
	98 R: Yeah [pause] Why do you think it was that 99 you never questioned it? 100 P: Ah, [sighs] I don't know really, um [pause] 101 maybe I [sighs] did in the back of my mind but I 102 guess I didn't really very <u>consciously</u> question it 103 um I think my [pause] this is going to sound really 104 <u>weird</u> , or it may do. So having hyperthyroidism I 105 wasn't diagnosed for quite a long time and it was 106 at around the point where you normally have your	

Emergent themes	Transcript (Dylan)	Exploratory Coding
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Is this a product of the hormone imbalance or of not "fitting in" & "failing"?

let down by medical profession

Peer comparison

Delay in becoming a "man"

incomplete/faulty man.

importance of puberty

Peer comparison

107 growth spurt, go through puberty and that sort of
108 thing that I was diagnosed and one of the effects
109 of being undiagnosed it that that's completely
110 delayed and so I went from kind of being the
111 tallest and slimmest in my year to being [pause]
112 really short and squat and depressed and all my
113 kind of peers were growing and becoming men if
114 you like, [pause] and because all of that was
115 delayed in me [pause] I think perhaps I
116 became...there was something in my head that
117 was kind of thinking: "uh you're not really quite
118 right" I learnt a bit about how your pituitary gland
119 works and how it all works in terms of
120 testosterone, kind of biologically, um and I
121 suppose when it did eventually happen, after I
122 had been diagnosed and so on, there was
123 something in the back of my head that said:
124 "you're not a proper man, kind of thing, you're
125 [pause] you're missing a piece", um but I never
126 really explored it.
127 R: This is when you got diagnosed with the
128 hyperthyroidism?
129 R: yeah year, um I started taking thyroxin and all
130 of a sudden I lost the weight, I stopped feeling
131 depressed, I grew, and it was such as relief I
132 kind of when [sighs] "oh thank god for that" you
133 know again you know, being a teenager at that
134 time, you are comparing yourself to your peers
135 [pause] so much, um and it was just such a relief
136 having gone from feeling really inadequate to like
137 'god thank god' [sighs] [pause] and then I
138 suppose I didn't really [pause] I don't know, I
139 suppose there was something in the back of my
140 mind but perha... I didn't really challenge it or kind
141 of [pause] I mean I guess I had no way of
142 knowing at that time um and the doctor never

normal development milestones.

peer comparison

perceived desirable characteristics vs undesirable

@ time feels like he should be growing he instead felt like he was regressing

Feeling of being "abnormal" / transgressing normal development.

-Impact of Biology on "masculinity"

Self-critical -> bullying / 'omnipotent' peer in his mind.

metaphor: essential ingredients needed to contribute to a man. not feeling good enough

Societal pressures & expectations internalised.

significance of the shift
saw that couldn't do without medication

(Back on track)

Repetition of 'relief' stressing its importance

planted "seed" of doubt about possible future problems with fertility.

Emergent themes	Transcript (Dylan)	Exploratory Coding
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Infertility
viewed as a
woman's
concern

143 said anything in terms of... I guess that was the
144 other thing because Pam, my sister, they said
145 you know you've got hyperthyroidism, we need to
146 do these checks, as a matter of course you know
147 standard protocol, um they never said any of that
148 to me um so I kind of, it didn't give me any
149 reason to suspect.

stops short of saying 'infertility'
↳ represent how
difficult it is to
vocalise

inequality → internalised
belief that
infertility
doesn't effect
men in
same way.
ratio of women's
infertility
higher?
feels
let down by
medical
profs.

150 R: Yeah, absolutely [pause] You said
151 something around this diagnosis making you
152 feel less of a man, [pause] is there something
153 you think [pause] shifted when you started
154 taking the medication and the bodily things
155 started changing?

peer
company on
hegemonic
view of
masculinity
not a 'real'
man

importance
of puberty
↳ im-potent,
14

156 P: Yeah no it did, I think it was a huge sense of
157 relief really, um because [pause] I dunno, as a
158 boy growing up all you want to be is big and hairy
159 and a man I suppose [laughs] and it turns out I
160 think probably biologically and genetically I
161 wasn't designed to be a big and hairy guy
162 anyway you know but at the time you don't think
163 that, you just think he's 14, he's growing a beard
164 and I want to [he gestures a beard and we both
165 laugh] and so you feel really left out I suppose
166 um so yeah, I suppose it was just such a huge
167 sense of relief and I was fortunate, when I finally
168 did get diagnosed, it seemed to happen so
169 quickly, the changes from the result of the
170 medication um probably because I was on the
171 cusp of it happening anyway, um just given that it
172 had been delayed a bit [R: right] um but I think
173 the biggest relief for me probably I was really
174 depressed and I didn't know why, I thought it was
175 my growth spurt, I thought teenagers get moody,
176 I feel miserable, I feel cold, I actually went bright
177 yellow, it's funny looking back at photos, you go
178 really jaundiced um and all those things just sort

conflation → big + hairy with
'masculinity' &
'being a man'

attempt to → encourage me
soften & → to laugh with,
defend → not at him,
not designed to → feeling
be a man... faulty

internalised & idealised
view of hegemonic
masculinity
humour as
a defence?

feelings of
inadequacy
Frustration @ doctors

allows himself
some credit

does he still feel
this?

temporal reference: present
tense - re-living the
experience?

Emergent themes	Transcript (Dylan)	Exploratory Coding
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179 of went away and I thought [laughs and sighs] 'oh
180 thank god for that'.

181 R: So, quite a big shift. [P: yeah] Um so then
182 zooming forward a bit, to the point when you
183 were then going for these battery of tests and
184 found out that you were infertile [P: yep], or
185 had fertility issues. [pause] How did you
186 manage that time?

187 P: Um [pause] I dunno, I suppose that [pause].
188 So what happened? I suppose we went to the
189 doctor and he sent us, well he sent me off for
190 standard suit of tests, um sperm sample, all that
191 kind of thing, um which I think I had to do 4 times
192 in the end [laughs], [pause] and [sighs] I suppose
193 the first time was the biggest shock because
194 [pause] I had gone from not knowing to being told
195 something, um [pause] and I just felt really...
196 guess emotionally crushed, remember coming
197 back from the doctor with Leila and I was
198 supposed to be going to work afterwards and just
199 thinking "I don't want to go to work" and we both
200 just took the day off [pause] and literally like sat
201 on the sofa feeling sorry for ourselves, like shit
202 [pause] that's that then, um we communicate... I
203 think we communicate quite well though, we talk
204 a lot about stuff like this and [sighs] yeah, I guess
205 I can't remember exactly kind of the order of
206 things, but after we kept talking and [takes breath
207 in] we definitely did want to have um children
208 [pause] It was funny I suppose, looking back, I
209 hadn't anticipated how upsetting Leila might have
210 found it... I kind of thought it's my problem, I'll be
211 the one upset but of course it affected her as well
212 so um [pause] she was kind of quite upset by it
213 understandably [takes breath in] um so [pause]
214 and I suppose at that point we started doing

Shock.
↑
emotional
impact of
discovering
MFI

'Flashback'
memory

joint
individual
loss

talking as
reparative
↳ communication

Desire for
children
whose
loss?

location
memory

pronoun use
shift between
we & me

emotion: 'shout'
'crushed' / 'shit'
'upset'

crystal clarity
of memory

minute detail

flashback memory
followed by
more fragmented
& hazy memories

who deserves
to mourn of
grief - is it an
individual loss
or a joint one?

painful to think +
talk about.

Emergent themes	Transcript (Dylan)	Exploratory Coding
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Doing
research -
taking
control.

215 research...I can't remember why now but the
216 [pause] I can't remember whether it was us
217 instigating it or the doctor just as part of whatever
218 might be their protocol saying; "right you need to
219 do another test to be sure", um but went back
220 and did more checks [takes breath in] um [pause]
221 and perhaps fortunately looking back I think there
222 was...there were no sperm in any of them, it
223 wasn't just that there was a few sperm and they
224 had poor motility or anything, I think there was
225 just nothing and we started to kind of say [pause]
226 'what are the causes of this?' and trying to delve
227 a little deeper into it, [pause] that's right they said
228 it could have been obstructional or kind of um
229 biological if you like, a kind of failure [pause] um
230 and so I think the further tests were in case it was
231 obstruction kind of thing um but it resulted in me
232 having a biopsy [tut] and that was the the kind of
233 absolute proof if you like [takes sharp breath in]
234 and they proved that there were no obstructions
235 and they took tissue from my testicles and
236 analysed them and and I think it was categorised
237 as primary testicular failure, which suggested that
238 I had probably never [pause] um made any
239 sperm or, you know, even if I had you know it just
240 wasn't happening at the moment you know and it
241 was irreversible. Um

repeated testing

looking / searching
for causes

feeling of failure

representing -
difficulty in
talking about
it.

words with never

'end of the
road'

nothing could be done

242 R: How did that feel? Hearing that?

243 P: that was [pause]...it was funny? I think I tried
244 quite level headed the whole way through it, and I
245 think it was until right at the very end [pause] and
246 um [pause] for some reason I felt...I think it was
247 to do with actually what we were told a little bit
248 um, [pause] that's right, it was the statistics of it
249 um [pause] and I remember statistics suggested
250 it was something like I had a a 40% chance of

importance of
staying in control -
not being taken over
by emotions
↳ pragmatism
↳ positivity

had calculated
↳ statistics / likelihood
if this a move
'male' trait?

Emergent themes	Transcript (Dylan)	Exploratory Coding
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251 them finding sperm, just due to the nature of the
 252 operation, and that kind of made me think [pause]
 253 "well god, you know I'm taking part in this, I'm
 254 going to contribute to those future statistics, so
 255 maybe there is a 40% chance" um and
 256 apparently when I was wheeled out from having
 257 the biopsy, kind of coming round from the
 258 anaesthetic, I told Leila that I felt quite positive
 259 about it [sniffs] only then to be later told of course
 260 [pause] that there was nothing Um [pause] so
 261 yeah I suppose I stayed [pause] reasonably level
 262 headed and I suppose it was quite crushing
 263 having then actually felt a bit optimistic, it's like
 264 you know that's it [sighs] um [takes sharp breath
 265 in] but at least it was pretty conclusive
 266 proof...[pause]

staying
'positive'
↓
disappointed

importance
of positivity

disappointment/
dashed hopes.

metaphor - feeling
squashed. "crushing"

↳ attempt to stay "level
headed" & in control →
keep self in check.

267 R: So there was a feeling of sort of being
 268 crushed a bit?

269 P: yeah definitely

270 R: Sorry to go into it but can you remember
 271 what that meant, what felt so crushing about
 272 that? It seems like an obvious question...

273 P: yeah I suppose it was um [pause] it's the final
 274 curtain isn't it. Its...up until then you've got...well I
 275 had all those thought in my head about "well I
 276 might still be able to be a biological father um
 277 [pause] I might still be able to carry my
 278 grandfather's kind of bloodline"... and it's when
 279 you say it...when you think about it rationally it
 280 really doesn't matter, but there is something
 281 emotionally in there that I really wanted, that was
 282 important to me um you know he hadn't known
 283 his parents and to think of just three generations
 284 kind of made it feel a bit sad really in that respect
 285 [R:mmm] [pause] and again I suppose, not being

Definitions
of father:
biological vs
social

The end

emotion vs.
rational

End of
genetic
line

connotation
with death
+ mortality
metaphor: the end

pronoun shift: "you're → I"
↳ talking generally on
behalf of men to claim
it as his own personal
experience

definitions/constructions
of 'fatherhood'

rational vs. emotion
↳ expectation for
men to be rational
& pragmatic.

comparing adoption +
DC

construction
of parent
as biological
↓
adoption
comparable to DC.

feel like
owed it to
grandfather?
short family
history - feeling of
letting down family

Emergent themes	Transcript (Dylan)	Exploratory Coding
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<p>feeling of being a failed provider.</p> <p><u>Mourning + loss</u></p>	<p>286 able to provide what I wanted in terms of my</p> <p>287 sister being um [pause] you know kind of having</p> <p>288 biological relations that she could be close with</p> <p>289 um [takes breath in] I suppose at the time I</p> <p>290 wasn't really thinking oh well we can have donor</p> <p>291 conceived children, cos I was just mourning my</p> <p>292 loss if you like, I suppose.</p>	<p>need to mourn before think about other options</p> <p>whom/wh?</p>
<p>impact on family</p>	<p>293 R: Sure, and then I guess thinking more about</p> <p>294 that, in whether you discussed what was</p> <p>295 happening at that time with people?</p> <p>296 P: yeah, um I did actually, so we told our families,</p> <p>297 um [pause] who were all [pause] pretty</p> <p>298 shocked...ah well maybe shocked wasn't the</p> <p>299 right word; they were pretty upset for us. Very</p> <p>300 very supportive, all of them um [pause] but quite</p> <p>301 a lot of tears from my mum and strangely actually</p> <p>302 from my dad, which really touched me because</p> <p>303 he's a very [pause] he's a great dad [smiles] um</p> <p>304 [pause] but he's very [pause] emotionally</p> <p>305 conservative you could say...he's a very matter</p> <p>306 of fact guy and and to see him get so worked up</p> <p>307 about it [pause] kind of really...it it it kind of made</p> <p>308 me realise he really did care and it was important</p> <p>309 to him, and he came back to me quite a few</p> <p>310 times to say if you want to talk and to offer</p> <p>311 support um which was really really helpful</p> <p>312 actually, um [pause] and perhaps it rung</p> <p>313 something in him to do with his relationship with</p> <p>314 his dad you know, maybe he he felt a bit sad.</p>	<p>upset</p> <p>shock & impact on family.</p> <p>felt supported</p> <p>worried about my judgement.</p> <p>ideas on how men manage emotion -> template that men are stoic and in control.</p> <p>to narratives around men talking.</p>
<p>'men don't cry'</p> <p>being given space to talk.</p>	<p>315 R: So it was your paternal grandfather who</p> <p>316 was adopted?</p> <p>317 P: yeah yeah, you know for the same reasons</p> <p>318 that line would not be carried on um. Other than</p> <p>319 family, um, my friends kind of surprised me</p> <p>320 actually. It was weird, I [pause] I went from</p>	<p>Stutter: emotional impact of this seems great -> mirroring emotion from his dad.</p> <p>connected - metaphor</p> <p>ways of showing you care -> being explicit & open about loss & emotion</p>
<p>end of family line.</p> <p>support from friends + family.</p>		<p>to impact on whole family not just hers.</p> <p>expected them to shut down conversation</p>

Emergent themes	Transcript (Dylan)	Exploratory Coding
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idea of talking as threatening.

men as supportive.

Continuum of 'manliness'

initial perception that MFI is rare.

normalizing experience

perception that MFI is rare.

321 thinking I didn't want to tell anyone to telling
322 quite a few close friends um and being a little bit
323 tentative and nervous about it but [pause] I dunno
324 I think [pause] I'm not very secretive, so it felt like
325 it was the natural thing to do um and I was pretty
326 overwhelmed really by how supportive they were,
327 particularly the guys, I kind of thought they
328 wouldn't want to talk about it, might go you know,
329 might go: "oh that's sperm don't want to talk
330 about that" um and it was really strange kind of
331 [pause] you know (all) (all) of them from the,
332 [pause] the kind of your standard guys to the
333 guys who are really big, butch men were really
334 happy to talk about it and that felt really
335 supportive actually
336 R: what was that like?

337 P: It was cool um it was a little bit weird [pause]
338 cos we would find ourselves in pubs drinking
339 beer talking about sperm, um but people were
340 fascinated um with different things, they were [cat
341 sits on my lap] um they were fascinated by the
342 biopsy with the mechanics of it and that kind of
343 thing and perhaps got a few of them thinking um
344 which certainly wasn't my intention to kind of like,
345 [pause] you know not maybe "do I need to get
346 checked", but maybe "there is a possibility that
347 you know I might have problems" cos its...I think
348 the more I learnt about it then more I realised it
349 is actually incredible common to have fertility
350 issues, whereas before I thought it was about
351 one in a million it's not at all.

352 R: did you think that for men and women?

353 P: [sighs] probably a bit of both. I think I thought
354 fertility issues in general were far less common
355 than they are, but in men I thought they were

- fear of telling people
- worried about their reaction?
- if he feels it makes him 'less' of a man - does he fear that others will think so too?

- expectation/prediction men wouldn't want to talk.

→ he links/correlates manliness with willingness to talk.

→ internalised discourses that men don't talk about emotions.

recalling.
// juxtaposing what he believed to be typically 'man' activities with untypical ones.
→ novel experience

→ Focus on the physically rather than emotionality

- raising awareness of MFI.

- discovery of MFI as common - talking helpful in normalizing

→ perception of rarity lead to greater sense of isolation & shame.

Emergent themes	Transcript (Dylan)	Exploratory Coding
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356 really uncommon. And again it is just not the
357 case [18:22].

unspoken in society - narratives of divorces around infidelity being a woman's problem or at least not a man's...

358 R: So they surprised you, being able to really
359 get into the 'nuts and bolts' of it [laugh] how
360 about the emotional stuff...did you feel you
361 were able to share some of that more
362 emotional stuff with them as well?

363 P: Yeah. Um [breaths out] maybe to a slightly
364 lesser extent because [pause] I suppose I am my
365 father's son a bit [smiles] and I don't know.
366 Maybe, yeah [pause] I did with a smaller group of
367 closer friends [pause] I kind of talked about
368 feeling pretty gutted and that kind of stuff and that
369 was [pause] maybe slightly different response in
370 that and not a response of lack of support but
371 maybe people found it difficult to know how they
372 could support me, you know other than just
373 saying, "I'm really sorry" but you know that was
374 enough

when Ted character traits

what is inherited from parents? / father.

enjoy the similarities between them

had something taken out / was missing something inside so possibly the life he will not create?

375 R: yeah, and you said that initially you didn't
376 want to tell anyone, do you remember what
377 that was about?

378 P: Yeah I guess it was [sighs] it was only a very
379 fleeting feeling really and it was kind of before, it
380 was while I was really in the throes of the
381 emotional response just so [pause] disappointed
382 and upset and just kind of...maybe not that that
383 didn't want to tell anyone, but that I just didn't
384 want to have to talk about it, just [pause] cos it
385 reminded me of...that it was real - suppose
386 [pause] um and I suppose that it was probably
387 talking to Leila that you as time goes on you feel
388 a little bit less [pause] like it's a raw wound kind
389 of thing...maybe you grieve a little bit and then it
390 becomes something you are naturally more

wish to avoid / suppress

feeling vs. thought

unconscious wish to forget?

temporal shifts

defence - denial / suppression

talking as painful... but reparative

STAGES OF GRIEF

puts / or replaces word, infidelity, trying his reluctance to vocalise / name it

painful - talking adds salt to wound & reopens.

Grief / bereavement

GRIEF difficulty articulating something so emotive & complex.

shift & movement gets easier - talking as healing & time.

Emergent themes	Transcript (Dylan)	Exploratory Coding
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empty.
stages of grief

Fragmented memories following disclosure

The couple together or separate

importance of making the baby

391 comfortable talking about, doesn't feel like it pulls
392 the life out of you so much. Um yeah [takes sharp
393 breath in].

394 R: Yeah [pause] So I guess thinking about the
395 journey for you and Leila to decide that donor
396 conception was the route you were going to
397 take. [P: yeah] How was that negotiated or
398 thought about?

399 P: Um [pause] trying to remember actually, I'm
400 guessing, as Leila mentioned she's a scientist
401 anyway so she knows about, these types of
402 things um she doesn't work in fertility but I
403 suppose she has a natural tendency to do
404 research to the extreme [laughs] very useful. So
405 I'm struggling to remember whether it was (her)
406 doing research or kind of (us) doing research or
407 whether it was a kind of, one of the things our GP
408 said was these are your options. It was probably
409 a bit of (both) Um we talked about [pause]...well
410 we looked, we talked about whether we would
411 consider things like (adoption) and we also looked
412 into things like adoption to find one about it
413 [pause] um we even talked about (fostering) that
414 kind of thing um, just to really thrash out where

415 we are. Was it that we wanted (children) or was it
416 that we wanted (babies)? And do we want to have
417 the babies? and [pause] um I think the more we
418 talked about kind of (donor services) [takes breath
419 in] the more it felt that that was (probably) what we
420 wanted to do, you know it gave us the potential
421 for the experience that we wanted, um you know
422 Leila was able to have the experience of a
423 pregnancy um to go through the (birth) together
424 and...the other thing to have a (baby) whereas
425 [pause] the more we looked into things like
426 adoption the more we realised that's actually very

stages of grief

metaphor: born the pain/piercing of talking about you and providing symbolic of the life he feels is not inside him i.e. potential baby.

hard memories, difficult decision was it: considering one did independently of him, considering options

was she the driving force?

Will something do this, make him feel comforted? manipulating + working through.

children vs. babies ambivalence?

at least one of them could have experience of being genetic parent.

joint venture.

Appendix 15: Extract from Reflexive Journal Whilst Transcribing

Notes made of my thoughts and reflections whilst transcribing and analysing Dylan's interview in an attempt to 'bracket' my experiences and suspend my assumptions. The examples chosen correspond to the section of transcript provided in Appendix 14:

Page 4:124 How does my being a woman impact on what was said and how I am interpreting this? If I were a man would Dylan feel so open in sharing his concerns about feeling an "incomplete man"?

Page 5:150 Whilst my intention was to encourage Dylan to elaborate on his previous comment, I suspect this question was excessively leading.

Page 5:164 I wondered whether Dylan used humour to bring me 'on-side' and make it easier to talk about 'emotive topics'.

Page 7:242 When considering the impact of my questioning: I wonder whether I have a greater tendency to be more alert to issues of difficulty and worry than moments of strength and growth in the face of adversity.

Appendix 16a: Example list of Initial Themes

Dylan's emerging themes and page and line references

Themes	Page:Line
Desire For Children	1:7
Life Cycle/Right Of Passage	1:11-22
	5:172
Making The Baby/The Difference Between Having And Making	2:47-52
	12:417
	13:433
	13:459
	13:455-462
	17:590-591
	18:607-608
	25:871-874
Mourning The Unborn Self	11:390
	9:292-293
	3:71-83
Reparative Talking	6:207
	11:387-394
Pain	11:389
	11:392
	3:72
Their Father In Them	11:365
Men Are Emotionally Conservative/Emotion Vs Ration	9:305-307
	18:639
	12:406-407
Togetherness	17:591-600
	19:650
	20:705
	35:1230

Themes	Page:Line
Taking Control/Research	2:46
	12:406
	12:404
	7:215
Bonding	25:875-862
	25:876-878
The 'Special' Child	26:906
	25:883
	32:1132
	33:1142
The Man In The Boy	27:939
	26:922-925
Emotion Vs Reason	27:941
	26:920
	31:1086
	28:975-976
	33:1156-1162
Roads And Journeys	28:991
Not A Real 'Man'	4:124
	4:117-118
Conflating Masculinity & Fertility	30:1065-1067
	31:1087
	31:1092-1093
Continuum Of Manliness	31:1088
	10:333
Society's Expectations	32:1106-1107
	31:1090

Who Deserves To Mourn?	6:211
The Guilt Of Not Rescuing A 'Damaged' Stranger	2:52-57
	13:427-434
The Guilt Of Denying Loved Ones	3:91-92
	3:75
The Family	18:620
Men Talking	10:328-352
	11:356
	11:332
Women's Problem	5:147
	33:1153
	1:29-30
The End Of The Family Line	9:319
	3:79-83
Its Private, Not Secret	21:728-730
People Who Get Paid To Help	21:744-746
	23:816-820
	24:836
	28:975
	28:981
Flashbulb Memories	6:197
	23:786
Fixing The Artificial With Natural	24:844
	24:855
	30:1031

Does Testosterone Maketh The 'Man'?	3:1096-1099
	5:161
	4:120
Role Models	31:1092
	27:940
The Man Who Succeeded	15:528
	32:1109
The Impotent Power Of Puberty	5:175-176
	5:159
	4:136
	4:112-113
Getting To Know/The Slow Hello	32:1111
	32:1125
The Therapy Test/Social Services For Foetuses	34:1171
	35:1210
	34:1194
Unmentionable	11:385
	1:26
	4:109
Peer Comparison	4:113
	4:133-135
	5:164-166
	1:18
Involvement	22:754
	29:1013

Appendix 16b: Example of a Participant's Clustered Themes

Dylan's clustered theme table

Cluster	Emerging Theme	Page:Line	Quote
The Couple	Togetherness	17:591-600	It was fun because it was something we were doing <i>together</i> .
		19:650	we were kind of on <i>edge</i> but on <i>edge together</i> so it was alright
		20:705	we're <i>pregnant</i>
		35:1230	Maybe if we weren't a couple that <i>talked</i> [...] it could have been very helpful
	Who Deserves To Mourn?	6:211	I kind of thought it's <i>my</i> problem, <i>I'll</i> be the one upset but of course it affected her as well
Disrupted Life Cycle	The Impotent Power Of Puberty	5:175-176	I <i>thought</i> it was my growth spurt, I thought teenagers get moody
		5:159	as a boy growing up all you want to be is big and hairy and a <i>man</i>
		4:136	feeling <i>really</i> inadequate
		4:112-113	I went from kind of being the tallest and slimmest in my year to being [pause] really short and squat and depressed and all my kind of <i>peers</i> were <i>growing</i> and becoming men
		32:1111	had I not had that <i>delay</i> in my growth spurt, it may not have been an issue at all
		3:106-110	<i>around</i> the point where you normally have your growth spurt, go through puberty and that sort of thing that I was <i>diagnosed</i> and one of the effects of being undiagnosed is that that's completely <i>delayed</i>
	Desire For Children	1:7	I think I always knew I wanted to have children
	Life Cycle/Right Of Passage	1:11-22	it just suddenly started feeling like something I wanted to happen pretty soon [...] friends started having babies [...] and it changed quite quickly
		5:172	the changes from the result of the medication um <i>probably</i> because I was on the <i>cusp</i> of it happening anyway
	Flashbulb Memories	6:197	I remember coming back from the doctor with Leila and [...] we both just took the day off [pause] and <i>literally</i> like sat on the sofa feeling sorry for ourselves
		23:786	I think we were doing some gardening and went for a walk, and I was about to start cooking supper when all of a sudden
	Women's Problem	5:147	my sister, they said you know you've got hyperthyroidism, we need to do these checks, as a matter of course you know standard protocol, um they <i>never</i> said any of that to me
		33:1153	there's <i>more</i> of a link there for women,
		1:29-30	she's known since the age of about 10 or 11 that she was going to have fertility problems
	Peer Comparison	4:113	all my kind of <i>peers</i> were <i>growing</i>
		4:133-135	being a teenager at that time, you are comparing yourself to your peers [pause] so much
		5:164-166	you just think he's 14, he's growing a <i>beard</i> and I want to [...] and so you feel really left out I suppose
		1:18	friends started having <i>babies</i>
	Mourning The Unborn Self	11:390	"you <i>grieve</i> a little bit"
		9:292-293	"I was just <i>mourning</i> my <i>loss</i> "

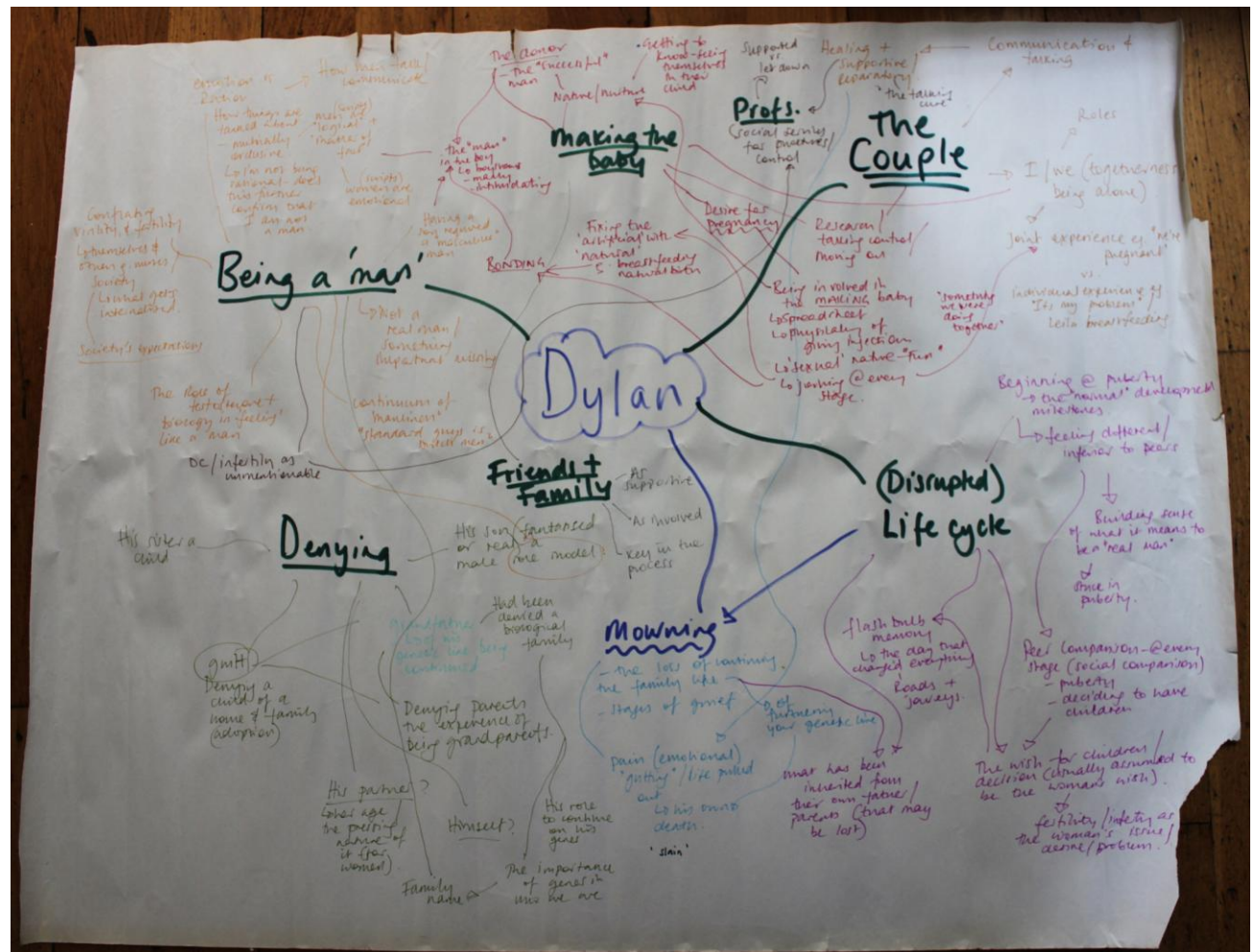
		3:71-83	"pretty <i>devastating</i> "
	The End Of The Family Line (Morrissey)	9:319	that line would not be carried <i>on</i> um
		3:79-83	<i>I'm</i> the only male on that side that <i>could biologically</i> carry on the Smith name
	Their Father In Them	11:365	"I suppose I am my father's son"
	Pain	11:389	a raw <i>wound</i>
		11:392	it pulls the life out of you
		3:72	<i>devastating</i>
	Roads & Journeys	28:991	it kind of felt like a flat end
Denying	The Guilt Of Not Rescuing A 'Damaged' Stranger	2:52-57	"Um I went through a period of [pause] feeling quite <i>bad</i> about, or certainly <i>I</i> did I can't speak for Leila, she may or may not have saying are we bad people if we <i>don't</i> want to <i>adopt</i> people"
		13:427-434	the more we looked into things like adoption the more we realised that's actually very <i>difficult</i> and um you're much more likely to get a kind of 4 year old um and [pause and sighs] so that's what I was talking about...we felt a feeling of <i>selfishness</i> in a way, there is a baby already <i>there</i> who [pause] could really benefit from a loving family
	The Guilt Of Denying Loved Ones	3:91-92	I really thought I wanted <i>her</i> to be really involved in <i>my</i> children's lives
		3:75	my <i>grandfather</i> was adopted [R: right] and never knew his biological parents
	Denying His Son A Role Model	27:940	you <i>need</i> to be that kind of guy to...it's so irrational isn't it?...to kind of um...to you know be a role model for <i>them</i>
	Denying Parents	9:313	perhaps it rung something in <i>him</i> to do with his relationship with his <i>dad</i> you know, maybe he <i>he</i> felt a bit sad
		9:301	quite a lot of <i>tears</i> from my mum and <i>strangely</i> actually from my <i>dad</i>
Being A 'Man'	The Man Who Succeeded	15:528	a CEO from a company um and [pause] you know, that sounds like <i>successful</i> [...] I <i>think</i> that probably being honest we were drawn to him because he had demonstrated that he was <i>successful</i>
		32:1109	I suppose it might be a kind of er traditional view of the kind of successful man who goes out and does this
	Unmentionable	11:385	I just <i>didn't</i> want to have to talk about it, just [pause] cos it reminded <i>me</i> of...that it was <i>real</i> I suppose
		1:26	something in the back of my <i>mind</i>
		4:109	being undiagnosed
	Not A Real 'Man'	4:124	<i>something</i> in the back of my head that said: "you're not a proper <i>man</i> , kind of thing, you're [pause] you're <i>missing</i> a piece"
		4:117-118	"uh you're not really quite right"
	Continuum Of Manliness	31:1088	You know men, masculine, men
		10:333	kind of your standard guys to the guys who are really big, butch <i>men</i>
	Does Testosterone Maketh The 'Man'?	3:1096-1099	I've got more testosterone in my body than <i>most</i> men
		5:161	I think probably <i>biologically</i> and <i>genetically</i> I wasn't <i>designed</i> to be a big and hairy guy
		4:120	in terms of <i>testosterone</i> ,[...] there was <i>something</i> in the back of my head that said: "you're not a proper <i>man</i> "
	Conflating Virility & Fertility	30:1065-1067	my virility [...] it was to do with the fact that Leila was pregnant with twins, "oh aren't you a fertile one"
		31:1087	You know men, masculine, men should be <i>virile</i>

		31:1092-1093	male role models are masculine and are [pause] <i>probably</i> virile
	Emotion Vs Reason	27:941	it's so irrational isn't it?
		26:920	It was complete nonsense I think, it was weird
		31:1086	I suppose <i>rationally</i> I think it's <i>stupid</i> but I <i>do</i> feel it definitely
		28:975-976	he was so matter of fact about this thing that had emotionally <i>slain</i> me
		33:1156-1162	I think they were much more focussed on [pause] the mechanics of it [...] whereas there wasn't a kind of, and if you want to talk to people in terms of <i>support</i> um.
		9:305-307	he's <i>very</i> [pause] emotionally <i>conservative</i> you could say...he's a very matter of fact guy
		18:639	she had quite a lot of <i>emotional</i> worry
	Society's Expectations	32:1106-1107	it's so [pause] <i>indoctrinated</i> in me, it's just such a gentle social massaging all of your life
		31:1090	I think all your life you grow up and you kind of...maybe there is a sort of stereotype that good, male role models are masculine
	Role Models	31:1092	male role models are masculine
		27:940	you <i>need</i> to be that kind of guy to...it's so irrational isn't it?...to kind of um...to you know be a role model for <i>them</i>
	Men Talking	10:328-352	I was pretty <i>overwhelmed</i> really by how supportive they were, particularly the <i>guys</i> , I <i>kind</i> of thought they wouldn't want to <i>talk</i> about it
		11:356	your standard guys to the guys who are really big, butch <i>men</i> were <i>really</i> happy to talk about it and that felt <i>really</i> supportive actually
		11:332	<i>all</i> of them from the, [pause] the kind of your standard guys to the guys who are really big, butch <i>men</i> were <i>really</i> happy to talk
Making The Baby	Fixing The Artificial With Natural	24:844	we both <i>really</i> wanted to have a natural birth
		24:855	in terms of thinking about things like <i>bonding</i> , [...] knowing that our children are DC anyway, we wanted every opportunity to be able to bond and we had heard, or read things about um [pause] <i>lack</i> of bonding through C-sections
		30:1031	Leila really wanted to exclusively breast feed
	Making The Baby/The Difference Between Having And Making	2:47-52	"we also really wanted to go through the process of being pregnant, it sounds really weird, but we both did um [sniffs] and kind of making, you know growing the baby you know because it seems like an important part of the experience."
		12:417	Was it that we wanted <i>children</i> ? or was it that we wanted babies? And do we want to <i>have</i> the babies?
		13:433	"we want to be...to get <i>pregnant</i> "
		13:459	"we started making a spreadsheet"
		13:455-462	so there was also the <i>picking</i> the actual, the <i>donor</i> . Which turned out to be really good <i>fun</i> ,
		17:590-591	"it started becoming really fun because it was something we were doing together."
		18:607-608	"Definitely not in the normal way [smiles] but we managed it <i>another</i> way"
		25:871-874	"I suppose going through the pregnancy [pause] and you know <i>touching</i> them and <i>listening</i> to them and literally <i>watching</i> them growing"
	Taking Control/Research	2:46	doing our own <i>research</i>
		12:406	I'm struggling to remember whether it was <i>her</i> doing research or kind of <i>us</i> doing research
		12:404	she has a natural <i>tendency</i> to do research to the extreme
		7:215	we started doing research

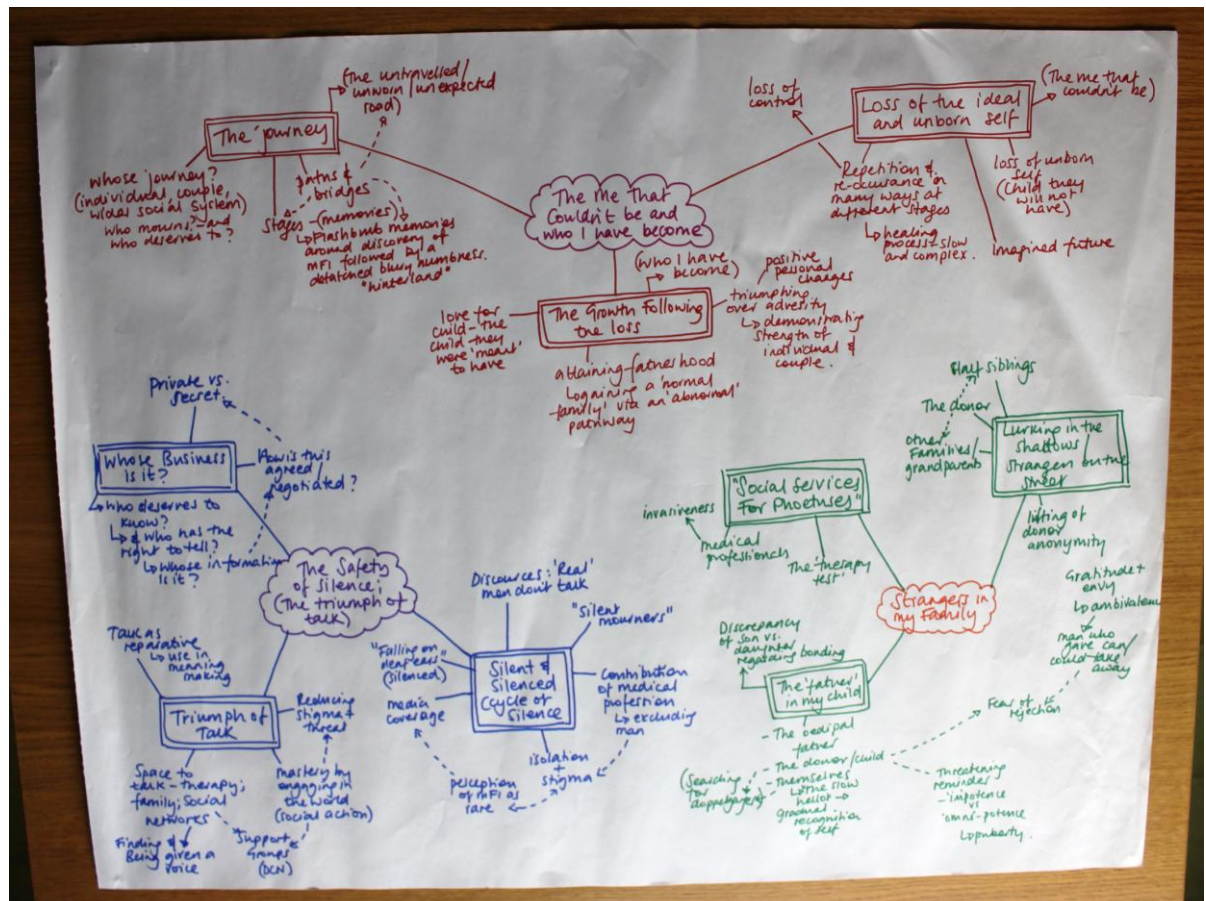
Bonding	25:875-862	I guess I felt so connected that...I don't think I did have a particular worry about bonding
	25:876-878	I suppose going through the pregnancy [pause] and you know touching them and listening to them and literally watching them growing
The 'Special' Child	26:906	"you kind of feel <i>special</i> you know,
	25:883	hopefully see the DC thing as quite a <i>unique</i> , special thing
	32:1132	introducing the idea and making it a positive thing
	33:1142	they can feel a bit <i>special</i> like that
The Man In The Boy	27:939	something in my head said that if you have 2 boys you <i>need</i> to be that kind of guy to be a role model for them
	26:922-925	I <i>envisage</i> , I don't know why but I envisaged them coming about as 5 years old or you know kind of <i>toddlers</i> , kind of really loud, shrieky boy toddlers, that wanted to play <i>football</i> and do <i>man</i> things
Getting To Know/The Slow Hello	32:1125	I think the next big, the <i>initial</i> future is just getting to know them and you know them growing up
The Therapy Test/Social Services For Foetuses	34:1171	this is an exam, we need to prep for this
	35:1210	let's get this nailed in one. I didn't want to go back for 6 sessions
	34:1194	social services for foetuses
Its Private, Not Secret	21:728-730	I wouldn't tell a stranger in the street, but my <i>friends</i> , people who have an influence on my life, yeah, they knew
People Who Get Paid To Help	21:744-746	buoyed by the staff who were very supportive and seemed to be very matter of fact
	23:816-820	wow" the NHS is amazing, because that continuity of care, to have a familiar face and someone who is clearly so practiced um she was just brilliant, very calming, lovely to me
	24:836	pissed off with the doctors
	28:975	My GP um, pretty shocking, not in an unprofessional way but in a [pause and sighs] he was so matter of fact about this thing that had emotionally slain me
	28:981	He just didn't help, he, was pretty emotionally um non-existent I think
Involvement	22:754	<i>my</i> role was trying to manage...was trying to <i>help</i> her feel comfortable really
	29:1013	I was literally helping at every feed then
The Talking Cure	6:207	we kept talking
	11:387-394	it was <i>probably</i> talking to Leila that you as time goes on you feel a little bit <i>less</i> [pause] like it's a raw <i>wound</i>
The Family	18:620	it was a really cool update to be able to give them

Appendix 17: Example of a Participant's Mind-Map of Themes

Mind-map of Dylan's themes



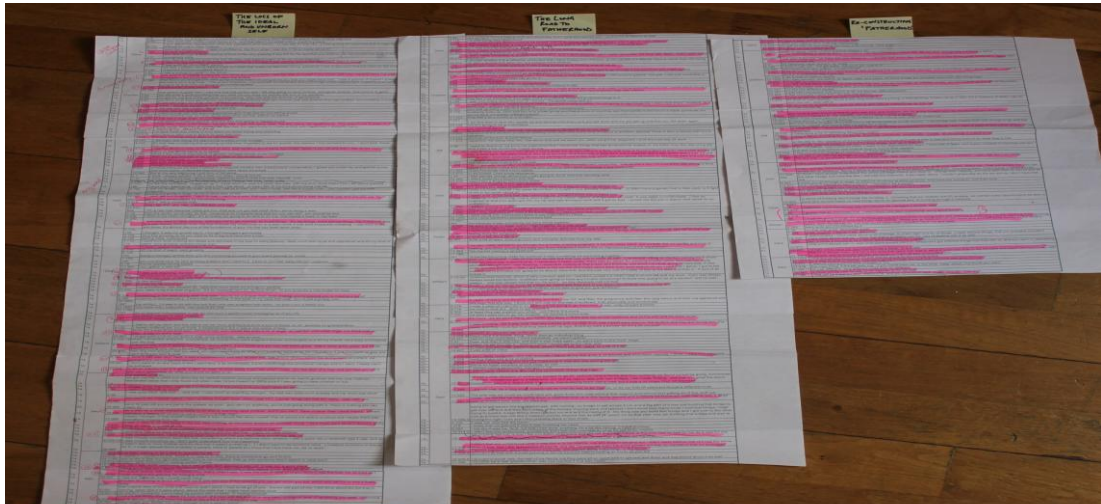
Initial mind-map of themes across cases



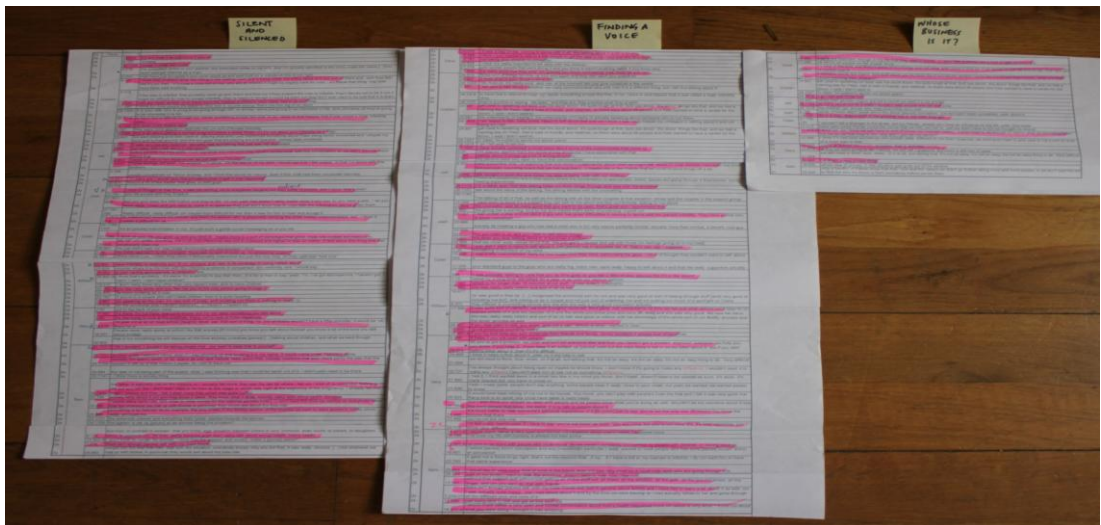
Appendix 19: Master Theme Tables

Participant extracts evidencing each of the nine sub-ordinate themes, clustered by super-ordinate theme.

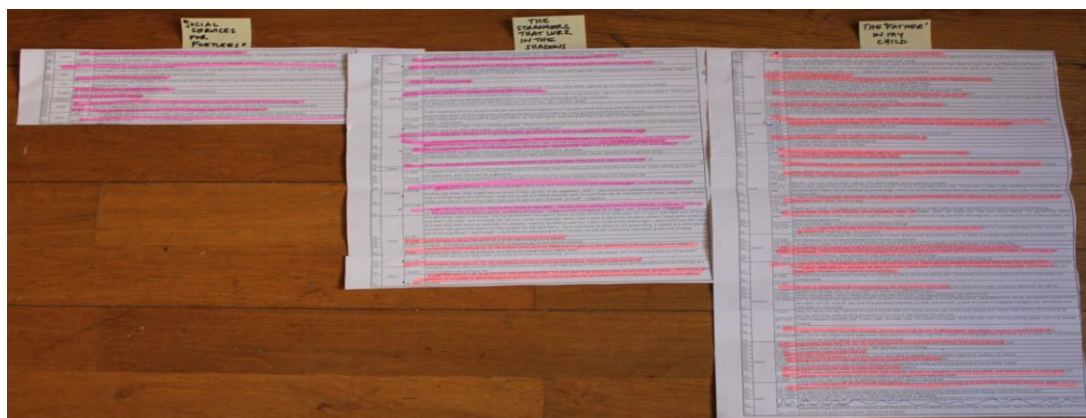
Picture a) Super-ordinate theme: 'The Loss of the Idea and Unborn Self'



Picture b) Super-ordinate theme: 'The Safety of Silence; the Triumph of Talk'



Picture c) Super-ordinate theme: "The Strangers in My Family"



Appendix 20: Supplementary Quotes Evidencing each Sub-Ordinate Theme

Tables are colour coded by super-ordinate theme (Figure 1)

'The Loss of the Ideal and Unborn Self'

Dave	1:12	I was born with undescended testes [...] that wasn't corrected until my teens
	1:24	we both wanted children
	3:77	she went through a kind of period of kind of like ehm grieving
	5:142	also feeling a little bit guilty
		kind of like <i>black mark</i> behind my name
Graham	22:768	bereavement of that person I <i>was</i>
	22:784	that person who I felt was going to have biological children, [...] is gone
	3:82	it's quite a profound thing that you think [...] it's entirely the end of the genetics
	4:136	I did feel very sad I mean I felt very very low
	7:220	I can't put up with this anymore you know and I'll go and do something stupid.
	34:1235	it has had a huge <i>strain</i> on our relationship.
Jed	3:103-5	terribly devastated [...] I couldn't imagine this was ever going to happen to me.
	16:618	you have to take time to grieve for your own loss
	4:156	I lost the ability to pass on this sort of <i>story</i> and narrative [...]and then I lost uh the opportunity to carry on the family name
	5:163	Well I'm a guy and part of my job is to pass on the family line
	5:175	lost the opportunity to create a child
	6:224	We both wanted to have kids
	6:225	thought that that would be part of our future
	15:592	But at the very beginning I just kind of felt <i>alone</i>
Josh	1:7	I think I always <i>wanted</i> to be a dad
	7:258	it's almost like one of the foundations of your life that has been taken away
	5:195	I didn't <i>really</i> feel like a <i>proper</i> man , cos I couldn't get my wife pregnant
	21:794	people are going to <i>laugh</i> at me or think <i>less</i> of me
	6:232	I thought I am probably <i>not</i> going to be able to do this, that sewed a <i>seed</i>
	10:354	I felt <i>devastated</i>
Dylan	5:159	as a boy growing up all you want to be is big and hairy and a <i>man</i>
	4:112	all my[...]peers were <i>growing</i> and becoming men[...]feeling [...] inadequate
	1:7	I think I always knew I wanted to have children
	9:292	I was just <i>mourning</i> my <i>loss</i>
	3:79-83	<i>I'm</i> the only male on that side that could biologically carry on the name
	11:389	a raw <i>wound</i>
	31:1087	You know men, masculine, men should be <i>virile</i>
William	1:11	we always wanted to have children
	2:67	emotional sledge hammer
	5:173	everyone was kind of [...]having kids [...] you smile and say well that's great, "that's really great news" but inside you're thinking why can't it be <i>me</i> ?
	24:848	to be an infertile man it is <i>quite</i> a <i>dent</i> to [...] ones <i>being</i> [...] you feel <i>less</i> of a man and you feel you <i>can't</i> , [...] <i>do</i> what you're put on earth to do
Gary	1:6	we wanted children
	1:34	I hadn't developed so much
	15:481-499	this was in the hospital before I had my testes brought down when I was 14 [...] <i>some</i> things like that are really... <i>stay</i> with you [...] you can't do anything
	15:493	freak show [smiles] something that people would need to see.
	4:105	It was disappointment
Sam	27:919	I've been waiting to be a dad for [pause] my <i>life</i>
	16:540	um life it was worth continuing, but it was pretty <i>dark</i> it was <i>not</i> a good place,
	3:90-93	the actual <i>feeling</i> was loss, complete <i>loss</i> ,[...] it was the loss of what of of you know [...] <i>grieving</i> for losing a child
	3:89	process of coming to terms with that we lit [...] one of the lanterns

‘The Long Road to ‘Fatherhood’

Dave	5:129	I was more worried about Louise [...], cos I'd accepted for a long time
	10:275	so I was there for everything
	30:893	think maybe it's because we're very close that we did everything together,
	20:574	I don't really remember it, no I don't [pause] I can't remember the time
Graham	1:13	found out I was infertile and [...] it was a long journey to thinking what we do
	19:677	sometimes a horrible horrible journey you know and you don't really want to go through it but you know you might as well
	20:720	she really really wanted to just go straight down the donor route
	2:43	I can't remember a time almost now I can't remember a time when there was
	2:58	she was very pushy
Jed	2:76	but at the end of the day we were both going to be childless
	1:21	our personal <i>journey</i>
	11:417	I remember her being very very sad about that and we spent um..when we got her diagnosis I took the next day off <i>work</i>
	6:208	I really honestly can't remember...that all just a blur
	11:394	those memories were much clearer
Josh	12:472	to be <i>honest</i> I had some <i>reluctance</i>
	2:24	I had <i>worries</i> though about how I was going to <i>bond</i> with this resulting child
	24:898	It's always two steps forward and one step back and may always be,
	3:100/108	made me think, <i>should</i> I be upset about this? [...]Cos actually I don't <i>have</i> [...] a genetic link to that child, is it right of me to be <i>upset</i> about it?
	9:351	I spent a <i>lot</i> of the time that day reassuring <i>her</i> which was a <i>weird</i> one.
	6:209	I was an engineer at that time and I got into my car and was driving to work and it got so <i>bad</i> , I pulled into the petrol station and called for an <i>ambulance</i>
	10:386	I walked around in a <i>daze</i>
	11:403	that you kind of <i>switch</i> yourself off <i>emotionally</i> from the whole experience.
Dylan	10:390	and I may well have still been a bit there today if I hadn't have been pushed into it
	19:650	we were kind of on <i>edge</i> but on edge <i>together</i> so it was alright
	6:211	I thought it's <i>my</i> problem, <i>I'll</i> be the one upset but of course it affected her
	6:197	I remember coming back from the doctor with Leila and [...] we both just took the day off and <i>literally</i> like sat on the sofa feeling sorry for ourselves
	28:991	it kind of felt like a flat end
William	2:47-52	we also really wanted to go through the process of being pregnant [...] growing the baby
	4:124	it was a <i>blow</i> for me as much as a blow for Claire
	12:441	it was kind of a little bit of a <i>mountain</i>
Gary	6:210	we had been in this <i>hinterland</i> for a long [...] time
	18:586	there are different ways that life goes, there are different paths
	9:307	it's more...it's all about Kerry
Sam	14:466	it was snowing, cos it was cold, that day outside
	13:424	became an issue for <i>me</i> or for <i>us</i>
	14:447	it was a bit of a blur
	13:435-437	I don't really remember very well because I stared at my feet quite a lot [pause] and shut down <i>mentally</i> I think, I went into <i>autopilot</i>
	13:419	we were driving along when we got the call
	12:388	it's not <i>over</i> by a long short, it never will be over for me, or for Yasmin, or for our kids [R:yeah] but its just a different route,
	17:581-584	we felt like we were going down a road that took us to this family and suddenly we found our road was a <i>dead</i> end, or it didn't even exist, we were <i>lost</i>
	11:353-358	I didn't really believe that she had the same level of <i>loss</i> that I did, [pause] but of <i>course</i> she did, because we didn't have the genetic kid that we wanted or that we envisaged
	13:445	Yasmin organised, she pretty much took over, she started doing <i>everything</i>

'Re-constructing 'Fatherhood'

Dave	21:592	to have a baby and all the normal things really.
	18:524	you get on with life and raising two boys is like bloody hard work
	31:900	it's given me this brilliant family
Graham	20:707	then there is like all the good, funny bit's, happy bit's, it's just normal life.
	3:81	it's obviously never going to go away
	6:124	I think things will... not get better, but you'll get used to it.
	12:434	no longer an infertile couple
	22:761	I just can't remember that person at all, it's like <i>two</i> different people
	23:803	I feel extremely happy that I am this new person
	10:352	it just tested me, it tested me and I came through it
Jed	19:666	all you can do is bring them up to be able to deal with as many things
	16:618	you have to take time to grieve for your own <i>loss</i> and whatever you do going forward won't <i>fix</i> the fact that you're infertile.
	15:591	I have almost <i>no</i> lingering feelings
	16:599	the first couple of years of our first-born's life those feelings would <i>reoccur</i>
	4:137	it certainly <i>was</i> . I don't know how much <i>now</i> I can let that be important to me because I don't want to pass on this sense of <i>loss</i> to my daughters
	20:773	I have done a lot of rethinking about my religion
	15:582	being a father providing for the family, <i>financially, physically, emotionally, socially</i> , all the things it means to be
	15:578	I feel sometimes feelings of isolation, uh most of that goes away
Josh	18:681	a lot had to do with the strength of our relationship
	25:960	the fact that I m genetically disconnected from them ever seem to matter any more...no it doesn't. I really feel like their daddy
	1:10-11	that's something I wanted to do or rather wanted to <i>be</i> .
	23:856-862	I think I have always <i>understood</i> the whole package [...] change their nappies [...]and all the other things, but nonetheless I still had this <i>insecurity</i> [...] I couldn't physically do the act and so I don't have that link.
	8:291	I think you go through a <i>range</i> of different emotions at different times. And there are <i>moments</i> and even <i>now</i> .
	11:411	and I knew <i>I</i> wanted to have a parent...I wanted to be a parent,
	23:865	I'm here sitting here now having this conversation with you so it matters.
Dylan	24:928	how I feel does shift and does change over time
	18:607	"Definitely not in the normal way [smiles] but we managed it <i>another way</i> "
William	25:876-878	I suppose going through the pregnancy [pause] and you know touching them and listening to them and literally watching them growing
	33:1181	if you could go back in time and if you had wishes...would you give yourself fertility so the child is <i>yours</i> and I would say no, cos that would mean that I wouldn't have Lily and Jack
Gary	6:209	were quite [pause] excited by it
	1:26	so that was great, absolutely great.
	7:239	it felt <i>magical</i> magical it felt, definitely.
	17:573	what some people can do and what some people can't do, everyone's got different things that they can do, and you can't do everything
	29:980	I'd hate not to have the opportunity to be a <i>father</i> or a <i>daddy</i>
Sam	31:1023	Nature is always there, but we're the ones that teach him how to eat and [...] how to say hello to people [...] that's all part of moulding him
	31:1059	once you've conceived and we just started going for the normal scans
	29:1005	a <i>parent</i> is about the person who's there, [...] for you when you've scuffed your knee or you're getting bullied
	27:939	the main thing, if the kid asks me, "if you could have <i>me</i> or the <i>other</i> baby, which one would you <i>want</i> "
	4:109	its just <i>different</i> , its a different route now, so different.
	12:387	it never will be over for me, or for Yasmin, or for our kids

'Silent & Silenced'

Dave	0	0
Graham	35:1244	sweep it under the carpet
	8:278	the consultant writes to your partner, the consultant writes to my wife. And I'm actually admitted to the clinic under her name [...] You don't ever get referred as a man
	9:301	men have just accepted it and never stood up and said hold on a minute uh this is not right
	9:307	I think they probably quite like sitting in the waiting room and it being under the wife's name and you just sit there and...and they feel like it's not their...
	10:335	men are never spoken of so the medical profession have never had to do anything
	17:583	I think for most people it's easier to deal with it, by just saying "that's not that big of an issue"
	9:297	they were more geared to deal with the um sort of female infertility
Jed	8:287	we really didn't talk about it with <i>anyone</i>
	9:320	they pretty much signalled and indicated they weren't <i>comfortable</i> with the conversation so we didn't discuss much about that.
	22:843	based on one or two experiences we just kept our mouths shut
	16:612	I'm isolated, I'm <i>alone</i> [...] with this problem,
Josh	3:100	people concentrate on <i>Tanya</i>
	25:947	"If I were you I would have this procedure then forget it ever happened"
	22:831	there's a lot of the <i>banter</i> that goes on with guys
	20:778	I kind of thought at that time, it was me coming out to everybody [laughs] but then loads of people, didn't think "that's Josh".
	21:807-809	you want to move it on because they just don't know how to cope with the information you've given them.
	21:787-789	Really <i>difficult</i> , really <i>difficult</i> um maybe more difficult for <i>me</i> than it was for him to hear and accept it
	27:1015-1018	its medicalized around the woman and she's the person who is physically carrying the child, totally understandable, but...I think it makes it difficult for us.
Dylan	31:1090	I think all your life you grow up and you kind of...maybe there is a sort of stereotype that good, male role models are masculine
	28:975	My GP [...] was so matter of fact about this thing that had emotionally slain me
William	3:79	the initial approach by the urologist, [...], no emotional support
	23:805	male infertility is [...] <i>obscure</i> and <i>rare</i> in its coverage in being <i>talked</i> about
	16:552	a man having <i>azoospermia</i> is relatively rare
	24:865-868	I think that's probably...it's easier for a woman to say <i>that</i> than...it is for a man to say "yeah, I'm, I've got <i>azoospermia</i> "
	22:759	you feel very <i>alone</i> and you feel like you're the only person going through it.
	25:870	its more isolating as a man
	17:576	So the emotional side I haven't explored [...] I haven't, I haven't no.
Gary	2:65	put to the back of your mind
	17:545	it's out there, everyone <i>knows</i> but it's not really something you talk about
	3:93	It's like trying to look at the positives, trying not to look at it too negatively
	21:717	"I wouldn't be telling people <i>that</i> , you want to keep that to <i>yourself</i> "
Sam	33:1151-1152	even if I was phoning up and booking it in my name, it would come under Yasmin's name
	36:1235	the father is basically just on the sideline [...] I already felt that I wasn't needed and then I felt it even more then which was quite hurtful.
	22:736	society talks about it um and they know it <i>helps</i> , they know what it does, nobody really talks about sperm donation
	28:968	everything is so <i>tailored</i> as an example, the only toilets in the fertility section of the hospital we went to were <i>women's</i> toilets which <i>really</i> annoyed me
	6:179	guys don't really <i>talk</i> about sexual health, men's health
	14:462	I don't think it's <i>harder</i> for women, I think <i>support</i> and <i>society</i> make it easier
	7:216	there isn't enough [pause] <i>talk</i> with my male friends

‘Finding a Voice’

Dave	14:390	I just needed to talk to a few people to get [...] in my head that this is a reality
	33:958	I <i>think</i> it's really important to be open with the children
	27:800	it's really good that they <i>exist</i> um you know <i>normalising</i> it as much as you can
Graham	35:1253	"no, hold on, it's really <i>sore</i> and <i>raw</i> at the moment lets just give ourselves a few weeks
	39:1418	to have had a referral through <i>my</i> name, something simple like that, in <i>my</i> name er and happier that it was called a <i>male</i> infertility clinic
	38:1376	they're positive in saying: "be <i>open</i> " and they are
	25:981	the unfamiliarity of saying it, the unfamiliarity of it really of actually speaking about someone who is <i>not</i> there.
	46:1658	I am happy to talk, really pretty happy to talk
	29:1027	in class, he suddenly spurts out about <i>sperm</i>
	29:1019	I'll tell him
Jed	27:1037	I have actually <i>published</i> a small piece about some of the controversies
	5:185	<i>talking</i> about it brings up a lot of strong emotions
	8:301	very <i>supportive</i> ...in exploring that and weren't <i>judgemental</i> about what we might <i>talk</i> about. [...] <i>my</i> parents have been the most <i>open</i> sounding board and then [...] maybe one or two friends that we could bounce things off a bit.
	29:1119	I find that talking helps me think things through and deal with the <i>emotions</i>
	30:1161	the talking started with the counselling
Josh	15:568	I want them to know it's a subject they can [...] feel <i>comfortable</i> talking to me about.
	25:944	the counsellor said "it's really good that you want to be open"
	25:935	But you need to air and you need to talk about things.
	25:937	It's when you stop talking about it, it becomes a problem.
Dylan	10:328-352	I was pretty <i>overwhelmed</i> really by how supportive they were, particularly the <i>guys</i> , I <i>kind</i> of thought they wouldn't want to <i>talk</i> about it
	11:387-394	it was <i>probably</i> talking to Leila that you as time goes on you feel a little bit <i>less</i> [pause] like it's a <i>raw wound</i>
William	17:595	talked to for longer than 10 minutes about stuff...it was quite [...] cathartic
	17:602	she was really really helpful and sort of let us <i>talk</i>
	8:275	they <i>offered</i> a counselling service and she she she was a very good counsellor actually
	17:596	it was quite sort of cathartic, we both [coughs] could tell third party, not connected to us how we felt and what options [...] really helpful and sort of let us <i>talk</i> and gave us <i>advice</i>
	26:937	"if you ever want to talk, [...] give me a call." Which is what I wanted to hear
	18:643	good emotional sounding board
	13:460-463	if you try and keep any sort of secrets from friends and family, family [stutters] it always sort of backfires
Gary	9:298	it helps if you are open with people
	26:873	If you keep it all <i>bottled</i> up [pause] yeah but the main thing is not to be too bitter about it, cos if you start getting bitter about it, then it's it's <i>difficult</i> .
	29:964	I think it helps to talk about it, yeah no it did help to <i>talk</i>
	31:1042	Wouldn't be too secretive about it cos the more people that know, the easier it is to talk to people about it.
	13:440	it's much better to hear someone's personal experience of it [R:mmm] just to say: you're not the only one. [R:mmm] You know the forums that there
Sam	14:471-472	I would much rather a very open and honest conversation about men's health happened more
	23:799	I've lived my life with honesty is always the best policy
	13:441-443	so nice to be there with people who <i>understood</i> , so we weren't constantly surrounded by people with children, or having children
	28:955	I would like to write some kind of book in the future, [...]so it could help dads
	28:953	part of me doesn't want to <i>hide</i> the emotions, doesn't want to <i>hide</i> how I feel now.

'Whose Business is it?'

Dave	16:460	they're not <i>important</i> enough in my life that they need to know[...] I don't feel anybody has a kind of <i>right</i> to know this
	17:485	we would tell people we felt <i>should</i> know
	29:844	it's kind of like Nick and Matty's piece of knowledge and not <i>mine</i> and Louise's and um if we decide to just tell everybody, then he's got no control over it
	18:511	it contains words like <i>sperm</i> and stuff which you do think like if somebody random came into my house they'd think, "what are these people teaching their children?"
Graham	29:1027	in class, he suddenly spurts out about <i>sperm</i>
	29:1019	I go I tell and I'll tell him
Jed	26:997	whilst their gamete origins are not a secret we want it to be private
	28:1103	its not a secret but its private I wouldn't walk around and tell everyone
	26:1018	the children can decide <i>who</i> they share that story with
Josh	4:148	<i>some</i> of them <i>didn't</i> know about the donor [pause] conception, cos we hadn't been <i>completely</i> open about it.
	19:720	So in a <i>way</i> , they're kind of like <i>growing</i> into it, the older they get.
Dylan	21:728-730	I wouldn't tell a stranger in the street, but my <i>friends</i> , people who have an influence on my life, yeah, they knew
William	15:513	there were some friends round the corner that we told, we had to, well we didn't have to but we thought we should
	13:453-458	I think we, we I think we just have to sort of chose our moment really [...] when they're old enough to realise what we are telling them but not so old that they're like "why didn't you tell me earlier?"
	10:366	keen to give Jack & Lily a sort of, a bit of a head start in that
Gary	16:522	you're at school, it's private anyways, that is <i>definitely</i> private
	20:675	at first we were going to tell Tommy, we still <i>will</i> I presume. But there is still lots of ideas
	21:694	we still need to think, <i>how</i> , <i>when</i> , or if at all, something that, it's not an easy, it's not an easy, it's not an easy thing to <i>do</i> . Very difficult
Sam	26:895	it is still a very private thing
	18:605	whole idea of <i>privacy</i> in this situation just goes out of the window
	25:840	only a handful of friends know that that I told and the reason we didn't go further telling more and more people, is we don't want the kid to find out who it's donor is form somebody before we tell them

“Social Services for Foetuses”

Dave	10:297	you know somebody else’s sperm being put there, it’s a bit er uncomfortable
	10:288	it’s done in a very clinical environment er and so that <i>helps</i> yeah, I think that <i>helps</i> . It’s like you’re going for some like kind of procedure, so that helps definitely
Graham	40:1423	counselling prior to going for donor conception, but that was rubbish actually[...] it made it feel raw, [...] what it made me feel is oh he is still okay to go ahead and have a <i>family</i> ?
Jed	31:1221	there was a male doctor involved in the fertility treatments, what did I think about that? You know...to cut right down to it, here is this guy who is going to get my wife pregnant and I’m not you know
	32:1234	this is professional this is a procedure
Josh	26:1008	she couldn’t quite get their head round it because the form said I need to get the dad’s details so she was insistent on taking down my details at the time
Dylan	34:1171	this is an exam, we need to prep for this
	35:1210	let’s get this nailed in one. I didn’t want to go back for 6 sessions
	34:1194	social services for foetuses
William	0	0
Gary	28:949	I felt like it was more of an <i>examination</i> to find out if I was able to proceed with the IVF and how my mental state was
	29:967	I sensed we were being assessed you know as to, were were right in the mind to go with it?
Sam	34:1178	The embryologist was there when we were with the turkey bastor, there as just this test tube and she said “in there is millions of little soldiers” [we both laugh] it was like the best thing ever

‘Strangers who Lurk in the Shadows’

Dave	24:684	if that relationship gets very strong and you know maybe they didn't see me as much I would be quite hurt in the future
	25:731	I presume he's a nice guy, um [pause] for what he has done
Graham	32:1142	That <i>could</i> be a sibling
	25:880	But she does feel, no we both do, very <i>grateful</i> for that...but initially it's quite hard to sort of have that person in your life, if you like. But he's in our life cos he's in Peter, so [46:10], so so ultimately the way we think about that, um erm is <i>grateful</i>
	30:1076	people getting past the age of 18 and <i>facebook</i> and things like that, have <i>really</i> opened up the tracking down on people
Jed	24:932	its common to have this heightened concern that at some point the kids are gonna say "well you're not really my father"[...] The extent to which something like that would be hurtful will increase the likelihood that they will use it,
	24:949	I'm always kind of worried that will they just decide one day I am not their <i>daddy</i>
Josh	15:559-561	I was really <i>glad</i> this guy just to give his sperm, go off and <i>never</i> ever be anything to do with us ever again and that s not actually the <i>reality</i> I don't think.
	14:543	I don't know how I feel. I am incredibly <i>grateful</i> , "thank you very much cos you have given me um two of the most important people in my life" and if he was here today I would, I would actually <i>hug</i> him
	16:605-617	I think it would be mixed emotions again [...] I would be very pleased [...] but none the less [...] insecure and [...] funny about it.
	17:654-659	but my nightmare scenario [...] the boys go, "well we never really had a genetic link with you and I know you have pretended to be our dad but now you're not with our mum anymore, goodbye".
	24:909-912	they'll be teenagers at some point won't they and when they're teenagers, they naturally reject their parents
Dylan	0	0
William	12:402	I suppose there is that sort of thought in the back of my head, that in a few years down the line there will be, there will be you know, um <i>questions</i> and there will be <i>arguments</i>
	12:418	we are kind of bracing ourselves for that but there haven't sort of, there haven't been any sort of <i>issues yet</i>
	31:1112	I am <i>aware</i> of the fact <i>that</i> Jack and Lily might want to go and track him down and I don't know <i>quite</i> how I would feel about that.
	14:478	as they get older, they might sort of throw it back at me, in an <i>argument</i> , and I...you know the teenage argument [...] "well you're not my daddy anyway" and I'm sure they <i>will</i> do that and it will <i>really really</i> , it will <i>really</i> really <i>hurt</i> me <i>but</i> you know, like I said you've got to sort of <i>brace</i> yourself, I suppose.
Gary	20:661	the last thing I want is to bring Tommy up and then the sperm donor knocks on the door and says "oh I'm your <i>real</i> dad" sort of thing, and that's not right, [...]I don't want to be in the situation where I have done a bad job and then this man turns up and then it's actually I want to be able to see him.[...] the donor has given the sperm to help people like <i>me</i> and <i>Kerry</i> .
	8:265	he has done a brilliant job by us. He doesn't know us from Adam but he gave <i>us</i> the opportunity to be parents and and made it possible for <i>Kerry</i> to be a parent, you know an <i>actual</i> parent rather than...
	22:736	if you were having an argument you know and then he would say "you're not my real daddy" sort of thing and that would be awful.
	22:741	arguments when he's 14, 15, 16, not tidying him room and that sort of thing, that when it all comes out
Sam	29:1005	18 year later and turned up at the door and said to the kid, "I'm your dad" they would be like" no you're not, go away

'The 'Father' in my Child'

Dave	11:317	we chose the donor where erm they [...] noted down my characteristics
	12:340	it's nice, for example, I've got <i>really</i> really brown eyes and Nick [...] has
	15:440	"oh he's the spit of you Davey boy!"
	21:611-644	I'll be honest and said that I kind of like [pause] the love for my children has been relatively slow burning [...] has just sort of grown as they get older
	22:641	I wouldn't <i>mind</i> having another child, but I don't want another baby first
	22:625	"isn't he dark! have you got like dark skin in your family Louise?"
	25:713	make jokes about there being this guy walking about in the North, really soft, with massive bushy eyebrows, cos Nick's got these bushy eyebrows
Graham	13:447	hair colour; eye colour; height; build and that was it I think.[...] similar to us
	25:902	she mentioned it on <i>father's</i> day
	14:472	I wonder what it's going to look like when it's born
Jed	23:891	we showed her a picture of the donor as a small boy
	23:901	<i>ironically</i> has blue eyes
	25:986	its just line descriptions...blood type, religious faith, occupation, education
	26:999	so we focussed on could we select a donor who would resemble me
Josh	11:424	Zack was 9 pounds 12 and he was a really <i>big</i> baby
	15:572	there's <i>something</i> of the <i>donor</i> , undoubtedly that is part of <i>them</i>
	12:466	But all I can say now is that I <i>adore</i> him and it really [...] gradual
	14:517-521	I'm making these <i>discoveries</i> about Zack, getting to know him and the <i>more</i> I discover about him the <i>more</i> I find out about him, the more I <i>love</i> him
	13:493	And we think <i>alike</i> a lot on some many different things
	14:510	she was saying how much Chris was like me
Dylan	15:528	a CEO from a company um and [pause] you know, that sounds <i>successful</i>
	27:939	something in my head said that if you have 2 boys you <i>need</i> to be that kind of guy to be a role model for them
	32:1125	I think the next big, the <i>initial</i> future is just getting to know them and you know them growing up
William	10:355	he was, is, physically quite a close match to me, and he is a, I can't remember what but he was university educated as well so.
	11:371	people would say "why do you look? he looks very different to you".
	10:352	"where does she get that red hair from?"
	10:334-340	Um in choosing it we were keen that it wouldn't um that <i>physically</i> it would have <i>some</i> resemblance to me
	12:401	less so Jack, cos as I said he is only 2 month old [...] men tend to find them a bit boring until they start smiling [...] so I'm sure it will fine for him as well.
	28:993	I felt that I wasn't bonding with him [...] because he is a boy,
Gary	22:741	arguments when he's 14, 15, 16, not tidying him room and that sort of thing, that when it all comes out
	21:687	my mates might blurt it out on his 14th birthday or something.
	6:204	"oh well he looks exactly like you"
	6:200	trying to <i>match</i> me with another donor, you know he's a really good looking boy and we're really happy
	19:637	they all had similar eyes to what we had, similar stature
	7:208	I think even if it's normal children with both parents, the son or daughter looks like the father, and father thinks "oh that's great, it's definitely mine" and gives you more chance to [pause] <i>bond</i> with the child.
Sam	35:1225	my dad did it a few times like saying " <i>father</i> " cos its the genetic thing, people automatically go "well the donor's <i>dad</i> "
	32:1085	I do want to girl still, I won't lie, I have always wanted a daughter
	32:1107-1111	generally boys are a lot more chaotic and they stand up, run about, crash into things, damage stuff, head butt things and are a [...] bit more mental

Appendix 21: Change of Thesis Title Confirmation

Amy Schofield



19 December 2012



Student number: 1037644

Dear Amy

Notification of a Change of Thesis Title:

I am pleased to inform you that the School Research Degree Sub-Committee has approved the change of thesis title. Both the old and new thesis titles are set out below:

Old thesis title: Donor Insemination: The perspective of non-biological fathers.

New thesis title: Donor Conception: The perspective of fathers where donor sperm assisted conception.

Your registration period remains unchanged. Please contact me if you have any further queries with regards to this matter.

Yours sincerely,

Dr James J Walsh
School Research Degrees Leader
Direct line: 020 8223 4471
Email: j.j.walsh@uel.ac.uk

cc. Paula Magee