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## ‘It’s like taking a bit of masculinity away from you’: towards a theoretical understanding of men’s experiences of infertility

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**Abstract** In the UK, nearly half of all cases of infertility involve a ‘male-factor’. Yet, little empirical work has explored how men as men negotiate this terrain. Three interrelated concepts; ‘hegemonic masculinity’, ‘embodied masculinity’ and the linkages between ‘masculinities’ and male help-seeking, provide the theoretical framework that guided a qualitative study conducted with 22 men experiencing infertility. The paper explores men’s propensity to delay their help-seeking in relation to infertility despite their desire for children. It also demonstrates how, in the context of infertility, the male body can be defined as both a failed entity in itself (unable to father a child) and a subordinated social entity (unable to measure up to hegemonic ideals) that characterises men’s masculine identities. The paper also illustrates how men appear willing to accept responsibility for their infertility and adopt aspects of hitherto subordinate masculine practice. This does not, however, constitute the total unravelling of well understood and accepted expressions of masculinity. Finally, the paper demonstrates how infertility is perceived as having the potential to fracture current and even future relationships. Moreover, regardless of how well men measured up to other hegemonic ideals, ultimately they can do little to counteract the threat of other (fertile) men.

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**Keywords:** men, infertility, hegemonic masculinity, embodied masculinity, men, masculinities and help-seeking

### Introduction

In the UK, it is estimated that infertility affects one in seven couples (HFEA 2013). Although nearly half of all cases of childlessness involve a ‘male-factor’, little theoretical work has explored how men as men negotiate this terrain. Men have variously been described as ‘missing’ (Culley *et al.* 2013), the ‘second sex’ (Inhorn *et al.* 2009) and ‘shadowy figures’ (Mason 1993) and have failed to adequately materialise within the field of infertility research. Recent reviews have called for more qualitative studies to access men’s perceptions and experiences

of infertility, particularly their desire for children, their awareness of their infertility, their help-seeking behaviour, and their feelings about trying to conceive through infertility treatment (Griel *et al.* 2010, Marsiglio *et al.* 2013). Whilst inroads are beginning to be made (e.g. Herrera 2013, Tjornhoj-Thomsen 2009) and in particular the recent text on male infertility by Walther Barnes (2014), this research remains in its relative infancy. As researchers endeavour to address this challenge, scholarship from the field of men's health can offer a valuable conceptual lens through which to explore men's infertility experiences. This paper draws upon three interrelated concepts much evident within men's health research; 'hegemonic masculinity', 'embodied masculinity' and the linkages between 'masculinities' and male help-seeking, which provides the theoretical framework for an ESRC funded project that explored men's experiences of infertility.

### **Theoretical framework**

A proliferation of social science research has explored the connections between expressions of masculinity and how men experience of a range of health problems (e.g. Chapple and Ziebland 2002, Emslie *et al.* 2006). One significant contribution to this has been Connell's (1995) concept of 'hegemonic masculinity'. This relational approach to theorising gender can account both for men's dominance over women and over less powerful groups of men because it introduces the notion of hierarchy and competition between different kinds of masculinity. According to Connell (1995), gender relations are not fixed but shift in historical context and are infused with other modes of social differentiation, such as social class and ethnicity, with certain configurations of masculine practice gaining dominance at the expense of other less powerful forms that become subordinated to and/or marginalised from hegemonic patterns. Defining gender as relational and intertwined with other modes of social differentiation provides access to the social dynamics of gender relations, their construction and the possibilities for change that emanate from the tensions and contradictions in men's experiences over time (Connell 2012). However, most work regarding men's health has been devoted to how cultural properties are transmitted to men and work as conditional influences on them rather than the other side of the structure-agency equation, namely how they are received by men and how new practices may be incorporated into the dominant culture causing aspects of hegemonic masculinity to change over time (Lohan 2007).

Theoretical work within the field of men's health has also called for men's physical bodies to be better considered when investigating men's conceptualisations and practices in relation to health (Oliffe 2006). Being male has been seen to be influenced by, and have an influence on, men's bodies through the notion of 'embodied masculinity' (Robertson 2007). Embodiment has become a way of conceptualising the body as more than simply 'the body we have'; the physiological vessel open to the scrutiny of others. The notion that people are 'embodied' widens our understanding to include 'the body we are'; a vehicle for how people perceive and experience their surrounding environments and is therefore a crucial factor in processes of identification (Hall *et al.* 2011: 79). Clearly, the physical/material and social/representational aspects of male embodiment can be threatened when men experience health problems (Robertson *et al.* 2010). Just as the body provides men with a vehicle to demonstrate masculinity, denoting activity, independence, and achievement, it also has the ability to render men vulnerable, passive and dependent.

Since the early-1990s men's apparent reluctance to access healthcare services has been seen as a key factor influencing gender differences in health (Broom and Tovey 2009; Meryn and Shabsigh 2009). Although the relationship between gender and help-seeking is complex, the

headline evidence that men commonly use healthcare services less than women has reinforced the presumption that men delay consultation and present with serious disease at a later and potentially less treatable stage (Wang *et al.* 2013). The majority of research conducted in this area has tended to concentrate on men's pre-diagnosis help-seeking, with a smaller body of work having begun to explore men's help-seeking in the context of diagnosed illness, including cancer and depression (Johnson *et al.* 2012, Wenger and Oliffe 2014). Specific to all of these studies is the attempt to move beyond oversimplified assertions that men are ignorant or not interested in their health to recognise how men's help-seeking is influenced by broader societal expectations that inform men's experiences and decisions.

The outlined theoretical framework has been used to guide a qualitative research study undertaken with a group of men experiencing infertility. Barring a few exceptions (e.g. Hinton and Miller 2013), qualitative studies in this field have tended to be retrospective in nature with men reflecting on their experiences from the vantage point of having assumed a parenting role, either through infertility treatment or adoption. Whilst this undoubtedly reflects to some extent the difficulties recruiting men to such studies, men's expressions of active desire for a child and the potential for pain regarding childlessness may be missing from such studies (Culley *et al.* 2013). This paper has also made a conscious decision to concentrate on men's experiences of infertility as a means of distinguishing the impact of the condition from the impact of its treatment.

## Research design

The analysis presented in this paper arose from a qualitative study conducted with 22 men experiencing infertility. Ethical approval for the study was obtained via the standard NHS Research Ethics (REC) process. The recruitment site for this study was an assisted conception centre in the UK. Men attending the centre were alerted to the study through posters, flyers and information sheets provided within the main reception/waiting area. This presented men with information about the study and the eligibility criteria, including self-identification as having a male-factor infertility problem. Men were encouraged to contact the researcher directly either by telephone or by email to discuss their participation. Men were also informed about the study by three different healthcare professionals. A consultant leading a male-factor infertility clinic presented men with flyers and information sheets and encouraged men to contact the researcher. A designated research nurse and an embryologist also provided men with information and recorded the name and telephone/email details of men who expressed an interest in participating that were passed to the principal researcher. The principal researcher then contacted potential recruits by telephone and/or email in order to discuss their participation.

Recruiting men into a study that asked them to share their thoughts and feelings about infertility proved to be difficult and time consuming. Very few men contacted the principal researcher directly and although over 50 men passed their contact details to the research nurse and embryologist well over half of these men decided not to participate when contacted by the researcher. The main reasons given related to family illness, being too busy at work or because, on reflection, they felt they had little to say on the matter. We can only speculate as to why so many men changed their minds, though men's anxieties regarding infertility were undoubtedly a factor. This adds to the general view that male infertility is under-researched, at least in part, because of a strong reticence among men to talk to researchers about the subject area (Culley *et al.* 2013).

Twenty-two men were recruited to the study; 13 self-identified as having a male-factor problem, three as having a male and female-factor problem, and two self-identified their infertility

as 'unexplained'. In addition, two men undergoing treatment as a result of vasectomy and two regarding a female-factor problem were recruited to provide further insight into men's experiences of infertility treatment. Twelve of these men had undergone a series of tests and were about to start their first cycle of IVF treatment and ten had received at least one cycle of IVF treatment. These men ranged in age from 25 years to 50 years. Eighteen of the men reported their ethnic category as 'White English', three as South Asian and one as Southeast Asian. Eighteen of the men were married and four lived with their partners. With the exception of one man, all of the men were in paid employment that ranged from IT consultant to machine operator.

Given the sensitive nature of the research and as a means of encouraging men to take part, participants were offered the choice of either a face-to-face or telephone interview (cf. Sturges and Hanrahan 2004). All except one man chose to be interviewed via the telephone. The main reasons given were that it was easier to arrange a time for the interview, they did not have to meet with the researcher and they could remain relatively anonymous. Telephone interviews were conducted at a time and place chosen by the interviewee with a number of the men choosing to be interviewed when sitting in their parked cars and/or driving home from work as a conscious means of ensuring their privacy. The face-to-face interview was carried out in the man's own home at a time chosen by him.

Each interview lasted between 45 and 75 minutes. All participants were advised that the interview was not intended as a form of counselling/therapy but an opportunity to learn about their perceptions and experiences of infertility, including how these linked to their understandings of being male and their experiences with healthcare providers. The majority of interviews were audio recorded with the permission of the interviewee and fully transcribed. Otherwise, extensive interview notes were taken and dictated to tape immediately afterwards.

Following transcription, the principal researcher carried out a 'thematic' review of the data. The men's accounts were systematically and thoroughly compared and contrasted in order to build up categories, test emergent theory and attach 'meaning' to the data (Russell Bernard and Ryan 2009). The process of reviewing the data began during the data collection period, which enabled the researcher to explore new avenues of inquiry during succeeding interviews. Once all of the interviews had been reviewed, excerpts were labelled with key themes relating to the main ideas and repeated experiences of the men, which were then coded in terms of broader categories, such as men's desire for children. Sub-codes were then identified within and across each of the main categories. In these ways, the coding scheme was generated both by the broader categories that informed the topic areas contained within the interview schedule and by the emerging empirical data. This process of 'analytic induction' aimed to reflect the complexity of the men's accounts and provided a framework to help make sense of this complexity as well as the social context in which these accounts are located (Bendassolli 2013).

Before moving on it is pertinent to acknowledge that this study, as with all research, has certain limitations. The number of men recruited was relatively small and all were attending the same assisted conception centre. Therefore, the extent to which the findings are generalisable to other groups of infertile men remains an open empirical question. However, a number of measures were employed to establish confidence in the quality of findings (cf. Mays and Pope 1995). The informal nature of the interview process helped establish rapport and to build fruitful relationships with respondents. The researcher used extensive notes to capture his thoughts during and after interviews and the data was analysed in a thorough and exact fashion. Thus, alongside ongoing theoretical contemplation, the study continually sought to enhance validity and to ensure that the findings are trustworthy.

When presenting the findings participant confidentiality is protected by the use of pseudonyms. In many cases, the men's verbatim has been shortened to omit superfluous expressions

and pauses though it continues to accurately reflect the meaning expressed by these men. An ellipsis (...) is used to denote when this occurs. The findings draw on those men experiencing a male-factor problem, a male and female-factor problem, or whose infertility was 'unexplained'.

### **Conceptualising men's desires for children and help-seeking behaviour**

The interviews began by asking men about their desires for children along with their help-seeking behaviour as a means of contextualising men's experiences of infertility. All of the men in this study had envisioned becoming fathers and tended to define their procreative desires in terms of a 'taken-for-granted expectation' and 'part of being human':

It's almost programmed into you ... Even though it's different for a man, there's still a sort of biological urge to have your own children. (Henry 42, male and female-factor)

As in this extract, the notion that men 'don't have the same drive' as women to have children was often apparent. Distinct embodied processes, linked to menstruation, pregnancy and menopause, enmeshed within notions of a female 'biological clock', were used to explain why women desire children in ways not applicable to men. The strong cultural associations between women and motherhood may have led some to dilute their expressions of desire for children and dictate who they report as the more interested partner. However, many men also questioned the 'exaggerated' or 'stereotypical' assumption that men are not as interested in having children as women, though it was clear that men may not express or act on their desires in the same ways as women. Thus, even though men may experience something akin to a 'biological urge', being explicit about these desires did not align with certain hegemonic characteristics, such as the concealment of emotional needs, which dictated why men may hide such feelings:

On the surface it's a bit different but deep down it's the same ... I want children as much as my wife does. But ... amongst men, it's obviously not as gushing or as ... maternal or however you would describe it. (Max, 32, male-factor)

All of these men described themselves as involved in the decision-making process and efforts to conceive a child. In hindsight, men often expressed a sense of regret that they had simply assumed themselves to be fertile, particularly the older men whose partners were also at increasing risk of age-related infertility. Most were fearful that they may have missed the opportunity to start a family though their lack of agency could also cause some to question their desire for children; that is, if having a child was so important to them, why had they waited? Whatever their age, men's assumed reproductive capabilities were clearly tied to certain masculine norms and expectations:

It's such a primitive thing that you just take for granted ... It's just a basic thing, a kind of given that you can have children ... and it's spoken about in a real masculine way ... In crude ways about getting people pregnant. (Max, 32, male-factor)

Men's reported desire for children was also somewhat at odds with the fact that all had delayed seeking help when their partners failed to conceive with one man waiting for five years before approaching his GP. In making sense of their delay, it was clear that men had a difficult time coming to terms with the fact they may have a problem, 'You've got to accept it first ... that there is something wrong' (Arnel, 41, male-factor). However, unlike other health

concerns that men may hide or face in isolation, infertility was a health problem that uniquely intertwined men and women's help-seeking. The necessity for joint investigations put men under particular sets of pressures. For example, indirect pressure related to the 'upset' and 'pain' men witnessed, but did not embody, when their partners failed to conceive. Direct pressure included a number of women initiating their own clinical examinations independent of their partners; 'My wife had her checks done and she was OK ... I was sort of putting it off ... going to have a semen analysis done' (Masud, 31, male-factor). In part, men's lack of acceptance and delay in seeking help appeared to stem from them confusing the production of semen with that of sperm and the fact their bodies seemed to be working normally. It was also located in wider notions of how men deal with health problems:

Most men ... they'll allow something to grow and they won't say anything until it's hurting them really bad ... I think a lot of men think they can get over things and it will change.  
(Paul, 28, male-factor)

Accessing help regarding reproduction was characterised as particularly difficult for men. Not only because it was associated with 'weakness' and negated their status as a 'strong alpha male', but also because reproduction was usually determined through biological processes/bodily action not conscious thought, 'If everything was fine you would just have got your partner pregnant ... it wouldn't be like you'd have to make a decision about having a baby' (Nathan, 25, male-factor). In overcoming these hurdles, men positioned themselves as courageous and as proactive and engaged in the process of seeking help. Their willingness to undergo tests was presented as indicative of their motivations to become fathers and part of a positive and active attitude towards finding a solution, though it was also evident that these men had not come to such decisions on their own:

It was quite a release in a way that we'd decided to do something about it. Because for so long we'd been trying but been disappointed ... So there was the sense of being energised ... we're going to take control of this. (Colin, 36, male-factor)

### **Men, masculinity and diagnosis of infertility**

All of the men were willing to discuss their diagnosis. When doing so, men demonstrated detailed knowledge and often exhibited a degree of self-deprecating humour. For example, men made the distinction between sperm count and sperm motility, used terms such as azoospermia, and referred to themselves as 'firing blanks'. Prior to diagnosis, few men had considered infertility as a personal concern or risk. Their sense of shock often related to the lack of fertility problems amongst their parents and/or siblings. Their surprise also related to notions of the super-potent male, which was associated with a certain arrogance regarding men's ability to deliver what is expected in the way of conception. Clearly, strong representations of masculine bodily power made a significant contribution to the kind of men they thought themselves to be:

I always thought it would be almost like flicking a light switch ... So never had a clue ... I never expected it to be me. (Colin 36, male-factor)

Unlike other studies (e.g. Walther Barnes 2014), men did not downplay the significance of their defective sperm or thought it easily rectifiable and none suggested that the majority of

the problem lay with their partner. Instead, their accounts were saturated with expressions of responsibility though they often sought to balance this by stating that they had not knowingly damaged their body's reproductive capability:

I know that the whole thing is my fault and I can't really blame anybody but ... I've never done any extreme sports, I've never took drugs, I've never drunk excessively ... It's just bad luck. (Max, 32, male-factor)

Men's demolished their sense of bodily power was evident in phrases such as 'You almost feel as if you're not a man. You cannot do the biological thing' (Nathan 25, male-factor). Their bodies, which had been assumed to function normally, were suddenly altered and emerged to trigger men's crisis of confidence regarding their ability to live up to dominant cultural expectations of men:

Obviously that's part of being a man is being able to produce children ... When they tell you that you can't, that your semen's no good, it's like ... taking a bit of masculinity away from you. A bit of being a man. (Leonard, 25, male-factor)

In some cases men sought to deliberately separate masculine self-esteem from the quality of their sperm. One man described his low sperm count as 'not badly down', though he went on to say 'that might be me trying to make myself feel better [laugh]' (Nathan, 25, male-factor). In a similar vein, Zackery, who experienced poor sperm motility, felt the large quantity of sperm he produced was important 'because they had more of the good stuff to look for' and he compared himself favourably to other men with more threatening diagnoses:

It wasn't a major emotional thing for me. The fact that they were saying to me that I wasn't ... not producing any good sperm. Had that been the case I'd have been devastated ... The fact that there was actually some good sperm let me have a little bit of self-respect'. (Zackery 44, male and female-factor)

All men reported hiding their feelings when given their diagnosis primarily as a means of supporting their partners who were characterised as less emotionally robust. Indeed, many reported that the hardest part of receiving their diagnosis was dealing with the emotions of their partners. Thus, even though their diagnosis was likened to a 'sledgehammer blow', they described how they deliberately pushed their own sense of shock and anxiety into the background and, therefore, their lack of emotion should not be equated with an absence of distress:

My main thoughts was with my partner ... I had to be strong for her ... I might look like I'm not upset about it. But it's not something you want to hear ... that I couldn't provide what she needed to create a baby ... It's sort of what men are meant to be able to do. (Paul, 28, male-factor)

### **Men, masculinity and living with infertility**

Not being able to start a family precipitated a range of negative emotions (cf. Griel et al 2010, Marsiglio *et al.* 2013). Men used phrases such as 'a bit gutted' to indicate how they were feeling, but often compared themselves favourably to other men with more serious, often life-

threatening, health problems. Men also compared themselves to their partners who faced both the emotional impact of infertility and the physical trauma of infertility treatment, which was a significant source of guilt and reason why men deemed it wrong to voice their own concerns, 'I don't want to give away how worried I am to my wife . . . I just don't want to . . . add it to her burden' (Arnel, 41, male-factor). Other emotions, such as men feeling 'embarrassed' and 'ashamed', could also prevent them from talking to their partners about their infertility. This was despite the fact that many men acknowledged how their partners were often left frustrated by their inability to discuss their situation; 'She wants to see a response and it's not that I don't want to give a response, it's just that I can't give a response' (Charles, 43, male-factor). This led one man to suggest that women should be told about the difficulties facing men when diagnosed with infertility:

If it is the male that's at fault I think the female needs to go and see somebody and get it explained how the male feels . . . because it's hard for you to explain to your partner how you're feeling. (Leonard 25, male-factor)

Nonetheless, these men felt they were doing all they could to support their partners, which they demonstrated through their actions rather than emotional expression. Moreover, their supportive activities appeared to be a change from their normal practices as husbands/partners and were not necessarily an easy option. For example, all of the men felt awkward and vulnerable within the clinic but made a point of making numerous visits with their partners. They also provided practical help with their partners treatment regimens though their aversion to medical procedures was evident, 'I help her take her injection. But I really hate it. I really hate it [laugh]' (Leonard 25, male-factor). Men were also keen to point out that this was not simply at the behest of their partners. In describing themselves as active and purposeful they challenged notions that they were disinterested or coerced into such actions, though it was also clear that they often felt restricted in their role, 'You're limited to what you can do. Because the procedure . . . it's happening to the woman isn't it' (Charles 43, male-factor) (cf. Hinton and Miller 2013). Men's role as agents of support was also characterised by elements of enthusiasm and hopefulness alongside cautiousness and control. Although men sought to be optimistic regarding treatment, they were far more sceptical of success than their partners and tried to reign in women's optimism and prepare women emotionally for the possibility of failure:

It hit her really hard . . . She'd built up an expectation that it was just going to work . . . choosing names . . . I was like, 'don't do it' . . . I was more wary. (Colin 43, male-factor)

Most made the decision not to discuss their infertility with other men. Paul (28, male-factor), for example, likened his internal conversation to a 'risk assessment' as he sought to predict what he stood to gain and how other men might react, 'Could I talk to this person? Yes or no? . . . If I step over the edge here will I get hurt?' There was also the flipside in that they wanted to protect other men. As such, they would not simply announce their infertility as it put other men in vulnerable positions. Among those men who did confide there was little sense that they expected expansive discussions with other men. As they predicted, other men responded in 'matter of fact' ways and were not proactive in terms of initiating conversations. One man used the analogy of a friend revealing their sexuality to contextualise the nature of these interactions:

I don't know what you'd expect their response to be. It's like a friend coming up and saying they're gay. You'd go OK [laugh] what am I going to do about it. It's not going to



change things. So let's just move forward ... if you need to talk then fine, but ... just move on. (Nathan 25, male-factor)

Three main reasons were apparent for why men chose not to discuss their infertility. The first related to men not wanting to be the focus of attention or the subject of pity and that others 'feel sorry' for them. The second related to men's fears that they could become the subject of ridicule (cf. Throsby and Gill 2004). Although none experienced name calling or other forms of derision they knew of the pejorative terms, such as 'Jaffa', that are used to ridicule infertile men, 'You think that's funny. ... It's only when it's you, you think aaah [laugh]' (Colin 36, male-factor). The third reason related to cultural associations between virility, impotence, and infertility and that people would think them 'incapable' (cf. Herrera 2013). Although, intuitively, they did not perceive that their friends would think in such terms the possibility clouded their decision-making, 'That's at the back of my mind. Even though on one level ... I think that is slightly ridiculous' (Henry 42, male and female-factor). Whatever their reasoning, many men viewed the prospect of discussing their infertility as extremely difficult, even with men in similar circumstances:

My best friend mentioned it to me about two weeks ago ... It's doubtful that they can have children. So even with him saying that to me, I still couldn't bring myself to say, 'I know how you feel' ... I just couldn't. (Max 32, male-factor)

This did not mean that other men were unaware of their diagnosis. Men's work colleagues might know because men required time off work to attend appointments, whilst other men knew because of the nature of their social relationships. But, this did not mean that men spoke about such matters:

My male friends ... definitely know what's going on but it's not something anybody discusses ... It goes back to that typical thing about what men talk about to other men and what women talk about ... At the top end of the room ... me and my friend were talking probably about work or cars ... and my wife was discussing with his wife what's going on with our IVF ... It's just something I don't discuss with them ... it's not a conversation I'd want to have. (Joseph 38, unexplained)

There were occasions when men came under pressure to explain why they did not have children or faced questions regarding their plans for fatherhood. In these cases men tended to deflect attention away from the present by suggesting that they would have children in the future. Whatever their individual strategy, men were aware that their explanations were time dependent, in the sense they were not acceptable longer-term life-stories and would have to be rethought if the outcome was not successful:

Sometimes you can get a question; 'Why you haven't kids yet?' I'll normally just say ... it's not our priority at the moment or I change the subject ... That is one of my strategies ... changing the subject ... But I can't do that forever [laugh]. (Arnel, 41, male-factor)

There was nothing to suggest that men sought to deflect the cause of their childlessness onto their partners, perhaps because biological fatherhood was still within their grasp. Nonetheless, because they did not see their infertility as easily remedied, the thought they may never have a biological family was a continual concern. When discussing the future, men often described themselves as more rational than their partners and more 'accepting of the situation'.

Moreover, although problematic, all of these men could envisage life without children, 'It will obviously be tough ... but I still think we'll have a happy life', though this man immediately went on to say, 'I don't know if my wife sees it that way' (Joseph 38, unexplained). In short, men's attempts to reconcile their situations were not perceived to be shared by their partners:

My world doesn't stop and end with this. I've said to my wife on numerous occasions we are so lucky to have each other. I see anything that we get as icing on the cake ... Now what it would actually mean for my wife ... she'd be devastated. (Zackery 44, male and female-factor)

Men were also concerned about the potential sustainability of their relationships should they not have children (cf. Tjornhoj-Thomsen 2009). One man presented this as his 'biggest worry' and went on to say, 'I don't know how it's going to affect our relationship when it doesn't work' (Leonard 25, male-factor). A significant element of their concern was the implicit threat that another (fertile) man could take their place, 'there is that bugging away in the background' (Colin 36, male factor). In short, infertility damaged their attractiveness as men and jeopardised their ability to maintain their place in the social world:

I know it's my fault and it's my problem and my partner could have kids with somebody else ... Even though she's not going to go and have a baby with nobody else, but she could. She's got the option. Whereas I haven't got the option to do that. (Leonard 25, male-factor)

## Discussion and conclusion

Relatively little research has explored men's views regarding infertility, particularly from the perspective of men who retain hope of becoming biological fathers (Culley *et al.* 2013). Drawing upon a theoretical framework that encompassed the relationship between masculine identity, men's bodies and their help-seeking behaviour, and using in-depth interviews, this study has demonstrated the challenging and often paradoxical experiences men face at this time.

The linkages between expressions of masculinity and the way men conceptualised their bodies and health were evident when these men sought to explain why they delayed seeking help in their bid to become fathers. In making sense of this delay, their accounts resonate with the distinction men often make between 'health' and 'ill-health' when deciding whether to access health services (Robertson 2007). Biologically, men were able to perform and had no symptoms and so lacked a legitimate reason to seek help. Added to which, their concerns regarding the nature of consultations/investigations made them extra fearful of approaching their GP. In short, hegemonic masculine norms, which encourage emotional and physical strength and reject weakness or vulnerability, coupled with men's lack of knowledge about their health and bodies, can help to explain these men's propensity to delay seeking help (Gough and Roberson 2010). Whilst the necessity for joint help-seeking may bring a unique complexity to men's decision-making around infertility, the known obstacles men face when considering whether to access health services appear to be amplified when men are faced with the possibility of such a diagnosis. Thus, any delay should not simply be equated with a lack of desire among men to have children or signal that women are more 'treatment orientated' when it comes to infertility (Slepickova 2010). Indeed, the men themselves sought to question what they considered to be over-inflated claims of gender differences in procreative desires that reified the stereotype

of women as mothers and made men believe they could not have comparable desires as fathers. Moreover, in accessing help, men (re)established themselves as motivated and unequivocal in their quest for fatherhood. They also sought to align themselves with certain hegemonic masculine ideals, such as control and determination, evidenced by their willingness to undergo difficult consultations and tests, and positioned themselves as knowledgeable regarding their diagnosis and the functioning of their bodies (Noone and Stephens 2007). As such, their accounts contrast with other studies which suggest that men are often pressured into a process in which they remain passive and uninterested and where the validity of the diagnosis is often questioned (e.g. Herrera 2013).

Whilst there was no sense of denial or scepticism regarding their diagnosis, it was clear that it could destabilise the ontological connections between a prized masculine identity, the male body and biological fatherhood. In short, as the suboptimal biological properties of their bodies emerged and they lost reproductive power, they were forced to re-construct embodied notions of themselves as men (cf. Robinson and Hockey 2011). Men's descriptions of their sperm as 'weak', 'lazy' and 'dead' was indicative of their diminished authority, and contrast with the more usual depictions of sperm as fast, strong, and successful that are also terms irrevocably associated with hegemonic masculinity (Tjornhoj-Thomsen 2009). In making sense of the resulting existential crisis, men would often oscillate between two contradictory subject positions; it was not a reflection on them as men (they were not implicated in the cause) and it did reflect something about them as men (they had lost the presumed basis of manhood). It is perhaps also not surprising that some men sought to define their diagnosis in less threatening terms; that is, not as bad as other men's, which enabled them to maintain certain aspects of masculine self-esteem. Nonetheless, regardless of how they reflected upon their situation, the masculine identities these men once conferred upon themselves were revised or rescinded as their bodies were found to be constitutionally incapable of accomplishing what is valued in terms of masculine identity/male embodiment (cf. Oliffe 2006).

Consistent with Connell's thesis that masculinity is best understood as a 'configuration of practices', these accounts also demonstrate how the formation of their self-identities as men was constructed within the social context in which these men found themselves. It was clear, for example, that aspects of hegemonic masculinity strongly influenced men's philosophical resolve not to show or discuss the emotional impact of their diagnosis, which they equated with gendered expectations about how men are supposed to behave in such situations (cf. Connell 1995). Although it is common for men to remain stoical when presented with bad news regarding their health (e.g. Emslie et al 2006), these expectations appear to be significantly heightened in relation to infertility. Their actions at this time may, therefore, be conceptualised as men being let down by their bodies, which suddenly defined them as incapable of living up to certain dominant expectations, who then draw on other identifiable markers of masculine practice to enable them to enact a masculine form congruent with hegemonic masculinity. Furthermore, men's on-going silence regarding the impact of infertility, despite the imploring of their partners, can also be interpreted as a means by which these men maintained a masculine self. Thus, whilst men framed their silence in terms of their feelings of guilt and humiliation or the lack of an 'emotional script', which precluded men from explaining how they truly felt, men's suppression of emotion and the shielding of women from their insecurities and sense of powerlessness can also be linked to how men restore threatened gender identities (cf. Schrock and Schwalbe 2009).

These men reportedly worked hard to transform their practices in the interests of their partners, which demonstrate that masculine identities are not static. For example, they sought to incorporate an increased sense of sensitivity and willingness to support and care for their partners through their treatment. They also redefined masculine values to accommodate the view

that infertility should be faced as a couple; that is, manliness was demonstrated through attentiveness, selflessness and unity with their partners. Infertility, therefore, appeared to usher in new and possibly less restricted thinking regarding their roles as men, which could also challenge hegemonic norms; namely, they adopted attitudes and behaviours ordinarily considered to be feminine and/or associated with subordinated groups of men (Connell 2012). Though change was apparent, men also conveyed a sense of ineptitude and superficiality regarding their contribution (cf. Hinton and Miller 2013), which is at odds with traditional demonstrations of hegemonic masculinity that is usually solution-focused and displayed in terms of technical competence and self-confidence (Courtenay 2011). In many ways, these themes echo men's experiences during pregnancy and childbirth (e.g. Dolan and Coe 2011), which may stem from the fact that it is women's bodies that are centre of attention in both arenas.

Unlike pregnancy, however, men's actions may also be influenced by their sense of guilt regarding their infertility and they felt forced to curb women's enthusiasm regarding the chances of them conceiving a child, which is evidently not the case with pregnancy. Whilst men's stoical role in the face of disappointment regarding infertility has been documented (Hinton and Miller 2013), this study suggests that men may define themselves as the 'voice of reason' throughout the process. Although men sought to characterise this in terms of masculine rationality over feminine emotionality, it undoubtedly limited men's ability to disclose their own concerns and aspirations. It also underpinned men's belief that infertility exacted more of an emotional toll on women because they were perceived to be beyond such reason and control (Petersen 2004).

Men's decisions regarding disclosure of their infertility illustrate the ways in which the maintenance of masculine identities is inherently relational and inescapable (Connell 2012). Those men who chose not to disclose their infertility tended to focus on key elements of the 'patriarchal dynamic', particularly how men use humiliation and ridicule to assign other men to subordinated masculine positions (Connell 1995). Given that men often avoid discussing health-related problems because they fear accusations of fragility and weakness (e.g. Dolan 2014) it is perhaps not surprising that such fears may be heightened in relation to infertility. They appeared highly attuned to their perceived inadequacy and their wish to avoid potential embarrassment and stigmatisation often characterised their decision-making. Those men who did disclose their infertility were relatively confident that other men would respond in supportive, if unemotional ways. Their disclosure was not defined in terms of psychological relief and there was no sense that they wished to communicate aspects of their inner-selves. Men's 'lack of community' regarding health or procreative matters may also have prohibited men from discussing their experiences concerning infertility (cf. Tjørnhøj-Thomsen 2009). Overall, there was little evidence that men sought to challenge those aspects of hegemonic masculinity that pervade the terrain of infertility or that they were able to champion their supportive practices around their partners. In short, whilst there was evidence of an 'emergent masculinity'; that is, men's attitudes and actions appear to have changed (cf. Inhorn 2012), there was little evidence that this was explicitly driven by male agency in relation to infertility. Instead, men appear to draw upon contemporary notions of the sensitive and involved father-to-be, which was extended to encompass infertility, albeit without the 'camaraderie' and shared understanding that permeates men's experiences of pregnancy (e.g. Dolan and Coe 2011).

Although none of these men were at the stage of having to (re)construct a masculine identity as a permanently childless man, their accounts demonstrate the temporal dimensions of such constructions (Connell 2012). Not only did men's explanations for their childlessness have to encompass the present and the past, they also have to extend into the future, and illustrate the relentless and inescapable challenge infertility can pose to masculine identities.

Alongside this were the ways in which men characterised their current relationships and whether they, rather than another man, were worth the 'investment' of their partners (Buchbinder 2013). Whilst they could provide their partners with a loving relationship and a desirable lifestyle, this was dependent on women accommodating their vision of a potential life without children. Time and again, men sought to construct valued masculine identities and worthwhile futures, whilst voicing concerns regarding the sustainability of their relationships (cf. Tjornhoj-Thomsen 2009). Infertility was, therefore, perceived as having the potential to fracture both current and future relationships because, regardless of how well they measured up to other hegemonic ideals, ultimately they could not counteract the threat of other (fertile) men.

In summary, this paper has explored men's experiences of infertility via a theoretical framework fashioned from within the field of men's health. It has demonstrated how hegemonic norms, that reject weakness and vulnerability, coupled with men's lack of knowledge about their bodies, help to explain men's propensity to delay help-seeking despite their desire for children. It has also illustrated the role of the male body in men's experiences of infertility. Their body can be defined as both a failed entity in itself (unable to father a child) and a subordinated social entity (unable to measure up to hegemonic ideals) that characterised how men negotiated and enacted their identities as men. Their accounts also illustrate the possibilities for change in masculine practice. In taking responsibility for their infertility and through their active involvement and support, men appeared willing to adopt aspects of hitherto subordinate masculine practice though this did not constitute the total unravelling of well understood and accepted expressions of masculinity. Finally, in demonstrating how men live with the uncertainty of infertility, it demonstrates that men could do little to dampen their own fears regarding the future and the possibility that their partners choose the chance of motherhood with another man.

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