Living with Infertility: An Exploratory Study of Men's Experience

Anastasia Panayiotou – Enness

Middlesex University and Metanoia Institute

Doctor of Counselling Psychology and Psychotherapy by Professional Studies

2018

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Abstract

Research on the infertility realm is mostly dominated by the female experience and on gender differences. Despite the fact that half of the infertility issues are associated with men, research on the male experience remains limited. There has recently been a change since more studies have been carried out, but the gap remains vast. This study attends to the research imbalance and aims to minimise the gap even further. It gives men a voice in the infertility realm by shedding more light on their experience. It captures how men conceptualise their infertility, what it means to become a father and the impact their condition has on their sense of Self.

The aims of the study were addressed by exploring the experience of five men with an exclusively male factor infertility. After careful consideration, Interpretative Phenomenological Analysis was deemed the most suitable methodology and two interviews were carried out with each participant. Following the analysis of the data, four major themes were established. These were the emerging notion of fatherhood, the disempowering impact of infertility, responding to the limitations of infertility and placing infertility in a relational frame.

This study makes a significant contribution as it provides a rich exploration of the male experience and makes an important addition to the limited research on male infertility. It also highlights how essential it is to provide this client group with an easier access to psychological interventions. The provision of information in a written format and the availability of online forums are also discussed as possible ways of supporting men with an infertility diagnosis.

Acknowledgements

A few people deserve a special mention here for helping and supporting me during my research journey. I would like to thank my family and friends for believing in me and supporting me along the way. Thank you for your encouraging words and for keeping me going during the difficult moments. A special thank you to all the professionals who believed in my study and helped me at different stages. This includes the consultants of the infertility clinic, the manager at the perinatal service I was working at, my critical research friends and my research supervisors. Last but not least, a massive thank you from the bottom of my heart to my participants. Without you, this study would not have taken place. So thank you for your time, honesty and willingness to participate. I hope I have done you justice and managed to meet the main purpose of this study; to give a voice to you and your experience of infertility.

Chapter 1: Introduction

1.1 Prologue

This study is an exploration of the experience of five men with an exclusively male factor infertility diagnosis. At the time of interviews, all men were waiting for a sperm retrieval operation in order to find out if they could go ahead with fertility treatment.

This chapter addresses the personal relevance to the area of study, followed by an introduction to the issue of infertility, when it is diagnosed and its prevalence rates. Possible causes for infertility and available treatment options are reviewed, as well as a discussion on the need for carrying out this study and its significance.

1.2 Personal relevance

Working in placements as a psychological therapist was one of the requirements of my Doctorate in Counselling Psychology and Psychotherapy. Being someone who values meeting people from different backgrounds, I wanted to work in a variety of placements. As a result, and before gaining my UKCP Registration, I worked in five different placements as well as in private practice.

When a vacancy came along in a perinatal service in an NHS hospital, I grabbed the opportunity and applied for it. I found the service fascinating, and this was what sparked my decision to carry out my research in infertility. At one end of the spectrum, I worked with women who had just had a baby and where there were concerns for post-natal depression so they were referred to the service. On the other end, I worked with women who were trying to conceive but to no avail despite IVF treatment. The emotional and physical impact that infertility had on my clients' lives was immense. Not only were they trying to come to terms with their diagnosis, they

were also going through invasive procedures and ethical dilemmas. Whilst I worked with women, I often wondered what it is like for men to know that they are infertile and the impact it can have on them.

On an explicit level, working at the perinatal service was one more placement to access in order to enhance my knowledge and experience. On an implicit level, however, my choice of this placement was due to personal and cultural reasons. I am originally from Cyprus, a country where family is very important, and where it is the centre of the social structure. It was at my mid-twenties when the first questions came from my not so immediate family as it was supposedly time for me to start thinking about having children. It was, therefore, a given that a woman at my age would want to have a child. The concepts of infertility on one hand and voluntary childlessness on the other were not ideas for discussion. Any attempt on my behalf to explore this was met with avoidance. That is when the first questions around infertility started forming: how did people with an infertility diagnosis feel? What was it like for them? Why was having children taken for granted? Why was it so difficult to think about the possibility of infertility? In addition, if it was so difficult to talk about this, where did that leave people who had an infertility problem? All of these questions formed the basis of my curiosity and interest around the issue of infertility.

The reader might wonder how it came about that I decided to carry out my research on male infertility and not female. Over the years, I struggled with finding my own voice. It was a long journey towards gaining the confidence to speak up and feeling comfortable to hear my voice. I knew from experience how painful it was at times not to have a voice but also how rewarding it was when I found my confidence.

When I started looking more into the possibility of doing my research on infertility, I often wondered what it was like for men. I was conscious of the fact that I

kept hearing about women and their experience but not so much about men and that was because the research on male infertility was limited. It was, therefore, important to give them a voice and not to keep them on the outside of an issue where they played an equal role.

1.3 An introduction to the topic of infertility

Most people approach adulthood with the assumption that they will eventually become parents if they want to. Some people consider parenthood an essential part of life (Gerrity, 2001). For some, however, becoming parents can be quite difficult and around one in seven heterosexual couples are finding it difficult to conceive. This amounts to approximately 3.5 million people in the United Kingdom (National Health Service, 2017). Around 84% of couples will conceive naturally within one year if they have regular unprotected sex (ibid). A couple, however, receives an infertility diagnosis if they have not managed to conceive after a year of trying (National Health Service, 2017).

Different medical factors contribute to a person being infertile, but for the purpose of this study, I have decided to discuss the most common cause for women and the most common cause for men. In women, infertility is mostly caused by problems with ovulation (the monthly release of an egg) where women do not release eggs at all or an egg is released during some cycles but not in others (National Health Service, 2017). In men, poor quality semen (the fluid containing sperm that is ejaculated during sex) is the most common cause of infertility (ibid). I will not address the possible psychological causes of infertility in this study. Despite the fact that psychic states make a significant contribution to physiological functioning, the relationship between them is not as straightforward as it was once

suggested in infertility diagnosis (Apfel and Keylor, 2002). Back in the 1960s, the argument was that a percentage of infertility was caused by emotional factors and that certain personality traits caused a person's infertility (Eisner, 1963; Mozley, 1976; Mai et al, 1972; Ford et al, 1953). As more research was conducted, however, no differences in the personality traits were found between the infertile and fertile people and when some differences were found, linking the cause of the difference to infertility was impossible (Greil, 1997). Some of these early studies did not take into account the psychological impact that an infertility diagnosis can have on a couple. One can therefore argue that the emotional problems came because of their infertility difficulties and not vice versa (Seibel and Taymor, 1982).

As far as prevalence rates are concerned, around a third of infertility is due to problems with the woman and another third is due to problems with the man. In around 40% of the cases, both the male and the female have an infertility difficulty and unexplained infertility accounts for around 25% of the cases. In this case, the cause is unidentified (National Health Service, 2017). Couples, who have been trying to have a baby for more than three years, have a 25% or less chance of getting pregnant (ibid).

Treatment for infertility falls in three categories: medical treatment (use of drugs in order to induce ovulation), surgical treatment or assisted reproduction techniques (ART) such as intrauterine insemination (IUI) and in-vitro fertilisation (IVF). The success rate of ARTs decrease as the woman gets older. In IUI, sperm is being placed into the womb through a fine plastic tube. This procedure coincides with ovulation in order to increase the chance of conception (National Health Service, 2017). During IVF however, the fertilisation of the egg occurs outside the body. The woman takes infertility medication to encourage her ovaries to produce

more eggs than normal. They are then removed from the ovaries and fertilised with sperm in a laboratory dish. The fertilised embryos are then put back inside the woman's body (ibid). Guidelines published by the National Institute for Health and Care Excellence (NICE) (2017), recommend up to three cycles of IVF if the woman is between 23-39 years of age and the couple had problems conceiving for two years.

1.4 Research Aims

Infertility is a condition that involves both members of the couple and as mentioned above approximately half of the infertility issues are associated with male infertility. Despite this, however, over the years, research has focused extensively on women, resulting in an enhanced knowledge of the women's experience of infertility (e.g. Daniluk, 1996; Greil, 1991; Menning, 1988). There are exceptions (e.g. Mason, 1993; Throsby and Gill, 2004; Vercollone, Moss and Moss, 1997; Webb and Daniluk, 1999), but similar attention has not been paid to how men experience infertility. The aim of this study, therefore, is to explore in-depth how men with an exclusively male factor infertility problem experience their diagnosis and how they feel about the possibility of not being able to produce a child. The research question for this study is what is the experience and meaning of infertility as lived by men diagnosed with infertility?

1.5 Significance of the study

Traditionally there was an assumption that as far as reproduction was concerned, the female was the "responsible" partner (Carell and Urry, 1999). This is perhaps one of the reasons for the plethora of research on female infertility. Studies

on male infertility were limited and it is only recently that it became the focus of medical and social science research (Wischmann and Thorn, 2013). The majority of research in the field of infertility has been quantitative studies, and when qualitative research was undertaken, the focus has been mainly on women or couples (Hanna and Gough, 2015). This, however, leaves us with limited insight into how men experience infertility and how they think about fatherhood. This study, therefore, attends to this imbalance in order to shed more light into men's perspectives, to find out more about their experience of infertility and any possible impact that it might have on their lives. Giving men a voice within research will also give them a more equal position in the reproductive realm instead of being viewed as the second sex (Culley et al, 2013).

A more detailed understanding of men's experience will provide valuable information to practitioners working with this client group and as a result, more recommendations can be suggested for better support in professional healthcare settings (Fisher and Hammarberg, 2012). This study, therefore, adds to a body of work, which can influence the design of infertility services.

Moreover, research is valuable for informing our practice and male infertility is an under-researched area of counselling psychology and psychotherapy. This study is useful for the counselling psychology and psychotherapy discipline as it provides therapists working with this client group with more awareness and understanding of the possible themes that might come up during therapy.

Gaining a deeper understanding of men's subjective experience of this complex phenomenon also has implications for the development of informal peer or social support settings. It is therefore of particular interest not only to therapists but also to the social group of the men as well as to their partners.

1.6 Structure of the study

In this chapter, I have discussed the reasons behind my decision to explore the experience of men with an exclusively male factor infertility. In the second chapter, I will provide a literature review of the infertility field with reference to different studies leading to a rationale for my choice of study.

The third chapter includes my philosophical stance and provides an outline of how I decided on my methodology. I also provide details on the steps I took in designing my study including recruitment, interviewing, analysis and ethical considerations.

In the fourth chapter, I will present my findings, outline the themes that emerged one by one whilst including my personal reflections throughout the writing of the analysis. The fifth chapter will include a discussion of my findings as well as implications for practice, the strengths and limitations of my study and some suggestions for further research.

Chapter 2: Literature Review

2.1 Introduction

The aim of this chapter is to situate my study within the infertility literature. In order to set the groundwork for understanding the context of my study, I have decided to divide this literature review into four sections. In the first section, I will address the general psychological responses to infertility by providing an overview of different conducted studies before moving on to evaluating them in the remaining sections. The second section will focus on research with women and the impact infertility had on them. Different studies that were carried out to explore the gender differences in response to infertility will be reviewed in the third section before moving on to the fourth section where the focus will be on both quantitative and qualitative studies that dealt specifically with male infertility. By attending to these four sections, I will aim to show how the limited studies on male infertility led to the development of undertaking my study.

2.2 Psychological responses to infertility

The experience of infertility seems to have a profound impact on a person's life. Apfel and Keylor (2002) capture this experience in a poignant way by saying that "psychological conflicts involving infertility reach into the deepest layers of the individual psyche, invade the interpersonal space of the couple, and radiate into the cultural surround and its definition of family" (p.85). Infertile people find themselves in the middle of existential issues surrounding meaning, life and death (Rosen, 2002).

Infertility is a very personal experience but common feelings amongst couples have been documented in both qualitative and quantitative studies. In Phipps's (1993) qualitative study, anger and loss of control were reported. Anger was also

indicated in Valentine's (1986) qualitative study. The couples in Cook et al's (1989) quantitative study captured their anxiety whilst frustration was documented in Mahlstedt et al's (1987) quantitative study. Menning (the founder of Resolve. Inc.), in her article (1980) on the emotional needs of couples, spoke about the denial and isolation that couples go through with infertility. These studies give an indication on the emotional impact of the people involved but it would be interesting to see whether these feelings also come up when the studies focus only on the individual and not on the couples. I suspect that partners will capture their experience differently when they are interviewed together rather than individually. Infertility also seems to have an impact on both physical and mental health and the longer the duration of the infertility treatment, the more the coping ability of the people involved deteriorates. Domar et al (1993) argued that coping with infertility is similar to coping with a major medical illness.

Different reviews, quantitative and qualitative studies argued that the distress of infertility and the medical treatment affects nearly all psychological aspects of a person's life: their self-esteem, life satisfaction, partnership and other social relations (Greil, 1997; Henning and Strauss, 2002). There are reports of feelings of inadequacy and some people see their inability to reproduce as evidence of their failure (Seibel and Taymor, 1982). For some people, there are changes in their relationship leading to marital disruption and sexual dysfunction (Andrews et al, 1992; Lee et al, 2001). People who are going through the experience of infertility may find themselves behaving differently and they might feel quite envious or jealous of people in their surroundings who have children. They can become consumed with themselves and feel disconnected from family and friends, which then puts a strain on their relationships. For them, the most important thing is to conceive a baby

(Rosen, 2002). It seems, therefore, that infertility is multifaceted; it involves the loss of parenthood, the loss of the pregnancy experience itself, the loss of children and of genetic continuity (Apfel and Keylor, 2002).

It is important to add here that infertility is not only a major life crisis, it also brings a variety of dilemmas in a couple's life; dilemmas that couples who can conceive naturally do not have to face. Infertility comes with a financial obligation for the treatment (if people choose to pursue further treatments following the ones available from the NHS) and failed attempts of IVF or other treatments can be very stressful. Couples are also faced with the possibility of considering different options of conception such as sperm or egg donation or adoption as well as what happens to unused embryos if they have a successful attempt (Savitz-Smith, 2003).

2.3 The impact of infertility on women

Despite the fact that infertility affects both partners, it is interesting to note that there is an enhanced knowledge of the experience of women in comparison to the experience of men. Women with the inability to conceive (irrespective of the source of the fertility problem) appear to experience considerable psychosocial distress, diminished self-esteem and high levels of depression (Abbey et al 1991, 1994; Greil, 1991; Koropatnick et al, 1993; Link and Darling, 1986; Nachtigall et al, 1992 and Valentine, 1986). In a qualitative study carried out by Williams in 1997, eleven themes emerged from the interviews with women. These were negative identity, a sense of worthlessness and inadequacy, a feeling of lack of personal control, anger and resentment, grief and depression, anxiety and stress, lower life satisfaction, envy of other mothers, loss of the dream of co-creating, the 'emotional roller coaster' and a sense of isolation. Studies carried out by Whiteford and Gonzalez (1995) and

Sandelowski et al (1990), further contribute to capturing the experience of women. In these studies shame, guilt, inadequacy, failure and feelings of incompleteness seem to predominate. Moreover, the psychological test profiles of women coping with infertility are similar to women who are suffering from cancer, heart disease, chronic pain, hypertension and HIV infection (Domar et al, 1993). All of these studies capture the powerful experience of infertility on women. I was left wondering, however, whether the experience of men is that dissimilar and what were the reasons for portraying the women as the most affected gender rather than focusing on individual differences instead.

The fact that most women are reminded on a monthly basis of their infertility and they are responsible for monitoring their ovulation could be a possible reason for the extensive studies carried out with women. The woman is the one who fails to become pregnant and lives with the constant reminders (Greil, 1991). Infertile women endure most of the technological investigations and treatments such as genital examinations, blood tests, basal body temperature charting etc (Webb and Daniluk, 1999).

Many women find the fertile world painful and as a result, they retreat into social isolation. They find hearing news of other women's pregnancy difficult and everyday events like going to the supermarket become a problem because they worry about the possibility of seeing pregnant women or women with children. Consequently, they distance themselves from friends and family who have managed to achieve motherhood (Ferber, 1995). Women will often talk about their experience of labour and childbirth and if a woman does not have that, she feels estranged from the female community (Weinshel, 1990). We live in a society though where it has become the 'norm' that women find it easier to open up and talk about their emotions

whilst men seem to find it more difficult. If women, therefore who find it easier to talk, seem to retreat into social isolation because of their infertility, how is that like for men and what do they go through with their infertility?

Having a child is one of the main ways, which define some women's identity. "Any failure to fulfil the motherhood role negatively affects a woman's perception of herself because the failure to biologically reproduce represents a failure to meet gender role expectations" (Nachtigall et al 1992: p.119). The centrality of motherhood in different societies is also important to keep in mind. In developing countries, it is through motherhood that women achieve adult status and acceptance in the community (Hollos, 2003). In Southern Africa, a woman earns the right to a share of her husband's property and wealth after she gives birth (Sundby and Jacobus, 2001). The Yoruba people consider children essential to the continuation of lineages and as a result, the adult woman's role depends on becoming a mother (Pearce, 1999). Infertility is a source of poverty in Cameroon (Feldman-Savelsberg, 2002). These views can therefore, make it more difficult for women to disclose their infertility problems and it is an indication of how stigmatizing their infertility can be. If developing countries place so much focus on the woman and the importance of achieving motherhood, one can only imagine what that might be like for men and the significance that these communities put on achieving fatherhood, let alone the implications involved if this does not happen.

2.4 Gender differences in response to infertility

Over the years, a number of qualitative and quantitative studies explored the gender differences in response to infertility. Other studies, however, looked at the couple's responses to infertility instead of comparing male and female. Valentine

(1986) in his qualitative study captured the experience of twelve couples and the strong emotional reactions they went through. Some of these included sadness, confusion, humiliation and desperation. Valentine's suggestion was to try to understand infertility as a multiple loss and a multiple stressor. Menning (1980) and Mahlstedt (1985) with their several years of experience working with infertile people, added to Valentine's contribution and both stated that some of the common emotional reactions are denial, isolation, anger and grief. Mahlstedt (1985) talks about the multiple losses that a couple can experience and Menning (1980) indicates the difficulty of the couple to grieve. These are all emotional responses that, over the years, I have also seen with my clients who presented with an infertility difficulty. Infertility influenced several aspects of my clients' lives and it subjected them to many dilemmas that they had to deal with. Some of these dilemmas included treatment options, their relationship, and their social life. Infertility, therefore, can be perceived as a significant multifaceted loss in people's lives.

Other studies focused on the fact that infertility affects women more than men. Abbey et al (1991) carried out a survey of 275 couples (185 of them were infertile). Their findings indicated that men and women differ in their response to infertility and women found the infertility experience more stressful than their partners. Having a child was more important to them and they reported a disruption in their personal, social and sex lives in comparison to the fertile women. They were very preoccupied with their infertility and they felt responsible for it, whilst men were more preoccupied with general aspects of married life. There is a limitation in this study, however, which makes the conclusion that women find infertility more stressful questionable. There was an under-representation of the male factor infertility. Out of the 185 infertile couples, only 10% were male factor, 46% were female, 30% were combined

factor and 14% were unexplained infertility. There was, therefore, an over-representation of the female factor infertility in this study.

Women's emotions of guilt, anger, frustration and isolation were more intense than their partners' in Bresnick and Taymor's (1979) quantitative study. Similarly, in Link and Darling's (1986) quantitative study, the level of life satisfaction was lower for wives than for their husbands. It is important to add though, that in this study, the participants were 43 husband-wife pairs and another 17 women on their own as their husbands chose not to respond. There is an under-representation of husbands in this study, and as a result, it is difficult to draw any conclusions. In Draye et al's (1988) quantitative study, women experienced more problems in their personal life and areas of self-esteem. Women also seemed to use more avoidance-withdrawal coping strategies than men. The source of infertility, however, is unknown in this study so it is difficult to determine the reason for the differences between the men and the women. These studies, therefore, suggest that infertility has a greater impact on women than on men. It seems though, that there are some limitations in the studies. The researchers did not take into account the source of infertility (combined factor, male, female or unknown) and in some studies, there was an under-representation of men. Moreover, the studies mentioned above are all quantitative and, despite the fact that they can add evidence to the body of literature, they fail to help us understand what is actually happening to the participants and to learn more about their lived experience. Emotional aspects are quantified with measures of well-being and distress but without any more detailed information on the experience.

When the source of infertility is considered, the results are contradictory. Nachtigall et al (1992) interviewed 36 couples using in-depth interviews. Men with male factor infertility experienced a similar intensity of distress to women. They

reported negative emotional responses such as reduced self – esteem, a sense of loss and stigma. Quantitative studies, which used surveys and standardized measures to analyse the psychological outcomes of infertility, showed contradictory results. Lee et al (2001), for example, had 138 couples as their participants who accessed treatment in China. Using the Chinese Infertility Questionnaire, they measured self-esteem, blame/guilt and sexual impairment. They found no differences in men's self- esteem or guilt between groups. Holter et al (2007) reported similar results in their study. Their findings indicated that male infertility did not seem to influence men negatively regarding their experience of infertility, view of life, psychological well-being and relationships. It did not make a difference whether the diagnosis was male, female, mixed or unexplained. In Canada, in Dhillon et al's (2000) study, there was a comparison of men whose partners were currently pregnant and they were presumably fertile, men who had a diagnosis of infertility and men who were part of a couple with unexplained infertility. They found no differences in depression, anxiety, anger or self-esteem in these groups. In America, however, in Smith et al's (2009) study, men with male factor infertility experienced a poorer personal quality of life than men from other couples. Some observations can be drawn from these studies. The qualitative study used here (Nachtigall et al, 1992) shows that when the source of infertility is male factor, men display more intense responses to their experience of infertility. The results of the quantitative studies, however, are contradictory and some of them show that there are differences depending on the source of infertility and others indicate that there are not. Further evidence of the limitations of quantitative studies can be seen from the above inconsistencies. Quantitative studies can give us an indication of their participants' views but we do not get a rich exploration of the participants' experience. There is a

difference between trying to capture your experience in words and in numbers. Numerical descriptions make the results more limited and a lot less detailed.

Nachtigall et al's (1992) qualitative study and the literature review by Newton and Houle (1993) make a significant contribution when exploring the impact of infertility on men and women. Infertility affects both men and women and there is no question about that. What is different though, are the ways in which infertility affects men and women (Nachtigall et al, 1992). Women seem to be affected earlier, they report distress and are more likely to experience self-image and self-esteem problems. They also take personal responsibility for the infertility difficulties. Diminished sexual satisfaction seems to happen for both genders. Women are more inclined to look outside the marriage for support and education, whilst men seem to focus more on work and other time-consuming activities (Newton and Houle, 1993).

It is important to consider the possible reasons for the different reactions of men and women instead of focusing on who is more impacted. The different perceptions of each gender's role in relation to parenthood as well as cultural expectations play a significant part. A few decades ago, if one had a quick look through traditional men's magazines not a lot of articles were about fatherhood. When we looked at women's publications, however, articles focused on how to make special clothing, costumes for Halloween or even what to watch regarding childhood illness. The same applied in academic writing where the topics of fathering and fatherhood were still in their infancy. Considering this, it is not surprising that our society views motherhood as the ultimate expression of being a woman (Phoenix and Woolett, 1991). Despite the fact that over the last four decades, career development has become more important for women, motherhood remains the primary social role for some women (Becker and Nachtigall, 1994; Daniluk, 1997).

Whilst some women define themselves through motherhood, fatherhood is one aspect of men's lives. The influence of society also plays a part in a man's identity but it seems to be in a different way than it is for a woman. Masculinity seems to be associated with a man's ability to show strength, virility and potency so a man with an infertility diagnosis fails to demonstrate these characteristics (Peterson, 2002). A potential loss of his manhood is what he is confronted with instead (Deveraux and Hammerman, 1998).

Moreover, there seems to be an expectation from our society that men should be the strong ones and this is somehow translated into maintaining an emotional detachment from painful events. Lemmens et al's (2004) study provides confirmation of this expectation. In their study, couples who were involved in a treatment programme at the Leuven Fertility Centre in Belgium participated as a couple in a body-mind group programme. As an attempt to protect their wives from any difficulties and in an effort to please them, men in this study pretended to be strong and did not show any negative emotions in order not to upset them. The ways in which men and women cope with negative affect seems different. "Women have been socialised to talk more openly about their problems, whereas men have been socialised not to show emotions" (Webb 1994:p.7). Daniluk (1991), Valentine (1986) and Brucker and McKenry (2004) confirm this significant statement. Women tend to voice their sadness and they have the need to talk about it, whilst men tend to avoid showing emotions and take the role of the stoic partner instead (Jaffe and Diamond, 2010). Men could therefore, be suffering in silence in order to support their wives/partners and as a result, they do not indicate their psychological distress in the questionnaire scales. The measures used in the questionnaires may also not be tapping into the way in which men express their experience of infertility. This was

also supported by Holter et al (2007) as they suggested that “methods of measurement may favour the female type of expression, and it may be necessary to develop new questionnaires to elicit information about the male gender role...in order to discover the effects of infertility on men” (p.2564). The roles men and women play in a relationship, therefore, can result in an incorrect perception; that men are not as affected by infertility as much as their partners are. Women could also be misinterpreting their partners’ silence as a lack of concern when this is not the case (Mahlstedt, 1985).

Another possible reason worth mentioning here is that men’s confidantes are their wives/partners. Women have to go through all the invasive procedures for infertility treatment so this poses a difficulty for men being comfortable to disclose to their partners how they feel (Jordan and Revenson, 1999).

In some cultures, masculinity is very important and male infertility is still a stigmatized condition. This leads to women taking the responsibility for the infertility problem in an attempt to protect their husbands from the shame involved. This, however, has the consequence of the women usually receiving more support than men do and the secrecy around male infertility continues (Snowden et al, 1983).

These are all important reasons to consider when thinking about the ways that men and women respond to infertility and how they deal with it. I think that it is not so much about thinking who is impacted the most but how they show their impact. Moreover, whilst reading the numerous studies on infertility I found myself at times, feeling frustrated and uncomfortable with this sense of the male/female binary split and the tendency to try and find out who is more distressed, instead of attempting to explore in more detail the individual differences and the nature of people’s distress. The concept of making comparisons on the level of distress between men and

women goes against some of my values as a psychological therapist. I value each person's uniqueness and difference and I think that by making comparisons we are taking away from the person's experience as we are undermining it. It is more important to try and capture the experience of individuals who are going through infertility and the possible themes that might come up for them rather than compare their level of distress.

Furthermore, before moving on to the final section of this chapter, I think that it is important to take into consideration another angle as far as parenting identity is concerned and the concepts of discourse and social interaction. Lazar (2000) makes a valid contribution regarding the realm of parenthood as she argues that there is nothing fixed about the identities of 'mother' and 'father' or in the way gender relations are structured. According to Lazar (ibid) the identities of mother and father are socially formed and fixed in and through discourse. The reason we perceive them in certain ways (for example motherhood as 'natural' and fatherhood as 'social' is "a result of conventional ways in which the societies we live in have come to express and think about them. What is fixed, therefore, can be analytically un-fixed or dismantled" (p.376). Lazar's views are further supported by Deutsch (2007), who argues that gender is an ongoing part of social interaction. People will behave according to what they think is appropriate depending on their gender but these can change with social situation, time and ethic group. The construction of the New Man is also discussed by Lazar (2000) who describes how this type of masculinity has become popular, (especially in the western media since the 1980s), as a response to feminism critique of the traditional forms of masculinity. The New Man is a much more involved father who is very comfortable with children and where care and emotion are expressed more easily. The New Man, therefore, is an attempt to break

down the gender stereotypes. Moreover, it is also important to note that alternative forms of parenthood such as lesbian or gay couples also challenge the traditional assumptions about gender roles and who is responsible for what in the family (Segal-Sklar, 1995).

2.5 Research contributions to the experience of male infertility

Research concerning the psychosocial aspects of infertility and its treatment tends to focus more on women than on men. This absence of research on male infertility, however, has been readdressed and the literature on fatherhood and fathering is slowly developing. In 2012, Fisher and Hammarberg put together a significant review of the studies that took place in relation to the psychological and social aspects of infertility in men. Despite the fact that the studies were diverse in conceptualisation and that included the setting and the data collection, the findings seem consistent. The desire for parenthood for men seems to be similar to those of women and there is an experience of anxiety during diagnosis and treatment. Men show a preference to receiving oral treatment information instead of written and a preference to having emotional support from the infertility clinicians. Men also seem to compartmentalise their emotions and they focus on helping their partners instead of showing their emotional needs. In addition to this, Cousineau and Domar in their research review in 2007 found that infertility affects men as they experience impaired self-esteem and an inadequacy regarding their role in society. Men tend to cope by becoming more involved in work and other activities.

It is worth mentioning here that there is a growing body of anthropological research, which considers the impact of male infertility on masculinity. In some countries, the connection between masculinity and male infertility features quite

strongly. In Muslim Middle East, for example, men show their masculinity by fathering children and especially sons. Men who are infertile are seen as weak and ineffective and as a result, they will keep their infertility a secret (Inhorn, 2003a). Men in India find their infertility so humiliating that they prefer to have a child through donor insemination than adoption. If a child is conceived through donor insemination, then their infertility can remain a secret (Bharadwaj, 2003). The stigma in male infertility, however, seems to exist in the United States as well (Becker, 2002). These studies indicate that male infertility affects a man's sense of masculinity.

In the two subsections below, the quantitative and qualitative studies on male infertility will be addressed in more detail.

2.5.1 Quantitative Studies

A number of quantitative studies report that infertile men have lower rates of self – esteem and experience more anxiety and somatic symptoms than men who are fertile (Glover et al, 1997; Kedem et al, 1990). This distress can continue even after eighteen months of treatment. The experience of impotence and sexual performance anxiety (Saleh et al, 2003) were also found in male infertility studies. In Glover et al's (1995) longitudinal study, men experienced increased anxiety, distress and self-blame for their infertility problems. In Band et al's (1998) study, 130 men were given questionnaires in order to investigate psychological distress. Three significant predictors of depression were found: "an anxious disposition, a tendency to appraise situations as stressful and an avoidant coping style. In relation to state anxiety, two predictors were identified: trait anxiety and failure to seek social support" (p.245). The studies aforementioned give us an overall indication of the existence of psychological distress but unfortunately, we do not get to find out more about the

type of distress, its manifestation and the personal implications. Qualitative research has the advantage of enhancing the knowledge we gain from quantitative research as it provides us with the opportunity to find out in more detail about the participants' experience.

Moreover, some studies have tried to find out whether men think of their infertility situation differently depending on the cause of infertility. The evidence is mixed. Iranian men scored higher for depression and anxiety when it was a male factor infertility (Baluch et al, 1998) and most of the respondents in Folkvord et al's study (2005), which took place in Zimbabwe, indicated that their infertility caused them stress and they reported signs of mild depression. In Peronace et al's longitudinal study (2007) in Denmark, however, mental and physical health, support and psychological and social stress were investigated for men with a male factor, female factor, mixed and unexplained infertility. Their results indicated that "involuntary childlessness is difficult for all men, and is not dependent on with whom the cause lies" (p.105). In the early 1990s, the intracytoplasmic sperm injection (ICSI) was developed which gave men the opportunity to have a biological child. Prior to the ICSI development, the available therapeutic options for men were limited and the estimation is that three-quarters of female problems can be resolved by assisted reproductive techniques but only one-third of male (Carmeli and Birenbaum-Carmeli, 1994). It was, therefore, suggested that with the development of the ICSI, men with a male factor infertility, started reacting similarly to when the cause of infertility was female, mixed or unknown (Holter et al, 2007). This, however, remains equivocal, as it is not indicated in all the studies that took place after the early 1990s. Mikkelsen et al (2012) recruited 210 Danish men. Despite the fact that the majority of their participants said that the infertility diagnosis did not affect their masculinity or

their sense of general well-being, nearly a third (28%) felt that their reduced sperm quality had an impact on their perception of masculinity. As has been indicated, there are inconsistencies in the above studies. One of the limitations of quantitative studies is that they only provide us with quantified evidence. We do not have access to what it actually means for people with infertility to have this diagnosis. Qualitative research, however, can address this and provide us with more information. In the following section, I will address the limited qualitative studies on the issue of male infertility.

2.5.2 Qualitative Studies

When researching infertility it seems that the focus is on women and their experience of it, which is a clear limitation of the infertility literature. Men have been mostly marginalised in the reproductive realm. Qualitative studies have the potential to help us understand more about men's experience and their perspectives as far as male factor infertility is concerned. Unfortunately, however, the qualitative studies on the male experience are limited.

Perhaps one of the reasons for the limited research is the fact that men are not as willing as women are to talk about their experiences. This argument was supported by Webb and Daniluk (1999) who found it difficult to recruit men for their study. This, however, does not mean that we cannot 'persist' in carrying out research with men as it is important to capture what they are going through and to give them a voice which was one of my aims in the current study.

Webb and Daniluk's study (1999) was one of the first qualitative studies that took place with the aim to explore men's experience. Their six Canadian participants were men who had achieved fatherhood through either adoption or donor

insemination. They found infertility to be a difficult and painful experience. They reported “intense feelings of grief and loss, powerlessness and a lack of control, inadequacy, isolation, and betrayal in response to being unable to father a child” (p.20). The nature of loss was multifaceted as there was the loss of fertility, of genetic continuity, of masculinity, of control, of meaning of life and of a life dream. There was also a profound sense of being out of control. They did not have any control over their fertility, the medical investigations, their sex lives, their emotions and their ability to parent. When the participants spoke about their feelings of personal inadequacy, they used words and phrases like ‘failure’, ‘useless’, ‘not a real man’. There was a tremendous blow to their masculinity. Some of them tried to compensate for those feelings by acting like ‘super jocks’ and having affairs with other women. Others and similar to the Mason (1993) study, they focused on work and tried to prove their worth through career successes. “In facing their infertility, these men were forced to redefine what it means to be a man and a husband and to reconstruct a sense of themselves as competent, worthwhile man, irrespective of their fertility status” (Webb and Daniluk 1999: p.22). There was an assumption from the men in this study that it was their wives’ fault and that is why they could not conceive a child. As a result, they were shocked to find out the results and they found the process of having to provide semen samples humiliating.

In Arya and Dibb’s (2016) recent qualitative study, their participants reported feeling less of a man for not being able to have a child and feeling a sense of stigma. The perceived threat to their masculinity and the fact that their “sense of themselves as men was called into question” was also reported in Throsby and Gill’s (2004) study (p.336). Hanna and Gough’s (2016) study of the examination of forum posts from a men-only infertility discussion board also provides us with valuable

information on the emotional impact of infertility for men. They characterise their experiences as fluctuating, pervasive and uncertain.

In terms of how the men coped, there seems to be this clear narrative where men seem to think that an ‘acceptable’ response is for them to be ‘strong’ for their partner and that also means suppressing their own emotions. Men, therefore, take the role of the ‘sturdy oak’ or the ‘emotional rock’ (Throsby and Gill, 2004) which some authors portray as being part of the traditional masculine role (Connell, 1995; Throsby and Gill, 2004; Wischmann and Thorn, 2013). The findings of the Webb and Daniluk study (1999) were consistent with this view, as their participants believed that they needed to be the strong ones and not share their pain with others. In Malik and Coulson’s (2008) qualitative study, (they examined the communication within an online infertility support group for men) men felt that their main role was to support their partners. Their participants had a “sense of helplessness in their ability to support their partner” (p. 22). They might try and play the role of the ‘rock’ but this does not necessarily mean that it is an easy role to play.

The fact that men do not tend to communicate their painful feelings towards their infertility also implies that their partners might not necessarily realise what they are going through. This was indicated in the Throsby and Gill (2004) study where women experienced their husbands as being distant and invalidating of their grief. One of Daniluk’s (1997) participants captured his reactions to infertility in a very poignant statement.

> “I did not want to seriously examine my feelings because I did not want to face the feelings of pain, sorrow, disappointment and inadequacy...and I did not want to hear my wife’s feelings of pain and anger about my infertility...a lot of it was not having the ability or the honesty to know what I was feeling” (p.108).

The work of Malik and Coulson (2008) with the exploration of the online forum is an interesting approach in having access to men's accounts and we have the opportunity to gain a unique insight into how men manage during the infertility process. Other than trying to be strong and supportive to their partners (which was mentioned above), their participants exhibited feelings of alienation and distance and felt that the medical professionals excluded them from the infertility treatment. Men found themselves playing a minimal role. This is consistent with the findings of Meerabeau (1991) and Arya and Dibb (2016). Meerabeau (1991) looked at the participation of men in fertility clinics. She found that there was a tendency of consultants forgetting to recall the husbands following an examination and men were asked to wait outside during internal examinations. Men were therefore marginalised during treatment. In Arya and Dibb's (2016) study, their participants reported a weak relationship with the medical professionals. They felt dismissed and some of them even reported feeling as if the professionals were trying to blame them for their infertility.

As far as alternative reproduction methods are concerned, Arya and Dibb (2016) found that the continuation of the genetic line and being able to have a biological child were imperative. The idea of using a donor sperm, therefore, brought a mixture of emotions but the participants spoke about their ambivalence and the reasons behind this ambivalence.

The studies above are a confirmation that there is progress, albeit slow, towards trying to shed some light on an under-researched area and an attempt to try to find out more about men's experience of infertility. The current study attempts to minimise this gap in the infertility research realm even further. In this section, I provided the reader with an overall idea of the available qualitative studies. In the

next section, I will attend to these studies individually and explore their limitations. These limitations are in fact, what helped in the emergence of the current study's research question which is what is the experience and meaning of infertility as lived by men diagnosed with infertility.

2.6 Rationale for the current study

Approximately half of the infertility issues are associated with the male and yet, as the previous sections in this chapter have indicated, there is relatively little research, which focuses exclusively on how men with a male factor infertility diagnosis experience their infertility. There are some quantitative studies, but there seems to be a paucity of qualitative research with the aim of exploring men's views, feelings and their perspective (Hanna and Gough, 2015; Culley et al, 2013). Moreover, there are numerous guidance books written for women but again, this does not apply for men (Rawlings and Looi, 2006).

There are several reasons that might explain why the lens of infertility has mainly focused on women. Women have been classified as being more impacted than men. They are the ones that have to go through most of the medical procedures (Johansson et al, 2011; Jordan and Revenson, 1999). Researchers, however, might have framed their questions around women's experiences and women might be more inclined to take part in research, so this could explain why women are displaying more distress in studies (Wright et al, 1991; Woollett, 1985). Another possible reason could be because male factor infertility is perceived as stigmatizing and as a result men do not tend to disclose their diagnosis and they do not want to talk about their feelings (Dooley et al, 2011).

A few quantitative studies have been carried out and despite the fact that we get to find out some information on men's experiences there are important limitations. With quantitative studies we do not have any access to "the type of distress men experience, how this may be manifest, the personal implications of such emotive responses, preferred support, and what this means in terms of understanding the nuances of how men...experience infertility" (Hanna and Gough 2015:p.1). A qualitative study, however, has the advantage of being able to tap into the participants' lived experience and give us a more in-depth exploration.

Over the years, there have been some attempts to try and explore men's experiences further. One of these attempts is the study carried out by Webb and Daniluk in 1999. They examined in depth the experience of men in couples who had been identified with an exclusively male factor infertility. It is important to notice, however, that the six men that they interviewed were already fathers at the time of the interviews; five of them decided to adopt and the other one became a father through donor insemination. The men talked about their experience of finding out about their infertility and how they came to terms with it. The aim of the present study is to look at how men feel about their infertility in the here and now and before they have achieved fatherhood. Men who are not fathers yet might understand and experience their infertility differently than the ones who are already fathers and it would be important to explore this.

In 2004, Throsby and Gill carried out a study investigating men's feelings, beliefs and practices in relation to IVF. However, the participants in this study were fifteen women whose male partners did not wish to participate and thirteen couples thus more women ended up talking about their experience of IVF and how their husbands viewed it. It seems that even when there is an attempt to bring the

attention to the feelings and experiences of men, this is mediated through women via couples' interviews. Considering the fact (and as it was mentioned above) that men are trying to be the 'strong' ones, one can argue that this might make it difficult for men to disclose their true feelings about their experience. In an attempt to support their partners and not give them any more anguish, men might not share their feelings so interviewing couples together might not be very productive in terms of finding out about their experience. This, therefore, implies that there is "a need for the lens to be more firmly on the male experience and for the experiences of men to be sought independently of the constraints that may exist in men discussing their experience of infertility in front of their spouses or partners" (Hanna and Gough 2015:p.7). The aim of this study, therefore, is to interview men on their own so that they can openly talk about their experience of infertility without worrying about being 'strong' for their partners.

Another qualitative study took place in 2011 by Dooley et al with the aim to investigate the subjective experience of men with male factor infertility. The researchers used grounded theory and they identified three themes; impact to self, social impact and relationship and support. Grounded theory generates a theory from the data collected (Glaser and Strauss, 1967). In my study, however, I have chosen a phenomenological approach as the aim is to explore the lived experience of the participants. This approach is useful when little is known about a phenomenon and this applies in this situation. In the next chapter, I will discuss in more detail the reasons behind my decision for the specific methodology.

In the most recent qualitative study, which took place in 2016, Arya and Dibb interviewed fifteen men who had experienced infertility. This was a valuable contribution to the male experience and it gave us an understanding of the

experience of men. They used Interpretative Phenomenological Analysis (IPA), which is the same methodology as the one I used in this study. There is a limitation, however, and that is the variation of the cause of infertility. The researchers did not take the factor of infertility into account and different factors can potentially influence the experience of infertility. The aim of my study, therefore, is to explore the experience of men with an exclusively male factor infertility.

Taking all of the above into consideration, there is still insufficient knowledge of how men experience their infertility diagnosis. The issue of infertility can be a difficult life challenge for men and I think it is important to capture that and give it a voice in order to be able to support men who are going through this experience. This study aims to provide us with more knowledge and to shed some more light into men's experience.

2.7 Personal reflections

When I decided that I wanted my research focus to be on the experience of men, I did wonder how feasible it would be and how my participants would feel talking to a woman about their diagnosis. I was mindful that what they would tell me would probably be different to what they would tell a man but this applies to every situation and every relationship is different. I did not want the idea of finding it difficult to interview men to stop me and I thought it was important to persevere. What I did have in mind was that I would aim to carry out the interviews with my participants in the same way that I work with my clients; with respect, humility and an interest in finding out about them. Unlike my work with clients, though, where I do not tend to disclose information about me, in this case, I would be open to inform my participants the reasons behind my decision to carry out this research and my wish

to give them a voice. Moreover, considering the fact that men tend to want to be supportive to their partners and as a result, they avoid disclosing their feelings, talking to a woman has the potential of being something different for them as they would not need to pretend in front of me. I was also mindful of the potential transferential dynamics where as a female researcher I could become either their father or mother. For that, however, my role as a psychotherapist and my reflexivity throughout the contact with my participants would be essential in maintaining an awareness of the different dynamics.

Chapter 3: Methodology and Method

The purpose of this chapter is to explain my rationale behind my choice of methodology and the methods I used to carry out this study. In the first section, I will inform the reader about my philosophical stance, and how this determined my choice of a phenomenological approach. I will explain why after considering different approaches, I chose Interpretative Phenomenological Analysis (IPA) and I will provide an exploration of the philosophical foundations of IPA. Following this, I will outline the methods used in the study, including participant recruitment, data collection and analysis, as well as ethical considerations and issues around validity and trustworthiness. My personal and methodological reflections will be captured throughout the different sections.

In order to explain my rationale behind my choice of methodology, I will address my epistemological, ontological and axiological assumptions. “Methodology emerges from the ontology, epistemology, and axiology and addresses the question of how we gain knowledge” (Morrow 2007:p.212). Epistemology addresses the question of how we know what we know; so how is knowledge acquired. It is also concerned with the relationship between the researcher and the participant. Ontology is concerned with the nature of reality and what can be known about it. Axiology focuses on the role and values of the researcher in the research process (Ponterotto, 2005).

3.1 *Philosophical Stance*

Existential philosophy and phenomenology lie at the heart of my values as a therapist, a researcher and generally in all of my relationships. I agree with Heidegger’s (1927/1962) ideas which place a focus on ‘being-in-the world’ and

therefore on the existence and our experience of the world as it is lived by us. I support Heidegger's argument that we are inseparable from the world we inhabit and agree with the importance he places on the historical and the cultural context in our way of existing and how this can be understood through the use of language (Langdridge, 2007). I take the position that it is impossible to separate the individual from the wider context and I acknowledge the influence that culture and society can have on an individual. As a result, my knowledge and meaning are socially constructed. I hold in mind the focus I place on the co-construction of meaning and action. This idea is an example of the importance of being able to maintain a flexible and open approach to different perspectives. Each person is unique and will be influenced by the wider context in different ways, which will then have an impact on the choices they decide to make in their life.

When it comes to what constitutes a valid source of knowledge, I agree with the phenomenological method of enquiry, which places importance on the subjective experience (Husserl, 1970; Heidegger, 1962). I support the view that a person's "subjective experience is his truth and the starting point of exploration" (Evans and Gilbert 2005:p.18). I value the notion of the co-creation between observer and observed which is also central to the phenomenological position (Orlans and Van Scoyoc, 2009). All relationships are co-constructed as both participants contribute; a fundamentally important position, supported by research (e.g. Beebe and Lachman, 1998).

My existential phenomenological positioning acknowledges the significance of a reflexive stance. This can only be achieved if I have the capacity to "experience, observe and reflect on *myself* as both a subject and an object" (Aron 1998:p.3) (italics are my own addition) and if I am aware and in touch with my own limitations,

reactions and feelings. This is why I have kept a reflexivity journal throughout my research journey where I have documented significant events, my thoughts and feelings and in general, my personal processes from the inception of the research topic to the completion of the project.

Moreover, I enter each relationship with respect and I value and trust each person's uniqueness and difference. I believe that a trusting and mutually respectful relationship is the foundation from where everything else can emerge; this is why it was important for me that my participants felt comfortable to tell their story and were supported to explore their experience of infertility.

Taking into consideration what I have mentioned above, and in accordance with my philosophical stance, one can, therefore, draw the conclusion that this study is based on an interpretivist constructivist research paradigm with a relativist ontology. In interpretivist epistemology, the attention is drawn to "the way our perceptions and experiences are socially, culturally, historically and linguistically produced" (Finlay 2006:p.19). A relativist ontology also "emphasizes the diversity of interpretations that can be applied" (Willig 2013:p.12). I hold the position that I shaped the research process as it is impossible to separate my values and lived experience from the research process. Bearing in mind that each of us goes through their own unique experiences and that their way of making sense of the world is as valid as everyone else's, then this also implies that if another researcher undertook the same study, their interpretation and understanding would have been different.

3.2 Methodology

3.2.1 Rationale for choosing a qualitative approach

Quantitative methods are useful in providing the researcher with a broad understanding of a phenomenon. Qualitative methods, however, maintain an interpretative approach with the main concern to understand the meanings that people attach to different phenomena within their world (Snape and Spencer, 2003). They are particularly useful to answering questions of 'how' and 'what' (Morrow, 2007). Taking into consideration that the aim of this study is to explore how men with an exclusively male factor infertility problem experience their diagnosis, a qualitative approach would be the best fit. Qualitative methods give the researcher the opportunity to "delve into complex processes and illustrate the multifaceted nature of human phenomena" (Morrow 2007:p.211). A qualitative approach has the advantage of offering a broader and deeper understanding of how men experience their infertility, whilst quantitative methods would only be able to gather surface information and not capture the richness of the experience (Polkinghorne, 2005)

Moreover, as it was clearly indicated in the literature review, male infertility is an under-researched area. When there is little research available and as a result, a phenomenon is not well known or understood, qualitative research has the potential of bringing new knowledge to the fore (Creswell, 1998; Marshall and Rossman, 1999). It also gives participants a voice, which was one of the aims of this research study.

In addition, another pertinent factor that contributed to my decision to use a qualitative methodology and not a quantitative one is my philosophical stance. Quantitative methods and in effect positivist research puts the interests and values of the researcher to one side whereas qualitative methodology acknowledges that the

experience and identity of the researcher will impact the findings of a study. Qualitative methodology is a much more personal approach and there is the recognition that in order to reach a rich understanding of the experience, the researcher will enter into a meaningful relationship with the participants (McLeod, 2001). A qualitative approach, therefore, fits better with my philosophical stance.

After evaluating the above reasons, I decided that the most appropriate approach to use in order to answer my research question on the experience of male infertility was a qualitative approach.

3.2.2 Rationale for choosing a phenomenological approach

Once I decided that I would use a qualitative methodology, different approaches were considered and these will be discussed below. I chose a phenomenological approach as the aim was to explore the lived experience of my participants. This approach is useful when little is known about a phenomenon and this applied in this situation. Infertility is a complex issue and in order to be able to grasp its meaning for my participants, it was important to use a holistic approach. According to Colaizzi (1978), the phenomenological approach is non - intrusive and allows the phenomenon to speak for itself. It is a method that “remains with human experience as it is experienced, one which tries to sustain contact with experience as it is given” (p.53). The goal is not to generalise findings to other populations but instead to provide a rich and detailed exploration of the phenomenon in question and to explicate themes and meaning that this homogeneous group shares (Colaizzi, 1978). Despite the fact that each person’s experience of infertility is unique, I foresee that the themes in this study will resonate with other men’s experience of infertility.

Phenomenology has roots in the philosophical perspectives of Husserl (1859 – 1938) and philosophical discussions follow by Heidegger, Sartre and Merleau-Ponty (Creswell, 1998). There are significant differences between these philosophers and I will attend to these below. Phenomenological psychology is a label for a family of approaches "which are all informed by phenomenology but with different emphases, depending on the specific strand of phenomenological philosophy that most informs the methodology" (Langdridge 2007:p.4). The focus of experience and the discussion on intentionality (a concept that considers that we are always conscious of something) are keys to all approaches. The main concern of phenomenology, therefore, is to understand the experience and the ways in which people perceive the world.

Despite the fact that all phenomenology is descriptive, there is a distinction between descriptive and hermeneutic or interpretative variants (Finlay, 2009a). Husserl (1900/1970) advocated for transcendental phenomenology whilst Heidegger (1927/1962) advocated for existential phenomenology. Transcendental phenomenology means being able to go outside experience. Existential phenomenology means focusing on existence and our experience of the world as it is lived by us. Heidegger (1927/1962) was more concerned with ontology and establishing the truth about our existence, instead of focusing on epistemology and what we know about human nature. Similar to Heidegger, Gadamer (1960/1996) also supported that understanding is fundamental for human existence and that we gain an understanding of our world via language.

Husserl (1900/1970) spoke about achieving epoche or bracketing (a process where we abstain from our presuppositions and preconceived ideas). My epistemological position is more in line with the existential phenomenologists who

argue that you can attempt to achieve epoche, but it is not possible to truly bracket off all presuppositions. Both Heidegger (1927/1962) and Ricoeur (1970) thought that even if we tried to bracket our presuppositions, we always speak from somewhere even if we might not be aware of it. I support Heidegger's (1927/1962) argument therefore, that we are inseparable from the world we inhabit and as a result, it is not possible to completely bracket off our way of seeing and identify the essence of a phenomenon.

Heidegger places a lot of importance on the historical and the cultural context in our way of existing and how this can be understood through the use of language (Langdridge, 2007). I also support his idea that our way of existing needs to be interpreted and not simply described as "the meaning of phenomenological description as a method lies in interpretation" (Heidegger 1962:p.37). Finlay (2009b) also argues that interpretation is "an inevitable and basic structure of our 'being-in-the world'. We experience a thing as something that has already been interpreted" (p.11).

Considering the fact that I take Heidegger's existential and hermeneutic phenomenology as my base, it follows that my choice of method was an interpretative one rather than a descriptive. I find the firmness of descriptive phenomenology incompatible with my epistemological stance. The interpretative one, however, is a much better fit as I see the impossibility of separating description from interpretation and I recognise that any understandings we gain are dependent on our experience and perspective. I have as a result decided to use IPA for this study. In the following section, I will provide more information on my decision to use IPA, including its theoretical and philosophical underpinnings as well as a critical appraisal.

3.2.3 Rationale for choosing Interpretative Phenomenological Analysis (IPA)

One of the reasons for choosing IPA is because it provides an in-depth view and understanding of the participants' experience. "IPA is committed to the detailed examination of the particular case. It wants to know in detail what the experience for *this* person is like, what sense *this* particular person is making of what is happening to them" (Smith, Flowers and Larkin 2009:p.3). IPA aims to explore the participants' view of the world and it provides us with an insider's perspective. Taking into consideration the relatively limited research on male factor infertility, I considered IPA an appropriate method to use. It will give my participants a voice and offer us an insight into their lives, as it will explore in detail their experience. In addition to this, IPA acknowledges the dynamic nature of the research process and the central role of the researcher. IPA recognises that there is an attempt to get close to my participants' lived world but "access is both dependant on, and complicated by,...[my] own conceptions which are required in order to make sense of that other personal world through a process of interpretative activity" (Smith 1996:p.264). The recognition IPA places on intersubjectivity is aligned with my epistemological position so it makes this a suitable method to use for this study.

IPA is informed by concepts of three key areas of the philosophy of knowledge: phenomenology, hermeneutics and idiography. The focus on experience and the meaning it has for the participants makes IPA a phenomenological method. It aims to examine in detail the human lived experience and for it to be expressed in its own terms instead of any predefined category systems (Smith, Flowers and Larkin, 2009). The second theoretical underpinning comes from hermeneutics, which is the theory of interpretation. Participants try to make sense of what is happening to them and this is reflected in the accounts that they provide us with. "IPA concurs with Heidegger that phenomenological inquiry is

from the outset an interpretative process" (Smith, Flowers and Larkin 2009:p.32). IPA uses a double hermeneutic since the researcher is trying to make sense of the participant, who is trying to make sense of an experience (Smith and Osborn, 2003). The researcher is therefore, implicated in how he facilitates and makes sense of the phenomenon explored. Moreover, there is another way in which IPA operates as a double hermeneutic which I think it is very valuable for the purpose of this study as it is a sensitive area and one that my participants might not feel very comfortable talking about. Smith (2004) and Larkin et al (2006) suggest that IPA takes a centre-ground position in relation to Ricoeur's (1970) two interpretative positions; a hermeneutics of empathy (an attempt to reconstruct the original experience in its own terms) and a hermeneutics of suspicion (use of theoretical perspectives from outside). The centre ground position combines a "hermeneutic of empathy with a hermeneutics of questioning" (Smith, Flowers and Larkin 2009:p.36). This means that I will attempt to explore what it is like from my participants' point of view but I will also want to "stand alongside the participant, to take a look at them from a different angle, ask questions and puzzle over things they are saying" (ibid). IPA, therefore, combines phenomenological and hermeneutic insights. The attempt to get as close as possible to the personal experience makes it phenomenological. This, however, makes it an interpretative venture for the researcher and the participant because "without the phenomenology, there would be nothing to interpret; without the hermeneutics, the phenomenon would not be seen" (Smith, Flowers and Larkin 2009:p.37). It is impossible therefore, to have one without the other. Idiography, which is concerned with the particular, is the other major influence on IPA. It situates participants in their particular contexts and it captures the richness of each participant's experience whilst providing a detailed exploration of divergence and

convergence across the participants' experiences. There is an emphasis on detail so it is important for the analysis to be thorough and systematic. "IPA is [also] committed to understanding how particular experiential phenomena…have been understood from the perspective of the particular people in a particular context" (Smith, Flowers and Larkin 2009:p.29).

Despite the fact that I have chosen IPA as the most suitable methodology for my study, it is still imperative to mention that I am aware of some of the criticisms that it has received. These were considered before making my decision. Both Langdridge (2007) and Willig (2013) have challenged the reliance of IPA on the social cognition paradigm and they find it problematic. Smith (2004) acknowledges that IPA could be described as cognitive psychology but they have a significant difference. Cognitive psychology employs quantitative and experimental methodology, whilst IPA uses in-depth qualitative analysis. Smith, Flowers and Larkin (2009), however, make an important argument which also fits with my epistemological and ontological stance regarding the intersubjective nature of all experiences. IPA is concerned with cognition but in the sense of cognition "as a complex, nuanced process of sense- and meaning-making…Cognitions are not isolated separate functions, but are one aspect of being-in-the-world, and are accessed indirectly through people's accounts and stories, through language, and ultimately, meaning-making" (ibid:p.191).

3.2.4 The consideration of alternative methodologies

In deciding what approach to use for this study, different approaches were considered such as grounded theory, narrative analysis, discourse analysis and

template analysis. In this section, I will explain the reasons for deciding against using any of these and going with IPA instead.

Grounded Theory:

Glaser and Strauss (1967) first developed grounded theory and its aim is to generate or discover a theory from the data collected. There are several versions of grounded theory and if I were to use grounded theory as my methodology, I would have chosen Charmaz's (2006) constructivist version as it offers a clearer epistemological position. Theory development is integrated into grounded theory, however, and this was the reason I decided against using it. The emphasis of this study is on my participants' experience and not on developing a theory. With IPA, there is an attempt to develop a rich interpretation of the data and the focus is not on making generalisations, like in grounded theory, but on examining convergence and divergence in a smaller sample (Brocki and Wearden, 2006).

Narrative Analysis:

Narrative analysis was developed from social constructionism and then it integrated some aspects of phenomenology and discursive psychology. The interest on the *content* of people's stories about events from some narrative researchers (e.g. Crossley, 2000) makes it more similar to grounded theorists and phenomenologists. For other narrative researchers (e.g. Gergen and Gergen, 1988), the focus is on the *structure* of people's stories. In this case, the aim is on the exploration of constraints and opportunities, which "these structures place upon human experience" (Smith, Flowers and Larkin 2009:p.44). This makes it more common to discourse analysis. This methodology was discarded, however. It was

more important to see how my participants make sense of their experience, instead of focusing on “how stories are structured and the ways in which they work...who produces them and by what means; the mechanisms by which they are consumed; and how narratives are silenced, contested or accepted” (Andrews, Squire and Tamboukou 2008:p.2).

Discourse Analysis:

I have also decided against using discourse analysis. This would have been an appropriate method if I was interested in investigating the use of language in context or if I wanted to study how language “gets recruited ‘on site’ to enact specific social activities or social identities” (Gee 1999:p.1). Despite the fact that both IPA and discourse analysis are linguistically based approaches and there is a close reading of the participants’ accounts, they differ in their rationale. The aim of IPA is to explore how participants make sense of their experience. In discourse analysis, the focus is on finding out how the participants are constructing their accounts of experience (Smith, 2011).

Template Analysis:

Template analysis was developed by King (1998) and it has a similar analytical process to IPA. There is a key difference between them though, and that is the fact that template analysis studies begin with a predetermined list of themes. These themes could emerge either from previous research or from the theoretical concerns of the researcher. This leads to a construction of a template of themes and the data is then analysed using this template (Langdridge, 2007). This is the reason why I decided against using this methodology, as the aim of this study is to give my

participants a voice and the emergent opportunity to talk about their experience rather than giving them a list of pre-selected themes. Using template analysis would have therefore gone against the aim of this study.

After considering the above methodologies and taking into account my research question, I decided that IPA was the most appropriate one as it is also compatible with my philosophical stance. As discussed in chapter 2, the research on male infertility is limited so it was important for the purpose of this study, to explore and capture in detail my participants' lived experience of infertility. After looking into different methodologies (as indicated above), I found IPA the most appropriate methodology in meeting this purpose. Moreover, my other aim was to give my participants a voice and I addressed this by making sure that I included a variety of excerpts from my participants' transcripts (as you can see in the results chapter) in order to make it easier for the reader to get a clearer picture of my participants and their experience. The fact that IPA recognises the idiographic nature of experience and there is a focus on the individual's account (Smith, 2004) also addresses this aim further.

3.3 *Method*

In the following sections, I will provide a detailed account of the research process and a thorough explanation of the procedures that took place. This will include the ethical considerations as well as my comments on validity and trustworthiness. Throughout the chapter, I will include my methodological and personal reflections during the research process.

3.3.1 Selection and recruitment of participants

This being a phenomenological study it was important for the participants to have experienced the phenomenon of infertility and be able to articulate the nature of it. Participants included in this study were men diagnosed with an exclusively male factor infertility who did not have any biological or adopted children. The study focused on primary infertility rather than secondary. This is because I believe the experience might be different for secondary infertile couples, as they would have already achieved parenthood.

Before gaining my ethical approval from both Middlesex University and Metanoia Institute and in effect starting recruitment, I contacted several infertility clinics. The aim of this was to inform them of my proposed study and explore the possibility of them being interested to be involved in it. I was also mindful of the fact that the difficulty in recruiting male participants was documented in some research studies. As a result, I thought it was important to identify an infertility clinic before my ethical approval in order to access my participants from there. Another reason for this decision was because I considered having a meeting with an andrologist/urologist essential as they would have been able to guide me more in terms of the different male infertility diagnoses and through a meeting with them, my inclusion criteria could be finalised. I place a lot of importance on one to one meetings, so having one with the 'experts' who get to see men on a daily basis would have been invaluable. I spent months researching the different infertility clinics in the UK and trying to contact them either via telephone or email but to no avail. The lack of response brought some questions regarding the absence of interest as well as some anxiety on the feasibility of being able to carry out my study. I wondered whether professionals were not interested to support another professional to carry out a study, which would benefit some of their patients or whether there was also an

element of uncertainty in the way I was making the contact with the clinics. This process has helped me immensely in finding my authoritative stance and starting to think more about the contribution that my study could make in the infertility arena. Interesting enough it was not long after I changed the way I composed my emails that I received an email from a consultant telling me he was interested and wanted to know more. Following this, a meeting was set up with him and his partner. This was a very fruitful meeting as they both expressed an interest in helping me find the participants that I needed. We also established the inclusion criteria and we agreed on the procedure of how the recruitment was going to take place. During our meeting, the ethical considerations and implications were also discussed. The participants would be interviewed outside the NHS and in the consultants' fertility clinic (patients attended appointments in both the NHS hospital and the private fertility clinic). As the purpose of the study was to explore the participants' experience of infertility as opposed to the specific treatment they were receiving, it was not necessary to obtain ethical approval beyond that obtained from Metanoia Institute and Middlesex University.

As far as the inclusion criteria are concerned, participants in the study were trying for a child for at least a year (or for at least six months if their partner was older than 36 years old) and as a result, all tests were carried out with their partners in order to find out if there were any infertility issues. Considering that some of the cases of infertility are of uncertain cause (25% according to National Health Service, 2017) and in order to ensure that this was an exclusively male factor infertility, participants in this study were diagnosed with azoospermia. This is a medical condition of a man not having any measurable level of sperm in his semen. Following this diagnosis, men go through an operation in order to see if sperm can

be retrieved from the testes. If this is the case, then the couple can start the process of IVF. For this study, I decided to interview men who had a diagnosis of azoospermia (following the consultants' recommendation) and were waiting for the operation to take place to find out if sperm could be retrieved. The aim of this study was to explore the experience of men going through infertility (not sterility where it is confirmed that they cannot have any children) and what it was like for them for the past year or so knowing that there was a *possibility* of not being able to have a biological child.

It is important to add here that I considered the possibility of my participants being of a specific age group and culture but I decided against this. Considering the fact that there is limited research in this area, I thought it was important to wait and see whether age and/or culture played a significant role in how my participants experienced their infertility, instead of assuming that it might. Moreover, choosing a specific age group and/or culture would have made the sample even more restrictive and I wanted to be able to interview any man who fitted the above criteria and who wanted to speak about his experience.

IPA utilizes a small and purposely-selected sample size and as a result, five participants were recruited. The major concern of IPA is to obtain a detailed account of individual experience where the issue is quality and not quantity. Bearing in mind the complexity of the phenomenon I was exploring in this study, it benefited "from a concentrated focus on a small number of cases" (Smith, Flowers and Larkin 2009:p.51). Moreover, by choosing to interview a number of participants I was able to obtain accounts from different perspectives regarding the experience of male factor infertility. As Polkinghorne (2005) argues "by comparing and contrasting these perspectives, (*I was)* able to notice the essential aspects that appear across the

sources and to recognise variations in how the experience appears" (p. 140). Multiple participants also served as a kind of triangulation on the experience as they provided a deeper understanding of the experience of male infertility.

After Ethical Approval was granted by both Middlesex University and Metanoia Institute (Appendix I), I informed the consultants that the recruitment of participants could begin. I prepared guidelines for the consultants, which included the inclusion criteria and the recruitment process (Appendix II). When consultants identified patients that met the inclusion criteria, they informed them that a study was being carried out independent of the clinic. The information sheet and consent form (Appendix III) were given to prospective participants. They were informed that if they were interested in participating or if they wanted to obtain more information regarding the study, they could contact me on the email address or the telephone number provided.

In order to ensure that I could interview all the participants that came forward and without having to decline any – as this also had ethical implications – I put certain practicalities in place. I was closely liaising with the consultants so that we all knew how many information sheets were handed out. As soon as a patient came forward and said they were interested in participating, I would notify the consultants. Moreover, the consultants kept track of which patients were given an information sheet. As soon as the patients went ahead with the operation that automatically meant that they were no longer eligible for the study and as a result, the consultants could give an information sheet to the next potential participant.

In thirteen months, thirteen men were identified as meeting the inclusion criteria. Out of those, five men wanted to participate in the study. Participants were interviewed twice and all ten interviews took place within a space of three months.

For the first eight months, recruitment was very slow. Five patients met the inclusion criteria but none of them were interested in taking part in the study. In the beginning, the consultants were handing out the information sheet as it was mentioned above, and I was in weekly contact with the consultant in order to check progress. Six months after we began recruitment, and taking into consideration how slow it was to find participants, the consultant and I decided to change the approach and for me to start attending the infertility clinics. By doing this, the other consultants would get to know me more and it would be a reminder for them to speak to the patients who met the inclusion criteria. If the patients met the inclusion criteria and showed an interest in participating, then they had the opportunity to speak to me about any queries they had if they wanted to. It was agreed that I would only meet the patients if they asked to see me. I experienced the recruitment process as a rollercoaster. I was excited that after many meetings with different professionals and a lot of perseverance in finding a clinic that was interested in my study I could finally progress in to the field. As time went on, I found myself feeling very disappointed and started wondering about other researchers' difficulties in recruiting men. It was important to persist though as one of my aims was to give men a voice so letting go was not an option. Going to the clinic every week helped to spark my enthusiasm again and it reminded me of the importance of carrying out this study. Two months later, however, and after attending the clinic on a weekly basis, only one participant was identified. As a result, the other consultant that I was in contact with suggested a different alternative. He went through the list of all the patients that they had booked in for a sperm retrieval operation and he spoke to them about the study. He spoke to seven patients and four of them said that they were interested in taking part. All four of them said that they were happy for me to contact them in order to send them the information sheet

and to arrange the date and time of the interviews. The last approach, therefore, proved to be the most productive one. The consultant identified patients and contacted them. It was therefore evident that during clinic times, where medical staff work under pressure and time limitations, talking about a study was perhaps not as feasible, as we originally thought, for both the professionals and the patients.

Contact was established with the five participants. They all received the information sheet and the consent form (Appendix III) and arrangements were made for the first interview, which included location, date and time. The infertility clinic provided me with dates and times where it was possible for me to carry out the interviews and I met four of the participants there. One of my participants had difficulties meeting at the clinic due to work commitments and the times given by the clinic. As a result, a consulting room was booked instead and the interviews were carried out there.

I found the contact made with the participants before the interviews essential, as it was an opportunity to minimise some pressure, ask for any clarifications and create an open dialogue between us in order to help with the interview process. As Finlay and Evans (2008) argue “in this pre-research stage, the foundations of mutual trust within a dialogical relationship need to be put in place and the research aims and process generally agreed upon” (p.1).

The table below outlines my participants’ demographic information. It is important to add here that all of my participants spoke fluent English except the participant from Sri Lanka who asked his brother to attend the interviews with us in order to help him with his English. All five participants attended both interviews. No potential participants were excluded from the study, as when the five men were identified, the consultants stopped informing other patients.

Table 1: Participants' information

Participant Pseudonym	Age	Marital status	Nationality	Diagnosis	When he was diagnosed
Michael	30	Engaged and married between our interviews	British	Azoospermia and Klinefelter's syndrome	3.5 years – 4 before our interviews
Simon	31	In a relationship	Other European	Azoospermia	1 year before our interviews
Peter	38	In a relationship	British	Azoospermia	1 year before our interviews
Seth	30	Married	British with Indian background	Azoospermia	1.5 years before our interviews
Payton	37	Married	Sri Lankan	Azoospermia	1 year before our interviews

3.3.2 Data collection

For the purpose of this study, it was important for the participants to be "granted an opportunity to tell their stories, to speak freely and reflectively, and to develop their ideas and express their concerns at some length" (Smith, Flowers and Larkin 2009:p.56). As a result, interviews were the main source of collecting data in order to facilitate this opportunity. I decided to carry out two interviews with each participant. Considering the nature of the study, it was important to allow time for the rapport to be developed and having two interviews facilitated this further. It also enhanced the richness of the data obtained as having two interviews provided the opportunity to explore in-depth the experience of my participants. I was aware that this could potentially lead to a higher drop out as some of my participants might not want to be interviewed twice. All of my participants, however, attended both

interviews. The interviews were two to three weeks apart in order to provide my participants time to reflect on their first interview and allow me time to go over the first interview and find points that needed further exploration. Arrangements for the second interview were made at the end of the first one. One participant did not have a date for his sperm retrieval operation and asked for his second interview to be carried out after he was given a date. He thought that having the second interview nearer the time of his operation would also mean that he could also talk more about what it was like waiting for the operation. As a result, his second interview took place with a two-month interval instead of two to three weeks.

I decided for semi-structured interviews as having a schedule of some questions to be asked could facilitate a comfortable interaction with my participants, which would then enable a more detailed account of their experience (Smith, Flowers and Larkin, 2009). The interview questions (Appendix IV) came about from different meetings that took place with male colleagues (as I wanted to get their perspective on the area) and from the manager and the supervisor of the perinatal service that I worked at as a trainee psychological therapist. I opted for a short interview schedule, as I wanted to maintain a balance between guiding my participants and being led. This was also in agreement with Smith, Flower and Larkin (2009) who encourage the researcher not to impose their understanding of the phenomenon on the participant's narrative.

Being able to develop a good rapport with my participants was fundamental. A successful research process depends on the quality of the rapport established between the researcher and the participants. In order to facilitate this rapport, it was important to build trust and to establish an atmosphere where my participants felt safe enough to talk to me about their experience of infertility (Kvale, 1996). As a

result, confidentiality was discussed and a signed consent form was obtained from the beginning of our interview. Despite the fact that my participants had already had access to the information sheet before the interviews took place, they were still given an explanation of the purpose of the study at the beginning of our first interview. I deemed it important to 'break the ice' with broad questions before I moved to more specific ones whilst always trying to be respectful and courteous. The process of the interviews was divided into five sections as it was proposed by Suzuki et al (2007). I began the interview with introductory questions in order to support my participants to feel at ease, followed by specific questions related to their experience of infertility before asking them if they wanted to add anything that they thought it was relevant. Debriefing took place and I gave them information on different kinds of support they could access if they needed to (Appendix V). Arrangements were made with a colleague who had a lot of experience in the field of infertility and who offered to see my participants if they wanted to at a lower cost. The information sheet included the therapist's details as well as the website for the British Infertility Counselling Association, some information on online self-help and forums they could access. We discussed the next step of the research process, which was the second interview, and arrangements were made before thanking them for taking part in the study.

All the interviews were tape-recorded and they lasted for approximately one to one and a half hours each. At the end of each interview, I made sure to listen to the tape a few times in order to make notes and see what points I needed to explore further on the second interview. Listening to the interview also gave me the opportunity to look at my interview style. There were times, for example, where I was rushing to ask too many questions, especially on the first interview and it did not provide my participant with enough space to talk about his experience. I knew that

my interview style was a result of my anxiety as it was my first time carrying out an interview, but it was important to reflect on it and try to adjust my way of asking questions. I also documented in my reflexive journal the experience of interviewing each participant, something which I found very useful when carrying out my analysis.

It is important to add here that being a reflexive practitioner is important for qualitative studies. By being a reflexive practitioner, I endeavoured to "acknowledge how *(my)* own experiences, (*assumptions)* and contexts *(which might be fluid and changing)* inform the process and outcomes of inquiry. *(Being aware)* of *(my)* own thoughts, feelings, culture, environment and social and personal history" was very important when interviewing participants, transcribing and writing their representations (Etherington 2004:p. 31-32) (*Italics are my own addition*). As a result, it is significant to discuss here my own assumptions regarding this study, which are based on my experience of infertility and on my culture.

As I mentioned at the beginning, I come from a country where family is very important and the expectation is that after getting married, the next step is to start thinking about having a family. The possibility of not wanting to have children is not something that is widely considered yet in Cyprus and this comes from different conversations I have had regarding this with different professionals as well as lay people. There is an expectation that a couple will have children which I think puts a lot more pressure on them, especially if this is not possible because of infertility issues. This could possibly make it more difficult for the couple to feel comfortable to talk about their experience. Moreover, men, especially in my country, are still viewed by some people there as the dominant figure so the possibility of them being the ones having the infertility issue is not something that is easily acknowledged, let alone something that they will want to talk about. From my cultural viewpoint,

infertility could have an impact on how men view themselves and their identity. Being aware of my assumptions was essential as it could have an impact on how I engaged with my participants and later on when I carried out my analysis. Culture might not have played an impact on how they viewed themselves and their identity so it was important not to assume that it did.

Moreover, I could not finish this section without trying to capture the personal impact that my research study had on me, and in effect, my intersubjective engagement with my project. In the middle of reading up on all the studies undertaken in infertility and during the recruitment process, I found myself questioning my own infertility. Tolman (2002) talks about embodiment as "the experiential sense of living in and through our bodies" (p.50). It was fascinating to see how my research got under my skin and under my body and for a few months, I was living with the impression that I possibly had an infertility issue as well. I started wondering whether one of the reasons I was so interested in infertility was because I had an infertility issue myself, even if I was not aware of it. During those months of questioning my own fertility, I experienced some of the emotions that were documented in the studies I was reading. I went through the anxiety, the disempowerment and the lack of control of not knowing whether I could have a child naturally or not. I started thinking of all the stages my husband and I had to go through in order to be able to conceive a child and for a while that was the only thing I could think about. Interesting enough, halfway through my interviews, however, I found out that I was pregnant! Interrogating the impact on my body was important. All of a sudden, I went from being similar to my participants to being what they wanted to be; fertile. The anxiety was no longer about whether I was fertile or not but it changed to wanting to finish my interviews before my bump started to show.

Despite feeling grateful that I could conceive naturally, I thought of the impact that my pregnancy could have on my interviews and essentially my research study. I perceived my pregnancy as a barrier to the interviews as it could potentially hinder the establishment of a good rapport between my participants and me. I also thought that it would be insensitive on my behalf to show up in the interviews with a bump. This, however, did not happen as all interviews were completed before I started to show. On a practical level, my pregnancy also had an impact on the way I conducted my interviews. As I was in the first trimester of my pregnancy, there were times when I felt very unwell and this had an impact on how present I was during my interviews. Despite this, however, there was also a sense of protectiveness on my behalf, as at times I did not delve deeper into what my participants were telling me. For most of them, our interview was the first time that they were talking about their experience of infertility and the impact it had on them, and because of that, I wanted to tread slowly. As a result, this held me back. Going through those months of questioning my own fertility, was an indication of how difficult this process was so I did not want to 'push' my participants. What felt most important was to show them my genuine interest in listening to their narrative. My interest as well as the use of some probing questions and active listening, contributed to obtaining some rich data. Despite some of the obstacles mentioned above, we still managed to build a good alliance and all my participants commented on how comfortable they felt with me, some more than others.

3.3.3 Data analysis

It is difficult to try and record in one word how I found doing the analysis of the transcripts. There were times when I felt overwhelmed by the amount of data I had

and times when I felt excited and found the data stimulating. After all the interviews were completed, they were transcribed but due to my pregnancy and other family circumstances, a year passed before I started analysing my data. It, therefore, took me longer than I anticipated completing my data analysis. I knew however, that trying to do the analysis whilst pregnant or straight after would not have done justice to my participants and my study as I was in a very different frame of mind so I decided to wait. I was aware of the fact that by leaving a big gap between the interviews and the analysis posed a risk of losing some of the flavour of the interviews and the emotional interactions that took place between my participants and me. This is why it was essential to try to keep my research alive and for me to remain engaged with my data during my 'break'. As a result, during that year when I was not 'actively' analysing my data, I listened to the tapes frequently as an attempt to immerse myself in the data, read on how to carry out the analysis and I made sure that I kept up to date with different studies on infertility. Keeping my research alive by the ways mentioned above, (which was not always easy), was very useful for when the time came to analyse my data and it also ensured that I remained interested in my study and in my participants' narratives.

Before I give an outline of the stages, I followed in carrying out my analysis, it is important to say that I decided to use the suggested steps of analysis from Smith, Flowers and Larkin (2009). This was my first time conducting an IPA study and I felt that having a guideline would be useful. Furthermore, in an attempt to capture each participant's experience as fully as possible, I chose to adopt an ideographic approach where each participant's transcripts were explored before moving on to the next one.

The first step involved immersing myself in the data by listening to the tapes again and then reading and re-reading the transcripts. Despite the fact that listening to the tapes again contributed to making the analysis process longer, the benefit was immense. It helped me to deepen the analysis based on the tone of voice and the different nuances in our communication that it was not possible to pick up just by reading the transcripts. Immersing myself in the data ensured that the participant became the focus of the analysis. According to Smith, Flowers and Larkin (2009), "This reading also facilitates an appreciation of how rapport and trust may build across an interview and thus highlight the location of richer and more detailed sections, or indeed contradictions and paradoxes" (p.82). Following the reading and re-reading of the interviews, I started taking detailed notes and comments on the data. This process included descriptive comments where the focus was on the content of what my participant said, linguistic comments with a focus on the language used and conceptual comments where the emphasis was more on the interrogative and conceptual level. The next stage involved developing emerging themes. This was "an attempt to produce a concise and pithy statement of what was important in the various comments attached to a piece of transcript" (ibid: p.92). The themes included both my participant's original words as well as my interpretation. In the fourth stage, there was a search for connections across the emergent themes where a table was developed indicating how the themes fitted together. I found this a very creative process. I put each theme on a separate piece of paper and then used a large space in order to move them around. Some of the techniques I used to look for patterns were the suggestions of Smith, Flowers and Larkin (2009). These included abstraction (putting like with like and developing a new name for the cluster), polarisation (exploring transcripts for oppositional relationships),

contextualisation (identifying the contextual or narrative elements within an analysis) (refer to Appendix VI for a section of the transcript with my participant, Seth, where there is an indication of the production of themes). Once this stage was completed, I moved on to the next participant where I followed the same procedure. When I finished with all the transcripts, I had five tables with major themes and subthemes. The final stage involved looking for patterns between participants. The themes of each participant were written in a different colour and all themes were put again on a large surface. The last stage was the most complex one but also the one I enjoyed the most as the aim was to create a detailed summary of all of my participants' experience. There was some rearrangement and renaming of themes and at the end, I produced my final master table with my major themes and subthemes. This table is provided in the next chapter and a table with all the relevant quotes from the participants' transcripts corresponding to each major theme and subtheme is presented in Appendix VII.

3.4 *Ethical considerations*

Ethical issues involve obtaining a consent form, securing confidentiality and considering any possible consequences for the participants. I was aware that ethics is a process, not just any set of rules (Orlans, 2007), and I maintained this mindset throughout the research process, in case any dilemmas came up. As mentioned previously, the project went through an ethical approval from Metanoia Institute and Middlesex University before any data collection began (Appendix I). Moreover, I was in line with the ethical guidelines of Metanoia Institute, Middlesex University, the British Psychological Society and the Health and Care Professions Council.

Participants were given the information regarding the overall purpose of the study before the interviews were booked in so that they could read and decide if they wanted to participate (Appendix III). At the beginning of our first interview, I informed the participants about the schedule of our interview. The purpose of the study was discussed again and participants were informed of their right to withdraw at any point. They were also asked to sign a consent form before the interview began and each of us kept a copy of it (Appendix III). This gave my participants the opportunity to discuss any issues that they had and decide whether they wanted to continue with the interview or not. Having said that I also "insure*(d)* their ongoing consent during the research process, and *kept* open the possibility of the participant withdrawing if it *was* in *their* best interest to do so" (Morrow 2007:p.218) (italics are my own addition). I also informed my participants that at the end of the interview we would have a period of debriefing where they would have the opportunity to reflect on the interview and discuss any questions that they might have. Moreover, and bearing in mind my gender, I was mindful of the fact that my participants might have questions about my interest in interviewing men and not women which did happen with some of them. I was transparent about my reasons and explained that I wanted to give them a voice, as there was limited research on men's experience and what it might mean to them.

As far as confidentiality is concerned, participants were informed that precautions were taken to ensure their privacy. As a result, they knew that I was the only person who had access to the tapes and that I would keep them safe and destroy them upon completion of the study. Participants were assured that all information would remain confidential and altered in case of publication.

Considering the nature of the study where sensitive issues were explored, I knew that there was a possibility of my participants to feel distressed. Their well -

being was my primary concern so I was monitoring how they were doing throughout the interview. If a participant felt distressed then I would have offered them support and reminded them of their right to withdraw and stop the interview at any point. This, however, did not happen in any of my interviews. I would also have ensured to make a referral for therapy if they wished to discuss things further. Debriefing took place at the end of each interview between my participants and I. This was in order to discuss any issues that came up for my participants and to assess the impact the interviews had on them. My participants were also given information on how to access free or low-cost support (Appendix V). As the clinic did not offer any therapeutic services, and as I mentioned above, I contacted different professionals and put this in place.

3.5 Validity and trustworthiness

According to Yardley (2000), there are four broad principles for assessing the quality of qualitative research: sensitivity to context, commitment and rigour, transparency and coherence and impact and importance. In the following section, I will indicate how I met all of them.

Sensitivity to context:

With my chosen methodology, my recruited participants shared a particular lived experience, which also implied more difficulty in accessing them than other kinds of samples, which are not purposive. Moreover, the interactional nature of my data collection (empathy, supporting my participants to feel at ease and recognising interactional difficulties was important) during the interview process, demonstrated the sensitivity to context. This continued throughout the analysis process and as

Smith, Flowers and Larkin (2009) argue “making sense of how the participant is making sense of their experience requires immersive and disciplined attention to the unfolding account of the participant and what can be gleaned from it” (p.180). In the following chapter when the results will be explored, the reader will see that I included a considerable amount of verbatim extracts from my participants in order to give them a voice and to allow the reader to check how I reached my interpretations.

Commitment and rigour:

As I indicated in this chapter, I made sure to show a lot of attentiveness and care to my participants during the process of this study. I was also very careful in selecting my participants in order to match my research question and to be reasonably homogeneous. My participants were, therefore, men who had experienced the phenomenon of infertility, diagnosed with an exclusively male factor infertility (in this case azoospermia). They also had no biological children. The long recruitment process is an indication of my commitment as far as undertaking this research study is concerned, as I have tried throughout that time to remain engaged and resourceful in order to find my participants. There was also a lot of thought put in place regarding the recruitment process in order to ensure that no patient who showed an interest in participating was declined.

Transparency and coherence:

I aimed to be transparent and clear throughout this thesis. This is why I explained to the reader my personal relevance to the subject area, included how my interest in infertility began and explored the rationale behind undertaking this specific research study. In this chapter, I gave as many details as possible on how I went

about contacting the different fertility clinics and discussed about my meeting with the consultants and the practicalities that we put in place. I described my recruitment process and the inclusion criteria as well as how I came about deciding on my interview questions and the steps I took when carrying out my analysis. Throughout this chapter, I have also included my reflective thoughts regarding the whole process. As the reader will see in the results chapter, I have attempted to show in a transparent and coherent way, how I reached my interpretations regarding the data I obtained. I also included a more detailed way of showing the different stages of my analysis in Appendix VI.

Impact and importance:

In an attempt to produce for the reader something interesting, I aimed to write the thesis in a relational and reflective way. I explained in detail the lack of research on male infertility, and how in effect, this study makes an important contribution to the field. It is important not only to my participants and their social network but also to other men having this diagnosis as well as to the counselling psychology and psychotherapy discipline and to the medical professionals. It can also have an impact on the support that men with an infertility diagnosis receive.

It is also important to add here that other than meeting the above principles, I also had 'critical research friends' throughout the research process. My 'critical research friends' were men who are also psychotherapists and have experience in undertaking research. Not only did I discuss my interview questions with them, but they also helped me in conducting an independent audit trail. The task was to check that my final report was plausible and credible considering the data I collected and

that there was a logical step-by-step path through my chain of evidence (Smith, Flowers and Larkin, 2009). During moments of ‘stuckness’ when carrying out my data analysis, I found it very helpful being able to talk to them. I was able to discuss with them what I was feeling and through some of their exploratory questions, I could reflect on the process. Finally, the fact that I have been very open about my philosophical stance, my motivations and my assumptions indicate a level of honesty, which contributes to the trustworthiness of my study (Morrow, 2005).

Chapter 4: Results

4.1 Overview

The aim of this chapter is to provide the reader with a clear and comprehensive exploration of the major themes and their subthemes. After analysing the ten semi-structured interviews, four major themes were identified which are the emerging notion of fatherhood, the disempowering impact of infertility, responding to the limitations of infertility and placing infertility in a relational frame. I will explore each major theme and subtheme separately and I will include excerpts from participants' transcripts in order to support these. I used the following pseudonyms and initials for the five participants: Michael (M), Simon (Si), Peter (P), Seth (Se) and Payton (Pa). The reader can refer to Appendix VII for the table with all the participants' excerpts for each subtheme, as not all of the relevant excerpts were included here due to space limitations. Moreover, the table below illustrates the four identified major themes with their subthemes and highlights the ones that represent each participant's experience.

Table 2: Major themes and their subthemes for the entire sample

MAJOR THEME	SUBTHEME	PARTICIPANT				
		M	Si	Pe	Se	Pa
1.The emerging notion of fatherhood	1.1 The imperatives of fatherhood	√	√	√	√	√
	1.2 Envisaging a life with children	√		√	√	
	1.3 Ambivalence in becoming a father	√	√	√		
2.The disempowering impact of infertility	2.1 Confrontation with uncertainty	√	√	√	√	√
	2.2 The debilitating sense of differentiation	√	√	√	√	√
	2.3 Carrying the burden of stigma	√		√	√	√
	2.4 Destabilisation of masculinity	√			√	√
3.Responding to the limitations of infertility	3.1 Sustaining avoidance	√	√	√	√	√
	3.2 Maintaining a pragmatic approach	√	√	√	√	
	3.3 Negotiating alternative options	√	√	√	√	√
4. Placing infertility in a relational frame	4.1 The sense of pressure by others' expectations	√	√		√	√
	4.2 Instability in the relationship with partner	√	√		√	√
	4.3 Oscillating between disclosure and concealment	√	√	√	√	√

4.2 Major themes and subthemes

4.2.1 Major theme 1: The emerging notion of fatherhood

Infertility and parenthood are interrelated so unavoidably when I invited my participants to talk about their experience of infertility, they also talked about their thoughts and feelings on fatherhood and the meaning attached to it. As a result, the first major theme captures how my participants viewed fatherhood. I purposely chose the word 'emerging' because via these interviews my participants were able to explore what it would mean to them to become fathers. Talking about their inability to

conceive provided them with an opportunity to evaluate their wish and their needs to become fathers. Participants highlighted different reasons for pursuing fatherhood and contemplated life with children. The ambivalence of some participants in becoming a father was also captured. I tentatively interpreted that the emergence of this ambivalence was due to talking about fatherhood, the possibility of not being able to have a child and the uncertainty that was present in their lives.

4.2.1.1. Subtheme 1: The imperatives of fatherhood

The first subtheme captures the importance that participants placed on becoming fathers and the reasons behind this. By starting to explore their experience of infertility, they also draw attention to their needs and wish to become fathers. The desire to become a father, viewing children as the next life stage, meeting partner's wishes and cultural expectations were the participants' considerations when thinking about fatherhood.

Seth's powerful extract highlighted his desire for fatherhood. For him, there was never a question of whether he wanted to have children or not.

> *I definitely knew I always wanted children. There was never a question if I wanted children or not. I definitely always knew that I always was going to have children and that kind of thing and I wanted...That was definitely going to be part of my life. (Seth)*

> *I haven't got a timetable in my head but I know that I am wanting to have them quite soon...I want to make that kind of...that step soon (Seth)*

I understood Seth's use of repetition as a way to convey the importance he placed on fatherhood. The words *'always'* and *'soon'* reminded me of the notion of time and temporality. There was a strong awareness of time in Seth's narrative. I wondered whether his wish to have a child and the inability to have one brought to the surface a confrontation with time. This could have contributed to the urgency of wanting a child and made his wish for one, even stronger.

Both Simon and Seth thought about fatherhood as their next life stage. For Simon, it seemed that certain necessities had to be in place before deciding to pursue parenthood. He was in a long-term relationship and since their work and financial situation was stable, they could start thinking about having a child.

> *We would like to have our own kids yes. And in terms of work we are, we are okay. Money wise, we will be…earn enough to have a kid. Yeah, we would like to have our own kid yeah. Having a kid is the next step. We decided erm, that erm we are ready for a kid. (Simon)*

There was a feel of uncertainty, however, in Simon's passage with the use of repetition; an uncertainty on whether parenthood could be achieved. Uncertainty, in fact, featured very strongly in Simon's narrative, as well as in all the other participants, and it will be explored in the next major theme when the impact of infertility will be captured.

Along similar lines, Seth also talked about fatherhood as the next 'chapter' in his life. In his case, his return from a trip, which he considered a life achievement, signalled his wish to move to the next *'chapter'*.

It was like a life achievement that I kind of ticked off my box. And then we're like okay now I can kind of, I can almost kind of go on to the next kind of chapter...children and kind of becoming parents (Seth)

Michael was recently married and similar to Seth and Simon, he also thought about having children as the *'next stage'*. In the first passage below, Michael seemed to indicate that timing and his age were also of significance since if he had known about his infertility earlier, having children would not have been a priority. For Michael, however, becoming a father was important for many reasons. With the second passage, Michael captured his close relationship with his younger brother and his feelings when he called him 'dad'. This highlighted the importance of taking care as well as how much he enjoyed being a father figure. It reminded me of his background where his parents were not around and how essential it was for him to have a child where love would be reciprocated. This also explained his third quote where being married was not enough, as he needed something more in his life.

I think if I knew about this when I was younger I wouldn't have been interested in children because obviously I was younger. Now I've come to that stage in my life... I'm married now so that's the next stage (Michael).

I've always wanted to... when I was 16 my brother was born... I had him all the time, my stepfather was always working away so he wasn't always there and the first words he said to me was 'dad'. I was like no I'm not your dad I'm your brother but it felt nice. (Michael)

Even though we are a couple, we're married, it's still not enough I need something else in my life. She's done wonders I'm not pushing her away or anything but I need more. (Michael)

Another reason for Michael wanting to be a father was his wife and her wish to become a mother. In a similar line, Peter shared the same reason but in his case, he presented his partner as the only driving force in considering parenthood.

She spent a year training to be a midwife, and she goes I'm only doing it to get the frills of babies away from me, she was getting broodier and broodier and broodier. (Michael)

In terms of my experience of the process...I am being driven by my partner she wants to do this. I am happy to do it. (Peter)

We were talking about it for a while or we started to talk about it and I have been saying 'oh I'm not really interested kind of thing' and then I think got to the point where she was; that she then made a definite decision that she said she wanted to do it. (Peter)

Peter implied that becoming a father would not have been a priority if his partner did not pursue it. As the interviews unfolded though, I thought about the possibility that perhaps fatherhood was more important to him than he wanted to acknowledge, something that will be captured in the following subthemes.

For Payton, the imperatives of fatherhood were multifaceted. In the two extracts below, he captured powerfully the implications of not becoming a father. The influence of his Asian culture and the significance attached to fatherhood were highlighted.

> *It's a big thing for me because one thing is…it's a big thing I didn't have proper family because me and my wife to take our relationship…to strengthen our relationship we need a child. (Payton)*

> *And I lose my generation…traditionally we have the male side carrying the tree...I'm not going to have that...yeah…so it's a big thing for me (Payton)*

For Payton, having a child meant being able to strengthen his marriage and maintain his generation. The consequences of his infertility, therefore, were the possibility of a 'weak' marriage and the loss of his generation. The importance his culture placed on parenthood was present throughout Payton's narrative and this will be evident in other themes as well.

4.2.1.2 Subtheme 2: Envisaging a life with children

For some participants, talking about the imperatives of fatherhood provided them with an opening in terms of contemplating a life with children and that was explored in their interviews. Michael focused on how much he was looking forward to having a child, whilst Peter captured the fun aspect of being a parent. For Seth being actively present for his children was essential.

Watching other people with children seemed to have a dual effect on Michael.

On one hand, it was difficult as perhaps it was a reminder of his inability to have a child, but on the other hand, it was also an indication of how it could be like.

> *What we're going through watching friends and family having children it's hard but it's also that's us one day, that's us one day. (Michael)*

> *I'm quite happy to do the father daughter thing, that's the sort of thing I'm looking forward to...so I've had dreams of it and can see myself already doing it (Michael)*

Michael's repetition in the first extract of *'that's us one day'* made me wonder whether there was a need to try and convince himself that it will happen for them as well. Michael communicated clearly how much he wanted children in the above subtheme. The fact that he mentioned his dreams about having a girl also indicated his high level of investment in becoming a father. There was also a sense of urgency, as he could not wait to have one and he could already see himself with one.

Peter presented the idea of fatherhood in the above subtheme as not that important to him. The reason he was pursuing it was his partner. As the interviews unfolded, however, I perceived Peter as more open to the idea of having a child in comparison to what he had originally said. He described having children as *'a lot of fun'* and he seemed excited with the idea of becoming a kid himself.

> *And I think it will be a lot of fun actually. If no other reason, then I get to become a big kid again myself. (Peter)*

I think I would enjoy having children. Because, yeah, I get on pretty well with kids. (Peter)

I remember noticing Peter's facial expression when he talked about having children and the smile he had on his face. I interpreted that as an indication of maybe wanting this more than he was willing to acknowledge. His phrase *'if no other reason'* in the first extract, was perhaps a way of highlighting that what was exciting was the idea of becoming a kid himself and consequently 'concealing' his wish of wanting a child.

When thinking about a life with children, Seth talked about not wanting to be an old parent so that he could be emotionally and physically there for his children. Being able to do things with them and not feel inhibited by old age was essential.

I don't want to be an old parent...And that or be old when my children are maybe turning 15, 16 and that kind of stuff... Erm I want to be able to kind of like be active and be a kind of erm. Be kind of obviously I think all parents will be kind of emotionally there but at the same time I want to be physically there and be able to do things with them and not feel inhibited by kind of, kind of old age. (Seth)

In the above quote, the notion of temporality is prevalent again as Seth seemed very preoccupied with time. Moreover, Seth's choice of words was interesting and I wondered whether some tentative and cautious conjectures could be made around this. Perhaps with talking about his worries of '*being physically there'*, wanting *'to do things'* and not feel *'inhibited'*, he was also capturing how he felt about his physical dysfunction as a result of his infertility.

4.2.1.3 Subtheme 3: Ambivalence in becoming a father

This subtheme captures some of the participants' ambivalence in becoming a father. During their interviews, an ambivalence about fatherhood was present for Michael, Simon and Peter but for different reasons. I tentatively interpreted this ambivalence as a way of protecting their feelings in the face of uncertainty, a feeling that was present for all participants and which I will explore in the next major theme.

I thought of Michael's extract below as a powerful indicator of the importance he placed on fatherhood.

> *I'm willing to go through ten – twenty more operations if I need to, I would do absolutely any, I would chop my arm off to have a child, that's what it is. (Michael)*

There was a determination to go through anything necessary, even *'ten – twenty more operations'* in order to become a father. There was also a sense of exaggeration with his phrase *'I would chop my arm off,'* but I thought of that as a way to emphasize what it meant to him to be a father and the desperation behind this. I thought of him amputating his arm and I wondered whether there was also an emotional amputation in his experience of infertility. Perhaps that was a way to capture the loss he was experiencing by not being able to have a child. Yet, despite this powerful illustration, he stated on the extract below how becoming a dad freaked 'the hell out of him'.

> *Don't get me wrong I can't wait to be a dad but that's freaking the hell out of me as well (Michael)*

That was a contradiction to the statement that he would do anything to have a child. For Michael the strong desire to achieve fatherhood, but at the same time, his fear of the unknown seemed to have contributed to his ambivalence.

Simon's ambivalence was different from Michael's. There seemed to be hesitation in Simon's speech when he was talking about his readiness to have a child. This was also evident from the pauses in his narrative.

> *But I have made a decision that we are ready, we are. (pause) I don't know. (pause) We are not ready to have kids. We don't know that. (pause) We are trying to have kids. And so we made a decision that we are going to change our life. (Simon)*

I experienced Simon as a person who was going through his infertility on his own and only sometimes 'dipping in' to talk to his partner about the practicalities of what was happening. I will provide further evidence of this in the following major themes. Noticing the change in his narrative from the first person single (I) to the first person plural (we) was a further indication of my experience. Moreover, for Simon, the sense of uncertainty and lack of control of the situation was very strong so I speculated that this ambivalence was a way of protecting himself. There was also a realistic evaluation in his extract, as he did not know what it was like to have children so how could he say that he was ready for one.

For Peter, there seemed to be an internal struggle going on as far as fatherhood was concerned and the below extracts were an illustration of this.

> *I'm not sitting here saying I really must have kids...really want them. (Peter)*

But I genuinely believe that once, if and when and once as it were that changes and we have children then you know I will wonder why I didn't do it sooner. (Peter)

My partner wants to do it. I can see that if I don't do something about it in the next number of years, I will look back and go why didn't I do that. (Peter)

I'm not so fussed about it. I think at the very end of the process if it turns out it doesn't happen, there will be some disappointment on my part. (Peter)

His phrases '*I'm not sitting here saying I really must have kids...really want them'* (first extract) and '*I'm not so fussed about it'* (fourth extract) imply somewhat of an 'indifference' to the idea of having children. I thought of the possibility of wanting to present it like this to both of us. These statements were contrary to his second extract where he said he would wonder why he did not do it sooner. Peter's ambivalence was further illustrated in the fourth extract where he is *'not so fussed about it'* but there would be *'some disappointment'* if it did not happen. I tentatively interpreted that as perhaps a way of not wanting to acknowledge that having a child was actually more important than he thought. By doing that, if he did not achieve fatherhood, then the disappointment would not be so big so it was perhaps a way of self-protection. Moreover, his use of the word *'some*' when talking about his disappointment was also another way to 'minimise' the effect that not having a child could have on him.

In this major theme, the attention was on how my participants viewed fatherhood and the feelings and thoughts that surfaced whilst trying to explore it. In

the following major theme, the focus turns on their experience of infertility and the impact that this diagnosis had on their lives.

4.2.2 Major theme 2: The disempowering impact of infertility

The essence of the second major theme captures the impact of infertility for my participants. Feelings of uncertainty seemed to dominate in all of my participants' narratives. There was a sense of feeling different from other people who could have children without any difficulties and the issues of stigma and masculinity were captured by most of them. As a result, the use of the word 'disempowering' felt appropriate for describing their impact of infertility.

4.2.2.1 Subtheme 1: Confrontation with uncertainty

The first subtheme focuses on uncertainty, an issue that was present for all participants. Whilst talking about their experience of infertility, participants highlighted not only a strong sense of uncertainty but also a lack of control over their situation. Uncertainty featured in different ways in my participants' narratives.

For Michael, Seth and Simon there was an uncertainty about the function of their body. Michael focused on the 'livelihood' of his sperm and if it was good enough. He also questioned the possibility of a blockage, which stopped his wife from getting pregnant.

> *The blood test before said they are but are they live? This is all it's about...we don't know if they are live or not. (Michael)*

Does that mean the fluid in its self you know from the tube, obviously that might be producing the sperm going with it or is there a blockage down there why they're not working and she's not falling pregnant. (Michael)

In both extracts, however, I experienced Michael as talking in a matter of fact way. There seemed to be a sense of detachment where the attention was on treating his body in a mechanical way. I tentatively interpreted that as his way of managing with his condition, where there seemed to be a split between his thoughts and his feelings. This was also present for other participants and it will be explored thoroughly in the next major theme.

Seth also spoke about the uncertainty of his condition but there was also the acknowledgement that the uncertainty would not end by having the operation. He was still unsure on whether the doctors would be able to retrieve sperm.

Because it's not 100% that once I have the operation they will find sperm. (Seth)

For Simon, his condition and the uncertainty on his ability to produce sperm also highlighted his lack of control.

Because we can't change it. (pause) I can't change the fact that I can't have erm, I don't produce sperm or if I produce they don't come out. Erm, so I can change nothing. (Simon)

I remember the tone of Simon's voice when he was talking about this and I sensed sadness in his statement. His repetition of '*can't change'* signalled his helplessness as there was nothing he could do. Further evidence for this claim is also indicated in his phrase *'I am just waiting. I am just waiting'.*

> *Because I can't control nothing. I can't erm. I am just waiting. I am just waiting. (Simon)*

Simon's experience of infertility also seemed to have given him access to his lack of control in a broader sense and not only with his condition. I found the extract below powerful, as it seemed that he was suddenly confronted with the reality; life is full of uncertainties.

> *Because time goes by and you experience more and more and more and there is a lot of things I can't control that I thought I could. (Simon)*

In a similar line to Simon, Seth also captured the lack of control he was experiencing.

> *I think I am a bit of a control freak so erm. I like to kind of, I like to plan... I like to know what I am doing, and when I'm doing it... Erm. (pause) So. (pause) This is maybe puts me out of my comfort zone because it's not part of my timetable. (Seth)*

The uncertainty of the situation and his condition put him out of his *'comfort zone'* as it was not part of his '*timetable'*. In fact, in the extract below, Seth gave a powerful account of how this uncertainty made him feel which I thought it was important to add here.

> *I felt deflated and to kind of in that way kind of in a dark place if you like. Erm. (pause) Just worried about the future and what the implications. Yeah and what this means and where we go from here. (pause) Erm. And kind of just kind of thinking like you have no options...It's definitely kind of worried about the future. (Seth)*

There seemed to be a feeling of restriction as Seth talked about his worries for the future and the possibility of *'no options'*. Time and in this case, his concerns about the future were present again for Seth. He seemed stuck in the disability of the present, which did not allow him to move to the future and be able to look forward. Interestingly, Seth also chose the word *'deflated'* to describe his feelings and I thought of his physique, as he was a man who exercised a lot and was very muscular. I wondered about this contradiction between his internal and external presentation where on the outside he looked very 'puffed up', whilst inside there was a 'deflated self' with a lot of sadness because of his experience. The difference in his internal and external presentation is also explored in another subtheme where the issue of masculinity is captured.

The confrontation with uncertainty was also present in Payton's narrative as it is indicated in the below extracts.

I want to have a baby soon but I have to wait….I can't do anything (Payton)

Suddenly I got really shocked then sad and I had to deal with it and I spoke to the doctor 'how can I do' (Payton)

There seemed to be a sense of urgency from Payton in terms of having *'a baby soon'* but there was also the realisation that there was nothing he could do, and he had to wait. I thought of Payton's shock as an indication of how unexpected his condition was to him, which also alluded to a feeling of helplessness since the situation was out of his control.

Peter's uncertainty seemed to be different in comparison to the other participants as he focused more on the time restrictions due to his partner's age.

We are realistic in the fact that the odds may not favour us because the age of my partner... Erm because she is now passed 40. (Peter)

But time has beaten us to it now. So now we just have to proceed and kind of make the best of it. (Peter)

Peter mentioned being realistic about the fact that having children might not happen for them. What was interesting was the emphasis he placed on his partner's age, which was also evident in other occasions during his interviews. There did not seem to be an acknowledgement that having children might not happen due to his condition. There was a tendency in Peter's narrative not to think too much about the

prospect of an unsuccessful operation and I tentatively interpreted that as one of his ways of managing, something that will be explored further in the next major theme.

The confrontation with uncertainty, therefore, was powerful for all participants but they experienced it in different ways. For some, there was a focus on the function of their body, for others, it brought to the surface their lack of control and the time restrictions.

4.2.2.2 Subtheme 2: The debilitating sense of differentiation

When exploring the impact of their infertility, all participants highlighted how different they felt in comparison to other people. There was something very debilitating about the way they described their differentiation, which is why I chose this title as a subtheme. For each participant, however, this sense of differentiation was illustrated in a different way.

Michael in a very poignant quote captured how *'terrible'* his experience of infertility had been and how many times he broke down because of it. Michael was also affected by the Klinefelter's syndrome, which he openly spoke about in his interviews. This syndrome contributed to his infertility and in the extracts below, he talked about not feeling like *'a human being'.*

> *Terrible, it's been hell because it's thinking that I'm not a human being, I mean the amount of times I have broken down thinking there's something wrong with me I'm not a human being (Michael)*

> *When I first found out I got the syndrome and they showed me all this weird and wonderful thing I thought to myself I'm not a human, there's something*

wrong with me, why has there always got to be something wrong with me (Michael)

Michael in a powerful way emphasized his disconnection from an inherent sense of humanness and captured how different he felt. I perceived Michael as someone whose infertility brought up many unresolved issues from the past such as not feeling good enough and his history of abandonment. His quote '*why has there always got to be something wrong with me'* (second extract) elucidated that further.

Peter's focus was on being fixed but similar to Michael in the previous subtheme, there seemed to be a mechanical way of looking at his body.

I am in a position now where I think well if something's wrong it needs to be fixed. (Peter)

Then if they fix me if you like, if they can find out what's wrong and actually sort that then basically that opens up a very slim possibility of something happening naturally. (Peter)

Despite the fact, that I experienced Peter as being quite mechanical when talking about his experience, his frequent repetition of the word *'fix'* signalled something different. When something needs fixing, it means that it is broken. Peter implied that fatherhood was not a priority and therefore his infertility did not have a massive impact on him, but interestingly he referred to his 'broken' part quite a few times. This has been one of the times where the use of language has been useful in

helping me try to understand my participants further and how impacted they actually were.

Simon highlighted their inability to have a child like '*normal people'* who can conceive '*naturally'.*

> *It's just we know that we cannot have a kid. Erm. Normally. Like normal people (Simon)*

> *The only thing which is difficult in the whole story is it is hard to find out that erm. You can't have a kid on like everybody else. Normal, naturally just doing love and after nine months you have a kid. That's what is hard on this. (pause) It's finding out that you can't have a kid naturally. (Simon)*

The two extracts above captured beautifully Simon's existential isolation and in effect, alienation from the *'normal'* others. There was a need for normality, which was not achievable because of his infertility, a need that was very important to him as he brought this up on different occasions during our interviews. Despite the fact that both of these quotes have a powerful meaning, there was a sense of emotional disconnection and his phrases '*It's just we know that we cannot have a kid'* (first extract) and *'The only thing which is difficult in the whole story'* (second extract) reiterated this.

There were similarities in Simon and Peter's presentation, therefore, as I experienced an avoidance on their behalf to talk about the emotional impact, and there was a sense of detachment. Their avoidance will be explored further in the following major theme.

In a similar line to Simon, Seth also captured the isolation and loneliness of his infertility.

> *It's nice that because you are doing the study and there is other people out there that are dealing with this so it's not just me. Erm so that's kind of comforting (Seth)*

> *You know you are, you know you are not the only one dealing with it but at the same time you kind of like where are these people. (Seth)*

Seth interpreted the fact that I was doing the study as an indication that there were other people dealing with infertility, which was comforting for him to know. His first extract reminded me of his eagerness to participate in the study. Due to his work commitments, it was impossible to carry out our interviews at the clinic and I remember thinking how keen Seth was to participate since he asked me if we could find alternative solutions so that he could have the interview. The first extract though gave me an indication of why it was important for him to participate. I also remember how excited I was at the time talking to a potential participant who seemed very interested in my study. Perhaps this 'shared excitement' was one of the reasons why Seth and I managed to establish a very good rapport.

Payton's sense of differentiation was presented in relation to his family. There was a sense of him feeling like the odd one out from the family.

I was shocked because my father, we are seven of us and my father's side and even my mother's side everyone has children, my siblings everyone had children so it was a big shock (Payton)

I felt shocked because in my family no one had this problem (Payton)

'*No one had this problem'* (second extract) so there was an assumption that he would not either and it was completely unexpected which also explained why it was '*a big shock'.* In a community, where having children was essential, I thought about the difficulties this would bring for Payton and the possible feelings of shame and stigma. This is captured in the next subtheme.

4.2.2.3 Subtheme 3: Carrying the burden of stigma

The essence of this subtheme is to record the stigma that my participants felt with their diagnosis. There were implicit connotations in Michael and Peter's narrative about stigma whilst both Seth and Payton made a specific reference to it, which is why I felt it was appropriate to include it when naming this subtheme. For Michael, Peter and Seth the notion of stigma was present when they were contemplating the idea of disclosing their infertility to others. For Payton, the emphasis was on his culture and the social stigma attached to infertility.

Michael was due to start a new job and in the first extract, he talked about needing to inform his employers about his sperm retrieval operation. He was not comfortable, however, with telling them the nature of his operation and he preferred to give them the letters where it explained about it instead.

I was like I'll give you the letters I won't actually tell you what I'm having done I'll give you the letters. (Michael)

There was a sense of embarrassment which I tentatively interpreted by the change in his body language. Michael maintained eye contact throughout most of our interviews but whilst talking about this he looked to the floor and his legs were shaking. He looked uncomfortable talking about this and about the possibility of telling others. The following extract was a confirmation of this as he chose the people he disclosed to, as he wanted to make sure that they would not '*spread it around everywhere'.*

A few of my pub colleagues know about it, a couple of them you can't tell about it as they would just spread it around everywhere but a couple of them I told them while they were sober because I know they're not going to say anything whist they are drunk, and I told them and it was easy I only told a section of family because they're close to me the rest of my family they don't need to know (Michael)

I thought of this last phrase as an interesting contradiction as Michael said at some point during his interviews, that he wanted to talk about his condition so that people were aware of it. This disclosure oscillation, which was present for all the participants, will be captured in the next major theme.

As far as Peter was concerned, he would not just talk about his infertility straight away. He would have a few drinks and then he might have discussed it.

Because you don't rock up in a pub and within 30 seconds go by the way. I have been had this test and this has happened...you would be like well actually we'll have a few drinks first and then I might talk to you about it. (Peter)

I heard this comment as an indication of the difficulty he had in talking about his infertility. It seemed that he needed something to help him (in this case alcohol) in order to discuss it. Moreover, for some people having '*a few drinks'* helps in lowering their inhibitions so I wondered whether Peter needed that in order to talk more about his experience and what that signified in terms of how impacted he was. Peter also commented on preferring to have a beer in his hand during our interviews, which I interpreted as a further indication of his difficulty.

In the following extracts, Seth powerfully captured the stigma that he was carrying due to his infertility. He was concerned about being judged and as a result, it was easier talking to someone '*removed'* from his '*social circle',* which was me. He explicitly mentioned the word '*stigma'*

I think definitely speaking to someone else removed from your kind of social circle and that kind of stuff is definitely easier...because there is no judgement (Seth)

I'm, it's, just how do you tell someone. I think it's almost it's kind of like if you was gay, how do you tell someone you are gay? Erm, it's kind of, it's almost like that. (Seth)

You don't want the questions and you kind of I don't know what it is. Yeah definitely obviously there is a stigma attached to it and you kind of, and in terms of kind of being less of not being able to. (Seth)

From his third extract, one can allude to the fact that his infertility put him in an undermined position as he talked about '*being less of not being able to'.* Seth also chose a very interesting parallel example of disclosing about sexuality to allow some more understanding of his difficulty to disclose about his infertility. I speculated that the notions of stigma and masculinity were relevant here and that is why the comparison was made. The issue of masculinity will be captured in the following subtheme but before this, it is important to add that with Seth I wondered about the possibility of him also experiencing some external shame. It seemed that Seth suspected that disclosing about his infertility would lead to him feeling exposed and humiliated because of his diagnosis.

The notion of stigma and external shame were also captured in Payton's narrative. Payton highlighted how infertility was viewed in his culture. Not only were infertile people not respected, they were also avoided.

Because we should have a family culturally, if someone didn't have a child they wouldn't be respected in the important festivals or celebrations... they will skilfully avoid them (Payton)

And in our culture it's a social stigma erm if you don't have children (Payton)

If she has donor we're not going to say it to anyone and they think it's our children (Payton)

I remember feeling very impacted by what Payton said about his culture and the lack of understanding as far as infertility was concerned. I got the sense that people with infertility difficulties were completely ostracised from his community and I thought of how isolating that could have been. They would even resort to lying about the way a child was conceived to avoid being stigmatized. It was not surprising, therefore, that some people preferred not to talk about their infertility as they had all this to deal with.

4.2.2.4 Subtheme 4: Destabilisation of masculinity

The destabilisation of masculinity is the last subtheme under the impact of infertility. Infertility seemed to have encouraged a confrontation with my participants' view of their masculinity and this was presented in different ways. Michael focused more on his body and the impact it had on it, whilst Seth captured the effect it had on his identity. Payton emphasized the view of his culture.

In both quotes below, Michael talked about wanting to be '*a normal man'.* In the first extract, he highlighted his inability to have sexual intercourse whenever he wanted whilst in the second, he captured the differences he had in his body in comparison to a '*normal guy'*. His infertility in addition to his Klinefelter's syndrome contributed to changes in his behaviour as well as in his body parts.

That is the hardest bit for that I just want to be a normal man, you know be able to do it as and when I want to be able to do it (Michael)

I've always noticed I've had small testicles and I found it very hard cause I just wanted to be like a normal guy, you know have bigger testicles (Michael)

Michael's big built was a contrast to his small body parts which I assume emphasized his condition even further. There was a sense of despair in his quotes about not being masculine enough and I wondered whether this was translated into not feeling good enough, a feeling that he was familiar with and was captured in his interviews.

Seth made a direct connection between '*not feeling like a man'* and having an infertility issue. There was an uncertainty on how other men handle their infertility, which indicated his lonely journey as captured in a previous subtheme. There was also an acknowledgement that his masculinity was destabilised due to his infertility.

I'm not sure how other kind of men handle it and deal with it. I guess it can be, there is definitely a big part of erm. Not feeling like a man.... Erm. Because you can't do that. Erm. But luckily that. I never had that feeling too much. (Seth)

You lose that part of your identity. As being the kind of, kind of chest out kind of, kind of, kind of guy. (Seth)

Seth seemed to have built this identity where he was the *'chest out kind of guy'* not only with the way he looked but also with how he presented himself. His infertility, however, brought a massive upheaval to his presentation. He was faced with an inability to reproduce which had a direct impact on his masculinity. As a result, there

was a difference between his internal and external self and I was mindful that when I first met Seth I 'colluded' with this presentation. His openness to talk about his experience led me to think that Seth had accepted his diagnosis and that there was no need for him to have any support from anyone. Once I entered deeply into the analysis, however, and following discussions with a critical research friend, it was interesting to see how different the situation actually was and how difficult it was for Seth to come to terms with his infertility and the loss of his identity as the masculine man.

When talking about masculinity, I thought there was a contradiction in Payton's narrative. In his culture, '*it is a manly thing having children'* but he said that he did not feel like this. Straight after, though, he stated that he had not told anyone, so I saw that as an indication that if he did, this is how he would feel as well. I tentatively interpreted this as his difficulty in accepting his infertility and the impact that it had on him.

> *It is a manly thing having children it's important like that (Payton)*

> *I didn't feel that I am not man enough, but if the society knew, they all talk about it but they don't know because I didn't tell anyone (Payton)*

The focus of this major theme was to capture the disempowering impact of infertility on my participants. In the following major theme, the attention is turned on how they responded to the limitations of their infertility.

4.2.3 Major theme 3: Responding to the limitations of infertility

The focus of this major theme is an exploration of how my participants responded to their diagnosis of infertility and the different ways they employed in trying to cope with it. For all of them, there was a strong sense of avoidance in an attempt to lower their stress levels. This was manifested by either avoiding to think about their infertility or by shifting the focus elsewhere. There was also an attempt from my participants to maintain a pragmatic approach to their experience as a way of managing. The need to negotiate alternative options since there was a possibility of an unsuccessful sperm retrieval operation was also explored.

4.2.3.1 Subtheme 1: Sustaining avoidance

All participants displayed a need to try to steer away from thinking and talking about their infertility as a way of managing. Michael, Simon, Seth and Payton were very similar in how they captured their avoidance.

Michael did not seem to want to attune to his affective state and recognised that if he were to think about his condition he would be *'in a hole'.* I tentatively interpreted that as an indication of the dark place he felt with his condition, how painful that must have been for him and that it was easier to try and not *'dwell on what he had'.* His way of dealing with it was to '*close up'.*

> *But you know I'm taking, I've got to be bright cause if I don't, I just shell up, (Michael)*

> *What I am trying to do is to focus on the future and not try and dwell on what I've got cause if I do I'll just be in a hole (Michael)*

She has to beat it out of me, cause I just close up and that's how I deal with it. (Michael)

Payton also seemed to '*close up'* as he decided not to talk about anything until after the operation.

We didn't think too much and paused for everything until the operation (Payton)

No stress. We don't discuss much and we are waiting for the Dr's operation (Payton)

'Closed up' was also how I perceived Payton at our interviews. Payton's English was limited but he wanted to participate so he asked if his brother could accompany him in order to help with the translation. Despite the fact that the presence of his brother was discussed in our interviews and Payton said that he was comfortable talking in front of him because they were close, I did wonder about the possible impact of his presence. Payton spoke about feeling the odd one out from his family since everyone else had achieved parenthood so I was not sure how easy it was for him to talk in detail about his experience of infertility. I wondered whether having his brother there also prevented us from establishing a better rapport since I experienced him as more reserved in comparison to my other participants. The language barrier also hindered that further as we had to rely on his brother to translate for us and as a result, some of the richness of his narrative was lost. On top of these, I wondered

whether there was also a worry about talking too much about his experience and the implications this could have.

Simon and Seth made a direct reference to their attempt not to stress about their situation. Simon in a powerful way captured his effort to '*put things on a special box'* where he could then only attend to them when he needed to. There was an acknowledgement that if he started thinking too much about his infertility then he would be stressed and he would not know '*what to do with it'.* Simon had *'a special box',* whilst Seth *'put it to one side'* instead of '*keeping it in front of*' him.

> *And I can choose what to think at the moment. I try to put things on a special box. And that is the type of thing that I don't think now. Because that is totally dependent of the outcome of next week operation. (Simon)*

> *And if I start thinking about too much about this I will be a bit stressed. And I don't know what to do with it. (Simon)*

> *What I try to do now is put things on a box and only think about closed things when I need to. (Simon)*

> *Why make it worse by kind of stressing about it. (Seth)*

> *You almost kind of you put it to one side because I think for me anyway, it's kind of there's no point in keeping it in front of you all the time and having it on your lap and worrying about it all the time because you can't do nothing anyway...You think about it when you need to think about it in terms of*

planning and that kind of stuff. But then otherwise you kind of, you don't kind of, it doesn't really. You don't really need to worry about it and be anxious and that kind of stuff because it makes no difference anyway. (Seth)

Lack of control had a strong presence for both Simon and Seth, as it was indicated in a previous subtheme. I speculated that their need to have a box and put it to one side was an attempt on their behalf to try and regain some form of control where at least they could choose what to think about. I thought of the box as a space where all their discomfort about their infertility could be contained. They both, therefore, engaged in suppressing their thoughts and feelings because they were exposed to uncertainty and this was their way of dealing with the stress of it.

Peter captured his avoidance in a different way in comparison to the other four participants. Peter's sense of avoidance had a different feel, as it seemed more detached.

So, we are doing it now. And that's sorted as far as I'm concerned. (Peter)

It can be fixed, dealt with just get on and do it I don't have to worry about it. (Peter)

I will only worry about children when as I said she has a baby on the way. (Peter)

Peter's firm tone of voice and the short sentences in the extracts above indicated to me that there was a wish not to reflect too much on what was happening. His phrase

'*And that's sorted as far as I'm concerned*' (first extract) demonstrated a sense of certainty of the situation when in reality nothing was certain and there was no way for him to know if it would be sorted or not. The same also applied to '*It can be fixed, dealt with'* (second extract) as he could not have known the outcome of the sperm retrieval operation. I tentatively interpreted that as an avoidance to think about the implications of his infertility as perhaps this was an easier way to manage it.

Before I move on to the next subtheme, which is about my participants' tendency to maintain a pragmatic approach to their infertility, I think it is important to add that there were times during the interviews where I chose not to delve deeper into my participants' responses. There was a difference in my role as a researcher in comparison to my role as a therapist and it was essential to keep that in mind. I was mindful that I would only meet with my participants twice and as a result, I chose not to ask too many questions about their ways of coping. There was a strong sense of avoidance in all of my participants, but I did not think it was appropriate to challenge that as the interviews were for a research study and they were not therapy sessions were difficulties could have been explored further.

4.2.3.2 Subtheme 2: Maintaining a pragmatic approach

There seemed to be a tendency from my participants to maintain a pragmatic approach about their infertility. I wondered whether that was another way of making the situation a bit easier for them by not attending to the emotional impact as much.

Michael tried to put things in perceptive when thinking about his infertility by commenting that there are people who cannot have children at all. At least in his situation, he still needed to have a sperm retrieval operation before finding out the next step. Telling me about the child who had leukaemia was a further indication of

this. It seemed that there was a need for a comparison in order to see that his situation could have been a lot worse than it was at the time and that was illustrated with his phrase '*that's a killer...I said mine's nothing'.* Focusing on another person's difficulties made it perhaps easier for him to try to manage his own.

There's people out there that can't have children full stop (Michael)

Her best friend works in a cancer ward she's a nurse over at (name of hospital) one of the main trauma centres and we was in the car with her a couple of days ago and she said she was dealing with a 15..no..9 year old who had cancer. Sorry not cancer, leukaemia who's obviously on the same ward, (pause) and that's a killer...I said mine's nothing. (Michael)

Simon and Peter tried to rationalise their situation and there was an attempt to be practical about it. There was an acknowledgement from Simon that there was pressure and that the situation was difficult but he quickly shut it down with his phrases '*It's what it is'* and *'We need to live with that'.* I tentatively interpreted that as an attempt on his behalf not to focus on his affective state. The same seemed to apply in Peter's situation where he kept things on the *'practical side'.*

And I know the problem, I know the solution. What can go wrong or what to do. And at the moment what I need to do is. Wait. And because I am all this situation, I can't control it. There is no point of be worried or concern, or, or unhappy or sad, or whatever. It's what it is. (Simon)

Will be difficult the, after the operation until we get a result. And then it will be difficult there will be pressure. But if we can't get pregnant by IVF, erm. We need to live with that. (Simon)

I come more from the practical side than worrying about whether it makes me less of a person or a man so to speak. Yeah. Because no one wants anything wrong with them. But at the same time, it's not a part of me that I needed to use before. (Peter)

Seth tried to explain his infertility by thinking that everyone has '*big hurdles'* in life to overcome and this was his. He had this issue to deal with and it was not '*ideal'* but he took a '*pragmatic'* approach.

This is what's meant to be this way. It's, it's by design. It's not ideal. But you make the best of it and you think about the next step... it's kind of definitely it's pragmatic. (Seth)

In everyone's world there are big hurdles... So yeah this is something that I am, that I have to kind of deal with (Seth)

There was a need for Seth to be in control but in this situation, it was impossible. I speculated that as a response to that, he tried to take a pragmatic approach to help him deal with it.

4.2.3.3 Subtheme 3: Negotiating alternative options

The focus of the last subtheme in this major theme is the negotiation of alternative options. I purposely chose the word 'negotiating' as there was a sense of my participants trying to work out what they wanted in terms of the alternative options. For some, the situation was clearer than for others, as it will be illustrated below.

In the extracts below, Michael beautifully captured what was going on for him when thinking about the different alternatives.

> *Initially I was petrified, having another person's child but now I'm thinking do you know what that's what they do it for. Because they want to give some happy couple a chance to have children (Michael)*

> *It was hard, it's like being cheated on, like if that's the case I'll say why don't you go and have a one night stand. (Michael)*

> *We've already said we are going to try a donor if not we will try and adopt. (Michael)*

> *But as long as it's on a level to what I've got then I'm fine. I don't really care if it's not my child because the minute that baby is born it's my child. I will raise that child as long as it's got the same sort of… well it could be blonde hair or dark hair because she had blonde hair when she was a baby but she's darkish now. As long as it's close enough to me it's not going to be exact but I'll raise it as my child (Michael)*

I saw Michael's use of the plural sense when talking about having a donor insemination as an indication of the closeness he had with his wife, something that was evident in his interviews. The relationship with my participants' partner will be explored in the last major theme. He also highlighted, however, how difficult this had been for him. He was *'petrified'* with the idea of *'having another person's child'* and compared it to being '*cheated on'.* I tentatively interpreted that as his way of communicating the extent of the compromise he was willing to make of what he considered important, which was achieving fatherhood. Despite this, however, he wanted to hang on to his authorship and wanted the child to be '*close enough'* to him. His consideration of donor insemination, therefore, seemed to come with conditions and that was illustrated with the repetitive '*as long as'.* I wondered whether that was his only way of trying to maintain some form of control over the situation. He could not do that with his diagnosis but he could at least try and profile it so that the child was similar to him. A similarity with the child could also mean the avoidance of a constant reminder of his infertility.

For Simon, the situation was different, as he did not want to consider the possibility of donor insemination. Despite the fact that he knew his partner would have liked her biological child, he tried to capture the difficulty of seeing her pregnant without his child. In the first extract, there was a sense of Simon knowing how painful this would have been for him and he wanted to avoid this. As he clearly stated he did not '*even want to be in that position'.* In the second extract, and taking into consideration that his sperm retrieval operation was imminent, Simon's approach seemed to have softened as far as donor insemination was concerned.

But at the moment I don't want to get a donor, not at the moment I don't want to get erm. (pause) A donor. For me that's very simple...What I don't want and I am not saying I wouldn't love the kid if she would get pregnant by other sperm. But I just don't want that. It's very simple I don't want that.... I don't even want to be in that position...To think about or when she is pregnant I will...thinking about she is pregnant and that's not my sperm. So I would prefer not to be in that position even if it, even if it's more difficult for her because she really likes to have kids with her eggs. (Simon)

Except if she does have a very good argument (chuckle) that can change the way I see things. But we haven't discussed that yet... So things can change. Because we haven't really discussed that.... I don't have any argument to say that I don't want because of this. I don't want because I don't want. Which will be a very (chuckle) a very short discussion with her so I really need to think about the argument. (Simon)

Simon's phrase *'so things can change'* (second extract) was an indication of his softening position in comparison to how firm he came across in the first interview when he was contemplating about the different alternatives. Despite his softening position and the fact that he did not *'have any argument to say'* against the possibility of donor insemination, however, with his uncomfortable chuckles I cautiously conjectured that this was a difficult and painful situation for him to be in. The fact that he moved on to talk about something else after this was a further indication that he preferred not to explore this further and I thought it was important to respect that.

Peter's ambivalence over the possibility of adoption was highlighted in the extracts below. He would have preferred a biological child because the bond would be stronger and he did not think that adoption '*would suit'* him. Following this, however, he said in the last extract that '*once you come into those options'*, referring to the sperm retrieval operation being unsuccessful, then '*adoption becomes more viable'*.

Adoption things like that, I don't think would suit me... So I feel that I would need that kind of genetic factor to actually kind of engage with the child. (Peter)

If the child is mine then I think there would be a stronger bond there. (Peter)

So once you come into those options then may be adoption becomes more viable. (Peter)

Peter seemed uncertain about what he wanted to do. This uncertainty also featured in Seth's narrative. Seth spoke more openly about the idea of adoption and the possibility of donor insemination (something that Peter did not talk about). Despite the fact, however, that he called adoption *'a genuine route',* his ambivalence became more apparent when he started talking more about it.

I have always thought about adoption anyway. Erm. And I always felt, always kind of like to think that if I had a child and may be and I wanted to have

another child adoption would be. Even if I could have a child biologically, adoption would be a kind of a genuine route. (Seth)

But then I have always kind of like worry if I was to do that. How would you, how would there be a difference in terms of kind of deep down how. Yes would there be a difference in kind of like well this is biologically your child and this isn't. Like. How I am. Because you. Anyone can say no I've feel the same. But then how do you know until you kind of are in that place. Erm. And I would like to think it wouldn't make a difference. So kind of like that's definitely kind of a worry erm. And even kind of going through the kind of, the sperm donor route, it's something, it's a concern. (Seth)

The lack of coherence on a linguistic note on Seth's second extract was a further indication of his ambivalence. In moments like these, I was reminded of all the dilemmas that people with infertility are faced with. Dilemmas that I even thought about when I was first questioning my infertility. It is also important to mention here that these two interviews with Peter and Seth, took place not long after I found out about my pregnancy. I was holding feelings of sadness, guilt, but also gratefulness. I felt sad for them for going through this experience and guilty that I was in the position that they wanted to be. Questioning my own infertility only lasted a very brief period and I saw first-hand how difficult it was. In their case, however, they were still a long way from achieving what they wanted and the uncertainty of it was very strong. Despite the fact that my pregnancy brought more distance between us in terms of our situation, I felt very impacted by my participants. It put things in perspective in terms of these difficult and major life decisions that my participants were confronted

with. They were life-changing decisions and it helped me to see why it was so challenging for them to think about all the different aspects of their infertility.

For Payton, the situation seemed clearer in terms of what the next step would be. He talked about always looking for alternatives and in this case, '*the first alternative would be from a sperm donor'.* I assumed that this decision came about partly due to the cultural pressures and the fact that it would have been easier to disguise his infertility issue if the first option was a donor insemination as he captured in a previous subtheme.

The first alternative would be from a sperm donor (Payton)

I will always look for alternatives... I will be calm then look for alternatives... once I get a problem that's unexpected I will be calm for a while then I look for alternatives (Payton)

The focus of this major theme was to illustrate how my participants responded to the limitations that their diagnosis brought about. The following and last major theme in the analysis is an attempt to capture the relational aspect of my participants' experience.

4.2.4 Major theme 4: Placing infertility in a relational frame

I have named the last major theme 'placing infertility in a relational frame' as the focus is on how my participants experienced the impact of 'others' on their diagnosis. This theme is divided into three subthemes; the sense of pressure by others' expectations followed by exploring the instability that developed with their

partner. The last subtheme captures the need/wish that my participants had about disclosing their experience and its relevant ambivalence as disclosure came with a cost.

4.2.4.1 Subtheme 1: The sense of pressure by others' expectations

In the first subtheme, the focus is on the sense of pressure that my participants seemed to have experienced from other people regarding having children. There was an expectation that fatherhood should be the next chapter in their lives and these expectations seemed to have been portrayed by different people.

The references that Michael and Simon made regarding these expectations seemed to have come from their immediate family. The way they experienced this pressure, however, was different. With Michael, there was a feeling that he owed it to his mother in law to have a child and I tentatively interpreted his phrase she is '*resting on us two'* as an indication of this. Not only was there a sense of Michael not feeling good enough about his difficulties to produce a child, there was also a perceived pressure as he felt that his mother in law '*desperately'* wanted a child and it was, therefore, their 'responsibility' to provide her with one.

> *So my mother in law is like its resting on us two. (Michael)*

> *Mm (nods) I especially told my mother in law this because obviously she deserves to know because you know she desperately wants a child (Michael)*

In contrast to Michael, Simon decided to keep his infertility diagnosis private in order to try and avoid this pressure from his immediate family. Despite the fact that both his mother and his mother in law asked about their timeline for having children, they opted not to disclose his condition. Simon suspected that if the parents knew they would keep asking them and that would only make the situation worse.

> *She asked when do I have a grandson and I said erm soon. We are trying... There is no point to talking too much about that. (Simon)*

> *My mother in law she asks my partner. But we. We…What they know er is that we are trying.... she is a midwife. So she is always asking about that stuff... Erm. But what we say is that we are trying. (Simon)*

> *And if we tell our parents, it will, they will be worried probably more worried than we are. And then they will ask every time they call they will ask, do you have news, do you have news, do you have news. They will not change nothing. It will make it worse. (Simon)*

There was an acknowledgement from Simon, that by not disclosing, he was trying to avoid making things worse but I also suspected that there was another reason for this. He did not want to have a constant reminder of his diagnosis. My assumption was based on my whole experience of Simon and the fact that he preferred to keep things locked up in his 'box' as he called it in a previous subtheme, so having someone constantly asking him would make thinking unavoidable.

Seth and Payton captured their experience of the pressure that non-relatives put on them. There seemed to be this expectation that '*as soon as you are married'* the next question is *'when are you having a child?'* Seth spoke about the pressure involved in this.

> *In terms of children it's more pressure like that as well... Erm. Because you always as soon as you are married it's kind of like okay so when are you having a child? Erm... So that puts on that puts pressure on (Seth)*

> *Just kind of old fashioned and in that respect kind of okay you are married start having children. (Seth)*

There was also this sense, especially from Payton's narrative, that other people were entitled to an opinion on the appropriate time for having a baby.

> *Some ladies ask me not friends some ladies ask me you know if you are delayed and when your time will be, you will be older and your child will be too young and it is very difficult to handle. (Payton)*

> *They all say to her don't wait for a baby because if you have a baby you can easily manage you know, you can have a baby quickly and have a second baby after... they say before you're 30 you should have a baby otherwise your body will not cope, sometimes you won't get pregnant, and if you are younger you will easily get pregnant (Payton)*

Whilst Seth and Payton were talking about this, I could not stop myself from thinking how inconsiderate this was from other people who had the need to ask questions about children and the difficulty this involved for my participants. The fact that there was this expectation that as soon as you are married, children are the next thing, added more pressure on a situation that was already quite stressful as they had already captured. This was one more thing that they had to contend with.

As far as Payton was concerned, I experienced him as keeping his distance from me in comparison to the other participants and I think part of this was the language barrier that we had. It was in moments like these, however, that I felt closer to him. His situation reminded me of my own culture and the expectations and pressure that some people put where they behaved in a similar way.

4.2.4.2 Subtheme 2: Instability in the relationship with partner

The essence of this subtheme is the effect that my participants' infertility had on their relationship with their partner. An infertility diagnosis is something that unavoidably affects both people involved and it seemed to have brought a period of instability in my participants' relationship. This was portrayed in different ways. For Michael and Seth, it brought instability in the present, whilst for Simon and Payton the uncertainty lay in the future and following their sperm retrieval operation.

With Michael, there was a sense of not being good enough and this was indicated throughout his narrative. He felt that his infertility was a barrier for his partner and as a result, before they got married he had asked her to leave him as he did not want to '*hold her back'.*

Well I thought if I can't do it why should I hold her back, (Michael)

I have told (name of wife) obviously before we got married so leave me leave me leave me...if you want children go have your children and if you want to come back to me. (Michael)

There was an assumption that Michael's infertility would have stopped them from moving forward and it seemed that he did not think that his partner would want to stay with him regardless of his infertility diagnosis. His wobbly tone of voice matched with my feeling that this was painful for Michael as he was unable to provide a child for his partner. In general, I experienced Michael as someone whose infertility had a profound impact on his self-esteem and his confidence so I could see why that would also bring questions about his relationship and the fact that he would doubt himself.

Similar to Michael, Seth's relationship seemed to be going through an unstable stage and as his extracts below indicated, there was ambivalence. On one hand, Seth stated that they were '*in a very good place'* and '*very happy',* but on the other hand, he thought that she would not understand what he was going through so he opted not to talk too much about it. As it will be captured in the following and last subtheme ambivalence regarding disclosure was intense for all my participants. This, however, brought questions about their relationship and the effect that his diagnosis had on them. There also seemed to be a disagreement on the alternative options they could take if sperm retrieval was unsuccessful as indicated in the third extract. Seth's wife, unlike Seth, did not want to consider donor insemination. This was therefore inevitably going to create some friction in the relationship.

Me and my wife are in a very good place. I guess in terms of our relationship... We are very happy (Seth)

With my wife I don't think she would understand. (Seth)

She's like no but it has to be yours, it has to be yours. (Seth)

For Simon and Payton, their infertility brought questions and uncertainties regarding the future of their relationship. The sense of uncertainty was evident throughout Simon's narrative, as it was also illustrated in previous subthemes. His tone of voice indicated a feeling of helplessness about the situation as his relationship was one more thing to add to his uncertainty. The fact that Simon was not keen on the idea of donor insemination surfaced some worries about the response of his partner if his sperm retrieval operation was unsuccessful.

At the moment yeah. I hope she continues to be in that opinion. Are you worried about that that she might come back and say that actually she does want to have? (researcher) Yeah sometimes... She can change idea I don't know. At the moment we are okay. She wants, she is supportive with the operation with everything and she is, she is in the opinion that if we don't, if it's not okay, we will adopt. But who knows. Tomorrow or the day after. She wanted to be a mother yeah. (Simon)

Payton seemed to share a similar anxiety about the future of his marriage as he clearly stated in his first extract. An unsuccessful sperm retrieval operation could

bring change in their marriage. Payton also had to contend with the cultural expectations as far as a child was concerned. I felt there was an implicit sense of shame in his extract where he captured the importance his culture placed on having children. There was an indication that marriage was devalued without children and it would make it weak.

> *If we can't produce to have a baby then it might change (Payton)*

> *Culturally...in our culture having a baby, marriage is for having a baby that's what marriage is for (Payton)*

> *It's a big thing for me because one thing is…it's a big thing I didn't have proper family because me and my wife to take our relationship…to strengthen our relationship we need a child. (Payton)*

4.2.4.3 Subtheme 3: Oscillating between disclosure and concealment

The focus of the last subtheme of this major theme but also of my results chapter is the oscillation between disclosure and concealment. My participants' experience of infertility was profound and the presence of oscillation was strong throughout their narratives. There was a need from my participants to talk about their experience but at the same time, there were obstacles to that. This is what I will aim to capture in this subtheme.

Michael talked about the importance of talking to family and friends about his condition as it made his '*life easy'.* In the same interview, however, he also mentioned how his way of dealing with it was to '*just close up'* and his wife needed to '*beat it out of'* him.

(Name) who is my auntie I tell her everything. (Name) knows my cousin, I tell them all because it's easier to release it off my chest. (Michael)

But you know talking to them made my life easy (Michael)

She has to beat it out of me, cause I just close up and that's how I deal with it. (Michael)

Cause I was having a lot of problems with it, it wasn't going back, it was going back, it wasn't going over (Michael)

Sorry to be a bit rude here but size as well cause beforehand it was erecting but not erecting as much (Michael)

There was a clear contrast in Michael's extracts, but the way I experienced our interviews helped to shed some light in this oscillation. I suspected that when Michael talked to his friends and family about it, the focus was on the practicalities of his condition and it was more information giving. When it came to talking about the emotional impact, it was more difficult, thus his tendency to shut down. I felt that Michael was comfortable with me and this was evidenced by the personal things that he shared (fourth and fifth extract). We managed to build a good rapport and I perceived him as quite open, but I did notice that when the interviews moved more to the emotional aspect of his infertility, Michael found it difficult and he easily diverted the conversation to something else. As a result, I wondered whether it was ok for

Michael to talk about the facts but the emotional aspect was more difficult to manage and thus the oscillation came about.

In the extracts below, Simon's oscillation regarding disclosure and concealment was captured beautifully. He seemed to focus on being '*easier'* if people '*don't know*' and stated that he did not '*feel the need to. Talk'* as he has '*always been okay without talking'.* Interesting enough when we discussed his experience of talking to me about his infertility, there was a stark contrast indicated with his statement *'because you made me talk about things, which is a good thing'.*

> *It's not hard because I have not told erm people otherwise it would be hard. Because they don't know they don't ask so it's a lot easier. (Simon)*

> *This type of discussion is healthy. Because you are doing a PhD. If I am having this type of conversation with friends. And we will just be talking about a problem that I can't solve. He can't solve. And I will feel it will be a waste of time. But with you I am here because you are doing a PhD. It's useful, it's useful. (Simon)*

> *I don't feel the need to. Talk. I am okay. I have always been okay without talking. (Simon)*

> *You helped being here talking about this Like the free... No, it's I am joking but it's probably true. Because I haven't thought about that but it and now I don't have any other comparison. Because I have been here. And I don't, I have an*

experience that. So it helps probably because you made me talk about things, which is a good thing. (Simon)

Which is a really nice job because sometimes people they need that and probably I don't know if I was needing that. I don't know if I was needing to but it helps me, yes it helps me or it helped me because I had to put and I am still putting out my what I normally don't. Just keep it in for me. And I also don't spend much time thinking about it but here I need to put it and I need to explain it to you in a foreigner like and my second language. Which is different as well... I never really explained my personal issues in my second language. (Simon)

There was a need to talk but there were consequences to this. Simon seemed to avoid thinking and talking about his infertility, possibly because he did not want to be in touch with how difficult this was for him. Talking could mean confronting his emotional world, so he opted not to in order to avoid being upset. He participated, however, in an infertility study. The fact that I was a stranger and I was doing a PhD made it easier for him as he stated. I wondered though whether he subconsciously knew that there was a need for men to talk about their infertility as he openly acknowledged the usefulness of a PhD. My sense of Simon was of a man who employed intense escapism and avoidance in order to interrupt his painful feelings but our interview had the effect of weakening this suppression as he was 'forced' to talk to me. The interviews seemed to have brought about a weakening of his defences, which brought more anxiety and I suspected that this was one of the reasons that contributed to his ambivalence. Despite this, however, he compared the

interviews to a free therapy session and acknowledged that perhaps he needed to talk. In Simon's situation, the benefit of having two interviews was evident. He seemed more comfortable in our second interview, which helped in his disclosure, despite the ambivalence.

Peter's contrasting statements indicated his oscillation as far as disclosure was concerned. On the first extract, he said he would tell people whilst on the second he stated that '*there is very few people that'* he would '*just start talking to about things like this.'*

> *And if I had more close friends, I would tell them even if they weren't necessarily quite as trustful. I would probably still tell them because they are close friends. (Peter)*

> *And certainly if they hadn't changed, erm, that means there is very few people that I would necessarily just start talking to about things like this. (Peter)*

> *It's just nice to talk without kind of, just whenever you talk to anyone there is always sort of boundaries and things you would adhere to... In terms of why I wouldn't, wouldn't tell people So it's quite cathartic, it's quite nice. (Peter)*

Despite the contrast in these statements, I tentatively interpreted his last sentence in the second extract as an indication that his infertility was something personal and perhaps something that was more important than he wanted to acknowledge. It seemed that the reasons, which stopped him from disclosing, were not present in our interviews and this perhaps contributed to making them '*cathartic'.* On hindsight, I

realised that the first interview with Peter had a different feel as it was light-hearted and I wondered whether I was drawn into something, which kept it to this tone and avoided the pain behind his diagnosis. I made this speculation after I saw Peter's tendency to minimise the impact of his infertility but implicitly through some of the words he used and the comments he made, the situation looked different. This also helped me understand why Peter would not want to talk about his infertility; similar to Simon this would confront him with the reality of it and the pain involved.

Seth's extracts captured in a powerful way his need to disclose and the potential consequences involved.

> *Every time you see that person, they know, they know and it's just like oh do I have to go and deal with that question and that kind of stuff. And now then it becomes kind of like a daily thing... Because you, if you… whenever you see your friends and that kind of stuff... And family it makes it kind of like part of your everyday kind of situation. (Seth)*

> *I would never discuss anything kind of that personal. That personal and a lot of things that are going on at home, that, that kind of I don't want to talk about, I don't want to share (Seth)*

> *Emotionally I kind of I can sort out my problems myself. (Seth)*

> *I think kind of sometimes you want to kind of put it out there kind of this is what I am going through... But you don't want the reprisals. (Seth)*

I think you are doing a service. Yeah. Even kind of something positive has come out of it in terms of kind of how maybe. I think maybe I don't know how it was with the other kind of people you spoke to but it's definitely kind of been a positive experience for me. (Seth)

I wanted to be able to speak about it... And you kind of because, I think maybe because erm. Because it's almost like a secret... you just. You want to just blurt it out and you want to say, and you want to kind of like say yeah this is how I am feeling and that kind of stuff erm. And bounce it off someone. Erm. So you kind of part of me wants to kind of like. I do want to speak about this. (Seth)

Similar to Simon and Peter, Seth tried to cut off thoughts and emotions and he did not want to make it '*part of* his *everyday kind of situation.'* He tried to justify that by saying that he did not have the need to talk about this anyway as he was dealing with it on his own. Seth, however, seemed more preoccupied with the '*reprisals'* if people were to know about his infertility and what that would mean to the way he was viewed by others. There was a clear indication that he had the need to talk about this and this was illustrated when he explored his experience of talking to me. He wanted to '*blurt it out'* and I saw that as a powerful way of capturing how many things he was holding on and the force in which he wanted to speak up about it.

'Judgement' and people talking about it was one of the reasons that seemed to stop Payton as well. The fact that I was a '*stranger'* to him made it easier as it was '*good to share it'* but that was not something he would have done with other people.

Payton seemed to put the focus on this when thinking about disclosure and this was what contributed to his ambivalence.

> *I felt good about it... It's good to share it and you are a stranger…you are not going to make any judgement (Payton)*

> *But if I talk to my colleagues and they are not good friends…they are acquaintances in my workplace if I talked to them they would… they would talk sarcastic (Payton)*

In this chapter, the four major themes and relevant subthemes were explored. As it was evident from my participants' extracts, they were profoundly affected by their experience of infertility. In the next chapter, my findings will be discussed in relation to the relevant literature and implications for practice will be considered. It is also important to add here that another researcher could have interpreted these findings differently and could have focused on other aspects of the participants' experience.

Chapter 5: Discussion

The aim of this chapter is to address my major themes and consider them in the light of existing research on infertility. Following this, I will outline implications for practice as well as explore the strengths and limitations of my study. I will consider ideas for further research and finish the chapter with my personal reflections.

5.1 Discussion of the major themes

5.1.1 The emerging notion of fatherhood

In the first major theme, the notion of fatherhood was explored where all of my participants elaborated on their thoughts of becoming a father and captured the importance they placed on it. We live in a world where effectively most societies are pronatalistic and parenthood is deemed valuable (Callan, 1982; 1983). It was not surprising, therefore, that when I invited my participants to tell me about their experience of infertility, they first spoke about their wish to become fathers and how important this was for them. According to Suarez and Gallup (1985) and taking a sociobiological perspective, there is an inherent drive to reproduce for genetic continuity. This theory, however, does not support the fact that some couples opt to pursue adoption or donor insemination. Economic and social factors could also contribute towards deciding to become a parent. Callan (1982) argued that some cultures consider children an economic necessity as they can potentially contribute towards income. This does not seem to apply in the Western world, however, where children can increase the family's financial pressure. According to Blake (1979), children are more of a social investment than an economic one.

In the current study, several factors contributed to my participants' motivation and wish for fatherhood and these included a desire to become a father, life stage,

meeting partner's wishes and cultural expectations. Consistent with Ramu and Tavuchis' argument (1986), the amount of importance for each of these factors was difficult to disentangle. Nonetheless, I think it was more important to acknowledge that there were different factors playing a part in their decision, rather than evaluating which one was more significant.

All participants spoke about fatherhood as the next chapter in their life but some of them captured it more explicitly. Marital status and socioeconomic indicators were highlighted as being important in their decision to start a family. Since these were already established, for all of my participants, they were ready to pursue the next step, which was having a child. These factors were in line with the findings of another qualitative study, which was carried out in 2011 by Hadley and Hanley where ten biologically childless men participated. In their study, life stage, genetic drive and cultural elements all contributed to their participants' reasons for seeking fatherhood. In the current study, the factor of the life stage was shared by all, either directly or indirectly, whilst genetic drive and cultural elements were not factors given by the majority of my participants.

For one participant, Payton, the cultural element played a massive role throughout his narrative. Despite the fact that he was living in UK for a few years at the time of the interviews, there seemed to be many expectations from his Sri Lankan community as far as fatherhood was concerned and the meaning attached to that. These cultural expectations were consistent with the findings of a study that took place in an urban slum in Bangladesh (Papreen et al, 2000). Men, who found it difficult to become fathers, lost their social status and they were excluded from their community. The value that they placed on children was immense as they were considered 'the light of the family' and the 'torchbearers of the family lineage' as one

of their male participants said (Papreen et al 2000:p.37). Considering this, one can assume how devalued the people who could not conceive felt and the pressure they possibly experienced from their community. Similarly, in a study that was carried out in Zimbabwe, it was indicated that when men were unable to become fathers, it brought shame to their extended family (Runganga et al, 2001) and social disadvantage accumulated (Chowdhry, 2005). These findings were also evident in the United States where in Nachtigall et al's (1992) study, men felt that if they were unable to achieve fatherhood, their status in the society was diminished. It seems, therefore, that for some men the society's expectations and 'pressures', contribute to their decision to pursue fatherhood. This was also evident in the current study with some of my participants. As far as culture is concerned, I think it is still open to interpretation whether some cultures place more 'pressure' on people to achieve parenthood in comparison to others. In the current study, two of my participants had an Asian background. Despite the fact that it was never my intention to generalise my findings, as this is also not the purpose of an IPA study, some observations can still be made. Payton was born in Sri Lanka and I experienced him as someone who felt the cultural pressure and the expectations. Seth, however, regardless of his Asian background, he was born in UK and the cultural expectations did not seem as intense as they did for Payton. This sense of pressure was also not documented from the other participants who had a European background.

In a cross-sectional study that took place in Iran, 300 men participated in an attempt to determine the influencing factors of the first childbearing timing decision (Kariman et al, 2016). The results indicated that marital age, marital satisfaction, social support, quality of life and economic status contributed to their decision to pursue fatherhood. The achievement of financial security was also highlighted in

other studies as a contributing factor towards the decision to pursue fatherhood (Thompson and Lee, 2011; Nilsen et al, 2013; Peterson et al, 2012). This factor did not seem very strong in the current study, as only one participant, Simon made a direct reference to it. Perhaps one of the reasons that it did not feature strongly for my participants was because they had already achieved a desirable economic status and the focus was now on trying to achieve fatherhood, whilst in the studies mentioned above, the participants did not have an infertility difficulty.

This major theme did capture, however, the importance that my participants placed on having a child and the different factors that led to their decision to pursue fatherhood. Ambivalence was also in the mix but I tentatively interpreted that as a possible response to the uncertainty that they were living in. The impact that their diagnosis had on them will be explored in the following major theme.

5.1.2 The disempowering impact of infertility

All participants in the current study were profoundly impacted by their infertility. There was a sense of powerlessness in their narratives, combined with a strong sense of uncertainty and a lack of control over their situation. They all captured their experience of feeling different and the notions of stigma, masculinity and the impact these had on them was explored.

Similar to the findings of the study carried out by Webb and Daniluk in 1999 where six men were interviewed about their experience of male factor infertility, the current study found that all participants were preoccupied with their lack of control over their situation. There was a strong sense of uncertainty that was illustrated in different ways. Due to their diagnosis of infertility, they were confronted with many limitations and they became aware of their lack of control over their fertility, over the

function of their body, over the outcome of the sperm retrieval operation, over the future. The concept of time was prominent for my participants. This finding corresponds with findings from research about 'delayed conception'. According to Shirani and Henwood (2011) "Parenthood is frequently assumed as a life course stage that will be achieved when intended, and remains a signifier of adulthood....when conception was delayed it gave the sense of stalling, arousing feelings of lack of control over time...For couples who experienced a delay in conception, time became a dominant feature" (p. 53). Time was a "dominant feature" for all of my participants. For Seth in particular, there was a sense of urgency in wanting to achieve parenthood as soon as possible, whilst for Peter, there was a realisation that they were running out of time due to his partner's age restrictions.

Feelings of inadequacy and of being different were reported in studies carried out by Webb and Daniluk (1999), Dyer et al (2004) and Johansson et al (2011). In Johansson et al's study (2011) men described finding out about their absence of sperm as the "harshest blow" in their lives and the "worst news they had ever received" (p.3). They felt powerless, different and that their identity was questioned. Similar to this, in Dyer et al's study (2004), men described feelings of sadness, emptiness and expressed feelings of anger, helplessness and of being left out. In the current study, in Michael's narrative, the feeling of inadequacy was very powerful. The remaining participants captured in other ways their profound sense of feeling different. Needing to be fixed, not being able to conceive naturally, feeling isolated, lonely and the odd one out were captured by my participants. Payton spoke in-depth about the cultural expectations of having a child and the response of his community when people were unable to conceive. He talked about feeling the odd one out from his family, but I wonder whether he also meant his community as well; a community

where the idea of the separate ‘self’ is at odds with the western view of this idea. In the study carried out by Dyer et al (2004) in South Africa, men captured how their childlessness affected their social status. They were completely ostracized; without children, they were not respected and they were told by the community that they were weak for not being able to have children. Similar to this study was also the one conducted by Papreen et al (2000) in Bangladesh. Consistent with these findings was what Payton captured in the current study about his culture and the stigma involved for men with an infertility diagnosis. The results of these studies imply that there seem to be negative implications of male infertility and a clear lack of understanding in the developing world. These indicate the importance of more research and awareness on infertility. “Infertility, specifically male-factor infertility, is identified in the literature as being viewed as shameful for men and still heavily stigmatized within society. Such stigma often links to notions about masculinity (or masculinity being compromised)” (Hanna and Gough 2015:p.6). The studies carried out by Nachtigall et al (1992) and Webb and Daniluk (1999) evidenced the above statement. In the Webb and Daniluk study (1999), the participants were reluctant to talk about their experience in order to avoid feeling further shame and considered their infertility “an assault on their manhood” (p.22). Consistent with the Webb and Daniluk (1999) study, my participants (Michael, Peter and Seth) spoke about their concerns regarding disclosing their infertility and the stigma attached to it. It was not something that they wanted to share with just anyone, there was a difficulty in talking about it and there could also be possible implications on how they were viewed if people knew about their diagnosis. This tendency, however, to keep their experience to themselves and suppress their emotions as a reaction to their stigmatizing diagnosis could also lead to a higher degree of alexithymia (a Greek word, which

means ‘no words for emotions’) (Conrad et al, 2001). Gannon et al (2004) conducted a discourse analysis of UK broadsheet newspaper reports on sperm count declines during 1992 – 1998 in order to explore the ways in which infertility and masculinity were represented in the media. They found that in Western societies vulnerability was denied, toughness and emotional control were promoted and the need for support was minimised. Despite the fact that these findings cannot be generalised to individuals with an infertility diagnosis, it nevertheless gives an indication of how difficult it might be for some people to speak up about their experience.

In the current study, Payton shed some light on how his culture viewed parenthood, infertility, the stigma attached to it and the impact on one’s masculinity if people knew. This was consistent with findings from other studies. In Chowdhry’s (2005) study, for example, which took place in Haryana, India, men were only fully considered men when they had a child and especially a son. Similarly, in Egypt, “infertile men (were) said to ‘not be good for women’, to have their ‘manhood shaken’ or to be ‘weak’, and ‘incomplete’, not ‘real men’” (Inhorn 2003b:p.248).

All of these give an indication of how disempowering the impact of infertility is on men. Taking into consideration the difficult feelings attached to infertility sheds more light on the ways that men respond to their diagnosis, a theme that will be captured next.

5.1.3 Responding to the limitations of infertility

When events take place in our lives that exceed our resources and can potentially impact our well-being, they are usually accompanied by coping strategies (Peterson, 2002). These coping strategies have been defined by Lazarus and Folkman (1984) as “cognitive and behavioural efforts to manage specific external

and/or internal demands" (p.141). Many studies have been carried out with the aim to examine infertility and coping strategies and they have usually used the stress and coping theoretical perspective of Lazarus and Folkman (1984) as guidance. The type of the coping strategy that people will use, will influence the level of stress involved. According to Stanton (1991) and Litt et al (1992) if people with a diagnosis of infertility employ escape/avoidance and self-controlling then there seems to be an increase in psychological distress. Planful problem solving, seeking social support and positive reappraisal strategies, however, seem to decrease the level of distress (Stanton, 1991; Levin et al, 1997).

Avoidance and maintaining a pragmatic approach were the prominent coping strategies used in the current study. All participants tried to avoid thinking about their infertility. With Simon and Seth, there was an acknowledgement that if they thought about their situation, they would be stressed out. In order to avoid this, they suppressed their thoughts and feelings. Peter and Payton, however, presented their condition in a different light. According to them, things were in hand; they were waiting for the operation, so there was no reason to worry about it. The use of avoidance, therefore, was employed in different ways. My participants also tried to maintain a pragmatic approach. This was achieved either by the use of rationalisation, trying to keep things in perspective or by focusing on the practicalities involved with their diagnosis. These findings are consistent in other studies as well. In the study carried out by Peterson et al (2006), gender differences were examined and they found that men used distancing, self-controlling coping and planful problem- solving. Webb (1994) found that men also used denial, intellectualisation, withdrawal and suppression. Unfortunately and taking into consideration the longitudinal study Peterson et al (2009) carried out, their findings indicated the

opposite of what my participants were trying to achieve. According to the above study, the use of avoidance as a coping strategy does not help with a person's level of distress. Quite the opposite; the more they try and avoid the situation, the greater the distress. This was also reported in other studies (Band et al, 1998; Berghuis and Stanton, 2002; Jordan and Revenson, 1999; Litt et al, 1992). I think this is a very important point to consider when thinking about possible ways to support men with a diagnosis of infertility. As the studies above indicate, using avoidance as a coping mechanism seems to make the situation more stressful so people with an infertility difficulty need to be made aware of this and different ways of dealing with their infertility to be suggested. This will be further discussed later on in this chapter.

Another response to a diagnosis of infertility seemed to be the need for male participants to be the strong ones in the relationship with their partner (Webb and Daniluk, 1999). This finding was consistent with the outcome of a body-mind group intervention programme for infertile couples that Lemmens et al (2004) carried out in Belgium. As part of the care of the Leuven University Fertility Centre, during their treatment, the couples had the opportunity to attend a body-mind group programme. Six group sessions took place and in one of these, men asked for concrete advice and "focused more on the impact of the infertility and the treatment on their partner, the relationship and their life" (ibid, p: 1919). This was also found in Stammer et al's study (2002). This tendency, however, was not evident in the present study and the focus of my participants was more on sustaining avoidance and maintaining a pragmatic approach. Perhaps this was because the above studies took place during fertility treatment or after whilst the current study was carried out before my participants went for their sperm retrieval operation. Considering the fact that during the IVF treatment, the women are the ones who go through all the medical

procedures, is perhaps the reason why men in the above studies focused more on supporting their partner. In fact, in the current study, Seth mentioned in our interviews that when they reach the stage of starting IVF treatment, his focus would mainly be on supporting his wife because she will be the one going through all the medical procedures, which confirms my above assumption.

My participants also considered alternative options; donor insemination or adoption. There was an awareness that if their sperm retrieval operation was unsuccessful, then they would be confronted with having to decide on their next step. Each participant went through his own process of thinking about the different options, and some of them were more open to exploring the available alternatives. Regardless of their level of openness, however, there was a sense of ambivalence, as there was a lot to consider. Michael wanted to try donor insemination before considering adoption. As he explored this possibility further, it became obvious that he wanted to have some conditions in place first. For Simon, donor insemination was an option that he did not want to consider, even if this position became softer in the second interview. Both Seth and Payton spoke about wanting to try donor insemination first. With the option of donor insemination, it is easier to maintain the pretence that they are the biological parents and it is easier to maintain the secret of the infertility issue. Once adoption becomes an option, then the secret is out. Both Payton and Seth captured these thoughts, which are also consistent with the findings of the study carried out by Bharadwaj (2003). It seems that in India men feel so humiliated with their infertility and their inability to become biological fathers, that they resort to donor insemination in order to maintain their secret (ibid). The decision between donor insemination and adoption, therefore, does not seem to be an easy decision to make. This could explain the mixed reaction of my participants when

considering their options. For some, reproducing their own child was essential and using a donor insemination could serve as a constant reminder of their infertility struggle, something that was also captured in Arya and Dibb's study (2016).

5.1.4 Placing infertility in a relational frame

The focus of the last major theme is the relational frame and how my participants considered their experience of infertility within this context. In this theme, my participants reported the perceived pressure they felt from other people in terms of conceiving a child. For some, like Payton, the pressure was very strong as it came mainly from his community and the expectations that his culture placed on the importance of having a child. For Michael, there was a sense that he owed it to certain family members to provide them with a child, whilst Simon and Seth opted not to disclose their infertility because they wanted to avoid this pressure that others would put on them with constantly reminding them of their situation.

My participants in the current study spoke about their relationship with their partner and the relative impact that infertility had on their relationship. It seemed that there was a period of instability for some and an uncertainty on how the relationship would develop following the outcome of their sperm retrieval operation for others. Consistent with the outcome of the Webb and Daniluk (1999) study, there was a powerful sense of inadequacy for Michael; an inadequacy that he could not provide his wife with a child. Before they got married, he even asked her to leave him, as he could not fulfil his role in having a child with her. For Simon and Seth, their diagnosis of infertility brought about a need to consider alternative options. Simon did not want to delve into this too much but there was an uncertainty on whether both he and his partner would carry on agreeing about the alternative option if his sperm retrieval

operation was unsuccessful. With Seth, there was already a disagreement on the alternative options as his wife was not particularly keen on the idea of donor insemination. It seemed, therefore, that their relationship was going through an unsettling period. In a cross-sectional survey of men diagnosed five years earlier as infertile that took place in Australia, men did not describe any adverse effects on their relationship with their partner; 36% of participants reported positive effects on their relationship and 20% on sexual satisfaction (Hammarberg et al, 2010). The researchers interpreted that as an indication that "the experience of infertility can make partners in couples feel closer and more protective of one another" (p. 2819). These findings were similar to the study carried out by Schmidt et al (2005) where 21% of their male participants reported marital benefit from their experience of infertility. The above studies are an indication that there are mixed results as far as the impact on the partner relationship is concerned. In the Hammarberg et al (2010) study, the men reported on their relationship retrospectively and as we know with the passing of time, our experience of events changes. Also out of the men who completed the survey, about 80% of them had achieved fatherhood during the last five years. One can therefore assume that the situation might have been different if they were still going through infertility treatments. Nene et al (2005) and Houseknecht (1979) argued that the marital relationship improves among childless couples over the years. Even if participants had not achieved fatherhood in the Hammarberg et al (2010) study, coming to an end with the infertility treatment could make a difference to the level of stress involved. Moreover, in the Schmidt et al (2005) study, the cause of infertility was not reported so that could possibly have an impact on the relationship. Another thing that needs to be considered when thinking about the impact on the relationship is that we do not know about the level of support

and the level of satisfaction in the relationship prior to an infertility diagnosis. The impact on the relationship could also be more pronounced in societies with more traditional gender roles. Payton in the current study spoke about the importance of children in the marriage and how devalued the marriage was without them. It seemed that infertility could bring a lot of instability in the marriage and as Inhorn (2003b) reported, in Egypt, "women will go to great lengths to uphold their infertile husband's reputations – literally shouldering the blame for the infertility in public – to avoid the stigma, psychological trauma, and possible marital disruptions such disclosure is likely to instigate" (p. 249).

The issue of disclosure was prominent for all my participants in the current study. There was a clear oscillation between wanting to disclose about their infertility, and yet something was holding them back. There were different reasons for this. For some like Michael, Simon and Peter there was a tendency to avoid attending to their emotional state and they were aware that the more they spoke about it, the more impacted they would be. They wanted to discuss it, but they knew there were consequences to this. With Seth and Payton, there was also the difficulty of portraying to people something different if they knew about their infertility. Consistent with the findings of Webb and Daniluk (1999), they decided not to reach out to others for support because they were worried that they would be humiliated and ashamed. This avoidance to share their infertility difficulty was consistent in other studies as well. In the study carried out in Sweden by Hjelmstedt et al (1999), approximately 50% of men chose not to share their infertility diagnosis with anyone else. Similarly, in Italy, in Agostini et al's (2011) cohort study, they investigated perceived social support for couples from treatment initiation to one month after the embryo transfer. Men again had less social support and were less likely to discuss what they were

going through. Consistent with some of my participants in the current study, in China, men spoke about the tension they were holding between wanting to disclose and receive support and at the same time wanting to preserve 'face'. Shame, therefore, seemed to be one of the reasons that prevented them from talking about their infertility (Lee and Chu, 2001). Moreover, the findings of the study carried out by Sherrod (2006) were similar to what some of my participants reported. The participants in this study were ten men who were 50 years old and above and who had not become biological fathers. Six of these men had a male factor infertility diagnosis. Participants avoided disclosure in order to protect their dignity and they opted not to report any emotional distress.

Regardless of the tendency of men to avoid talking about their experience of infertility, however, this does not imply that they do not wish to talk. As indicated above, different factors contribute to their decision not to disclose. The current study though as well as other studies have indicated that men do want to share their experience. An example of this is the study carried out by Malik and Coulson in 2008. In the safety of an online infertility support group bulletin board, men captured the "value of being able to vent their emotions within the context of the group" and spoke about the "significance of having individuals with similar experiences to turn to" (p.24). Arya and Dibb (2016) also found that men wish to talk and suggested the importance of providing men with the opportunity to talk in order to improve their infertility experience.

These four themes clearly indicate how multifaceted the experience of infertility is for men and all the different difficulties that they have to contend with. In order to address these four major themes, I was theoretically informed by the biopsychosocial theories and this is echoed in the studies that I used. According to

Gerrity (2001), the biopsychosocial theory is an attempt to explain human behaviour in a way that addresses the interaction of biological, psychological and social factors. Infertility is conceptualised as “an acute life crisis and a non-event with long term complications” (p.152). My findings were consistent with the view that “the stressors of infertility occur in existential, physical, emotional, and interpersonal realms and maybe beyond the average person’s usual coping abilities” (ibid). The existential stressors consider the impact on identity, self- esteem and self-image and how these are affected by the experience of infertility. As it was evident in my findings and especially in the second major theme where the disempowering impact of infertility was captured, my participants spoke about how their view of self, self-image and self-esteem was affected by their diagnosis. The biopsychosocial theory also looks at the emotional and relationship stressors of infertility, which again were evident in my participants’ narratives. My participants captured the effect that their diagnosis had not only on them, but also on their relationship as well as on their support network.

Considering that the current study is to my knowledge, the only study in UK, which captured the experience of men with an exclusively male factor infertility in the here and now, I think it is fair to argue that it has managed to shed some new light on the experience of men. The following section will capture the implications that these findings have for practice.

5.2 Implications for practice

In the results chapter, the profound impact of infertility for men and the variety of emotions and thoughts they go through was captured. A powerful theme in the results has been my participants’ oscillating need for disclosure. All participants in

this study were interviewed before they went ahead for sperm retrieval operation and it was obvious that even from that point there was an anxiety for the future and the possible consequences of their infertility. Taking into consideration these findings, some possible implications for practice can be made and these will be discussed in this section.

In the Webb and Daniluk (1999) study, participants were asked to talk about their experience of infertility retrospectively. One of the things they captured was how finally talking about their experience helped as it “started to feel like a shared experience”. In fact, one of their participants said, “If I had known enough to think about it and spend time talking to somebody about it, I would have gotten through that time more quickly. It wouldn’t have taken years to finally put it to rest” (p.18). Consistent with the Webb (1994) study, some of my participants indicated that other than their partner, I was the first person to talk to about their experience. Despite their ambivalence in disclosure, they described our interviews as being “cathartic”, a “positive experience” and “helpful”. I consider my participants’ feedback essential in challenging the assumption that men might not want to talk. All of my participants came to both interviews and talked about their experience of infertility. They said things that were not spoken about before and they also shared them with a woman. At times, I wondered whether I had become their wife/partner and whether these interviews gave them the opportunity to talk about the profound impact of their diagnosis. Having a female researcher provided them with an opening where they could see what it was like talking to a woman about the difficulties involved in their experience, without having to worry about their partners since the focus was exclusively on them. The richness of the data and the findings from the study mentioned above, therefore, is an indication that it would be important to have things

in place so that men are given the opportunity to talk about their experience and what they are going through.

There is a worldwide recommendation to provide psychosocial interventions for people with a diagnosis of infertility (Lemmens et al, 2004) and in fact, a range of them has developed over the years (Boivin et al, 2001; Boivin, 2003). Some of these include provision of information (McDonough and Takefman, 1990), supportive group interventions (Ferber, 1995), cognitive-behavioural therapy (Tuschen-Caffier et al, 1999), mind-body therapy (Domar et al, 1992), emotion and problem-focused interventions (McQuenney et al, 1977) couple therapy (Stammer et al, 2002). It is important to add here though that all of the aforementioned studies are focused either on the couple or on women. RESOLVE, (the United States national infertility association) for example, offers supportive group meetings for men as well as for women and for the couples. To my knowledge, however, worldwide, psychosocial interventions are not as easily accessible to men as they are for couples and for women. According to the NICE guidelines (2017), “people who experience fertility problems should be informed that they may find it helpful to contact a fertility support group...Counselling should be offered before, during and after investigation and treatment, irrespective of the outcome of these procedures” (p. 6). Moreover, the Human Fertilisation and Embryology Authority (HFEA) (2017) which regulates assisted reproduction in the UK, stipulates that patients seeking IVF or donor insemination should be offered psychosocial counselling. This, however, implies that it is mostly left to the individual to pursue the offer of counselling or to attend the fertility support group. It is important to consider the fact that some people might find it awkward to contact a professional or they might be unsure of the benefits of seeking this support. The use of avoidance as a way of coping was very evident in

my study. The possibility of my participants reaching out and asking for professional support is therefore minimal and this could potentially apply to other men. In Hernon et al's (1995) 'review of the organised support network for infertility patients in licensed units in the UK', they stated that concerns about privacy, the cost of sessions and how they may be perceived if they attend counselling are possible factors which prevent people from accessing support. Considering these then, it might be worth making psychosocial interventions an integral part of the fertility treatment. This was in fact indicated in the Emery et al (2003) study, which was carried out in Switzerland and where the acceptance rates reached up to 80%. Taking into account the findings from the current study, I think that it would be important for an assessment of the emotional well being of men to be carried out at the beginning and throughout their journey of infertility.

As it was illustrated in the current study, there are different dilemmas that people with a diagnosis of infertility might be confronted with. One of these is the duration of treatment. If couples start treatment and it is unsuccessful, when do they decide that it is time to stop? Or if in my participants' situation their sperm retrieval operation was unsuccessful, what happens if the couple is not in agreement over the next step and the possible alternative options? This was one of my participants' concerns. These life-changing decisions, therefore, might be easier to confront with the help of a professional so I think it is vital to have this in place in all the infertility clinics.

Other than psychological interventions, "written information or video presentations about common emotional and psychosocial reactions to infertility in women and men, about coping with this condition and about typical issues in infertility counselling should be provided to the couples from the beginning of

infertility treatment" (Wischmann et al 2009:p.383). The importance of information for patients to take home was also documented by Schmidt et al (2003). Following on from this, Mikkelsen et al (2012) in their article, reported how they published a leaflet called "Men also undergo fertility treatment" in order to be distributed in the Danish fertility clinics. The aim of this was for the male perspective to be addressed. I think that initiatives like these are paramount for all fertility clinics and considering the findings of the current study, leaflets like these could go a long way in making the male journey less isolating and more supportive. In the current study, during debrief, my participants seemed to appreciate the information sheet I provided them with which included details on the different means where they could get support. In fact, Seth said during his interviews that he was hoping one of the things he would get out of participating in the study was information and more details on the kind of support that is available. I consider that in times when men have so many things to think about regarding their infertility, having some available information regarding the process, what to expect, the emotional aspects, how and where to access support would be of significance. Moreover, patients could also be informed of the different online forums that have become available recently as this was another thing that my participants were not aware of. Considering the difficulties some of my participants mentioned, access to an anonymous online forum might be very useful as a means of sharing and getting support.

Access to psychological interventions, the provision of information in a written format and the availability of online forums are significant ways of supporting men with an infertility diagnosis. The easier the access and the more easily available information will contribute to making it easier for men to talk about their experience and receive the support they might need.

Moreover, this study is relevant to counselling psychologists and psychotherapists working with this client group as it provided valuable information to practitioners about the possible themes that might come up during therapy or psychological support. Taking into consideration the recent sensitivity on men's mental health, this project can encourage a more careful consideration on the intersection between mental health and men's infertility. It can also encourage the growing number of counselling psychologists working in the community and who facilitate men's support groups to address male infertility more explicitly. This can also be echoed in research, as I think that Counselling Psychology researchers have not addressed this phenomenon adequately.

Last but not least, this study is relevant to the medical professions as it is important to attend to the interdisciplinary area as well. Potentially it can encourage conversations between different professionals. This study has indicated the importance of being relational during the patient's infertility journey. Taking into consideration how structural the NHS can be, it can bring contribution to so many levels. In order to carry out this study, contact was established with consultants who recognised the value of being relational so something important was dropped into the frame with the research. I brought the human being back into the clinic and hopefully with this study, there will be some rethinking regarding service delivery.

5.3 Strengths and limitations of the study

5.3.1 Strengths

One of the aims of this study was to try and reduce the gap in the infertility research realm as research on the male experience remains limited. This aim was met as the current study has provided the reader with more knowledge on how men

with an exclusively male factor infertility experience their diagnosis. To my knowledge, this study is also the only UK based study with the specific inclusion criteria and which used IPA as a methodology. The fact that all the participants had an exclusively male factor infertility diagnosis and they were all waiting for a sperm retrieval operation, added to the strengths of this study, as it has not been explored before. The use of IPA was consistent with my epistemological position but it also provided me with the opportunity to bring to the surface the subjective experience of my participants whilst also using my own interpretative take on it. The adoption of an idiographic perspective was a further strength in this study as it gave voice to each participant's experience but also gave me the opportunity to explore commonalities across the cases.

Throughout this research process, I have aimed to be transparent. I tried to achieve this by informing the reader about the decisions I made along the way, including my choice of methodology and the different methods I contemplated on, the interview questions I used, my recruitment process, the ethical issues I considered and the way I carried out the analysis. I tried to capture as honestly as possible the difficulties I encountered along the way and included my thoughts on my pregnancy and the possible impact this had on my interviews and subsequent analysis. As far as my contact with my participants is concerned, my aim was to be respectful and sensitive to their experience. My approach was a further strength to this study as my participants commented on its encouraging nature and the fact that they felt comfortable talking to me about an issue that was difficult and painful. Throughout the chapters in this thesis, I have included my reflexive pieces, which I think added a richer flavour to it. I ensured that I allowed plenty of time and space for the analysis to take place and for me to feel immersed in the data. The in-depth

experiential analysis of my participants' experience gave valuable insights into how it feels to have a diagnosis of infertility and all the different issues that my participants had to attend. I used a rich variety of extracts from the interviews in order to capture the experience of my participants as much as possible and to meet one of my aims, which was to give them a voice.

Moreover, my participants came from different cultural backgrounds and this could be perceived as a strength but also as a limitation. I will address the limitation of it in the next section but for now, I think the varied cultural backgrounds of my participants enriched the data as different perspectives were also explored. It was fascinating to find out how developing countries such as Sri Lanka view infertility and the different cultural expectations in comparison to developed countries.

Finally but yet importantly, it is documented, as indicated in both the literature review and the methodology chapters of this thesis, that the recruitment of men for research is difficult. Despite the fact that my recruitment process was long, one of the strengths of this study was that once participants were identified, they actually attended two interviews and not just one. The willingness of my participants to come back for the second interview comes to challenge the impression that men do not want to talk about their experience. Once they were given the opportunity to capture their experience, it seemed that they were happy to take it, even if it was a difficult issue what they were invited to talk about.

5.3.2 Limitations

Despite the contribution that the present study has made, there are also some limitations, which will be addressed in this section. This was my first experience of carrying out an IPA study and at times, I found the process daunting. My lack of

experience as I never carried out semi-structured interviews before this study, impacted on my interviewing style and my level of confidence. There were also times when I decided not to delve deeper into what my participants were capturing. For example, when they were exploring their ways of responding to the limitations of their infertility and their strong use of avoidance, I opted not to challenge them further. As I indicated in my results chapter, my experience as a psychotherapist facilitated the development of a good rapport with my participants but I was also mindful that the interviews were not a therapy session so I chose not to question them further on their coping mechanisms. Perhaps another interviewer who was more comfortable with carrying out interviews would have attended to this differently and felt more prepared to delve deeper into their experience.

When thinking about the strengths of this study, I included the different cultural backgrounds of my participants as one of them. This, however, can also be perceived as a limitation as by having participants from different backgrounds also means that the sample is not so homogeneous. This in effect means that it is more difficult to look at commonalities in the data.

Another limitation is the amount of time my participants have known about their infertility as some of them knew for a longer period. "Infertility is not a stable trait but a process with an uncertain trajectory....(*As a result*) it is crucial to know where individuals being studied stand in the infertility process" (Greil 1997:p.1689) (italics are my own addition). Despite the fact that all of my participants were still at the same stage (i.e. waiting for a sperm retrieval operation), the fact that some of them knew for a longer period about their infertility also meant that they had more time to process their diagnosis.

Finally, the recruitment process took a long time but once participants were identified, the interviews were carried out in a relatively short period. The majority of the participants had their operation date approaching so in order to ensure that I interviewed all of them, there were times when I interviewed two participants in the same week. This though meant that not enough time was spent in between participants. If I had this opportunity then I would have had more time to listen to the tapes and identify things to follow up on subsequent interviews, which effectively could contribute to enriching the data even further. The time it took me to carry out the analysis because of my pregnancy was possibly another limitation. Considering the circumstances, however, I put things in place in order to remain engaged with my data as was discussed in the methodology chapter.

5.4 Suggestions for further research

The current study added to the limited research on male infertility and provided the reader with an insight to the experience of men with an exclusively male factor infertility diagnosis. The gap, however, remains big and more studies could contribute to enhancing our knowledge on the experience of male infertility.

I suspect that the experience of men with a male factor infertility will be different to the experience of men whose partners are the source of the infertility difficulties or of men who share with their partner the infertility difficulties. This is one of the areas that could be explored further since if their experience is different, then the type of support and the information available will also be different.

As it was documented in the current study, my participants discussed their relationship with their partner. Some of them went through a period of instability and others spoke about the possibility of a future instability depending on the outcome of

their operation. This was not surprising as an infertility diagnosis throws many uncertainties for the future of a couple. Considering this, one question that is raised is what about the experience of men who did not succeed in continuing their marriage/relationship after a diagnosis of infertility?

Moreover, in the current study, the participants came from different cultural backgrounds. The information given by Payton, the participant who came from a non-Western country, added to the richness of the data. It also gave a clear indication of the difference in how infertility is perceived in more traditional oriented cultures. Further studies where all of the participants share the same culture, the same socio-economic background or the same age group will enhance our knowledge regarding men's experience of infertility. In my study, all the participants and most of the partners were in their thirties. I suspect that the experience of men and their partners who are younger might have a different experience of infertility as perhaps the time restrictions will not be so powerful.

Another area where more studies could be conducted is on men who have decided to persist with infertility treatment or on men who decided to discontinue. There is limited research on this area and what might contribute to this decision. The same applies to men who have decided to remain childless following infertility treatment. The value of longitudinal studies is also highlighted as it would be useful to know more about the experience of men at different time points during their infertility journey.

The fact that the majority of the studies on male infertility are quantitative studies, points to the importance and the need of more qualitative studies as then the men's experience can be captured in a more thorough and detailed way. All of these suggestions for future research indicate the amount of knowledge gaps that

exist in relation to male infertility. The more studies are carried out, therefore, the more knowledge we will gain on male infertility. This could potentially make a significant difference for men going through infertility, for their partners and people close to them as well as professionals who work with this client group. This includes not only fertility professionals but also counselling psychologists and psychotherapists.

5.5 Personal reflexivity

Throughout the different chapters, I aimed to capture my reflexive thoughts so in this section I will address the process of writing this thesis. Carrying out a doctoral research study had a tremendous impact on both my professional and my personal life. Previously I described the process of analysis as a rollercoaster but this term also applies in the writing up of my thesis. I am mindful of the amount of time it took me before I actually started writing it. I went through different phases and a plethora of emotions during this process. First and foremost, there were times when writing up my analysis where I felt worried about my participants and what they might think of it. I felt protective of them and privileged that they came to talk to me about their experience. For some, this was their first time of talking about it other than their partner. I wanted to do them justice and for them to feel that I captured their experience in a way that they agreed with. At times, I also found writing the analysis paralysing and felt unsure on how to capture what I wanted to say. I felt a loss of control and wondered about the possibility of a parallel process between my participants and I as they captured their own lack of control in their experience of infertility. Being able to talk through my ‘paralysis’ with a colleague was a tremendous help in moving things forward.

Overall, the journey of my research study so far has been a powerful experience. During this time, I have remained excited about my research area and the possible contribution it could make to the infertility realm. I hope I have managed to capture my enthusiasm and my interest in this area for the people reading this as well.

5.6 Conclusion

The five participants in this study captured their experience of infertility and the profound impact this diagnosis had on their lives. They described their feelings of uncertainty and lack of control. Their diagnosis made them feel different from the others who could conceive naturally. They talked about the stigma of infertility and the destabilisation of their masculinity. In an attempt to manage these powerful feelings, they responded by trying to avoid thinking about their diagnosis and by maintaining a pragmatic approach. Their infertility also confronted them with the need to think about alternative options in case their operation was unsuccessful and that gave them the opportunity to capture the dilemmas that they went through. The relational context of their experience was explored and they discussed their relationship with their partners as well as their ambivalence on the issue of disclosure. They saw the benefit of talking about their experience but at the same time, they worried about the implications of disclosure.

This study added to the limited amount of research on male infertility and contributed to enhancing our knowledge of men's experience. Possible implications included making psychological therapy an integral part of the treatment process, providing male patients with written information and making them aware of the availability of the different support groups and online forums.

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Appendices

Appendix I – Project's Ethics Approval

METANOIA INSTITUTE

13 Gunnersbury Avenue
Ealing, London W5 3XD
Telephone: 020 8579 2505
Facsimile: 020 8832 3070

Anastasia Panayiotou-Enness
Doctorate in Counselling Psychology and Psychotherapy by Professional Studies (DCPsych)
Metanoia Institute

14th May 2018

Dear Anastasia,

Re: Living with infertility: an exploratory study of men's experience

I am pleased to let you know that the above project has been granted ethical approval by Metanoia Research Ethics Committee. If in the course of carrying out the project there are any new developments that may have ethical implications, please inform me as research ethics representative for the DCPsych programme.

Yours sincerely,

D. M. Steed.

Duncan Steed
Senior Academic Coordinator DCPsych
Faculty of Post-Qualification and Professional Doctorates

Patricia Moran [redacted]

Sun 17/06/2012, 11:08You; [redacted]

Dear Anastasia

RE: Living with infertility: an exploratory study of men's experience

I am pleased to let you know that the above project has been granted ethical approval by Metanoia Research Ethics Committee. If in the course of carrying out the project there are any new developments that may have ethical implications, please discuss these with your research supervisor in the first instance, and inform me as Chair of the Research Ethics Committee.

Yours sincerely

Patricia

Dr Patricia Moran

Research Co-ordinator

Chair of Metanoia Research Ethics Committee

Metanoia Institute

Registered in England and Wales at:

13 North Common Road, Ealing, London, W5 2QB

Company No. 2918520

Tel: 020 8579 2505

Fax: 020 8832 3070

Web: www.metanoia.ac.uk

Registered Charity No. 1050175

Please note that the original email was sent from Dr Patricia Moran who was the Chair of Metanoia Research Ethics Committee at the time. As this was done by email, the present Senior Academic Co-ordinator of the DCPsych, Duncan Steed has also confirmed the ethics approval via a letter.

Appendix II – Guidelines for the consultants

Guidelines for handing out the information sheet to prospective participants

Which patients will be eligible for this research study?

- Men diagnosed with ***an exclusively male factor infertility*** who ***do not have any biological children***
- Primary infertility
- Participants will have a diagnosis of ***azoospermia***
- Two interviews will take place two to three weeks apart ***before*** patients go ahead with the operation to see if sperm can be retrieved
- ***Number*** of participants needed***: 4 – 8***

Guidelines for handing out the information sheets:

When the patient meets the above criteria:

1) Please hand them out the information sheet and inform them that an independent study is being carried out to look at the experience of men going through infertility.
2) If they want any more information or they are interested in participating then please ask them to contact me (details on how to contact me are on the information sheet)
3) ***Due to ethical implications certain practicalities need to be put in place*** so that it will be possible to interview all the participants that come forward and not having to decline any: please keep account of how many information sheets you hand out. Start by handing out 8 and keep a note of the names of

the people you have given it to (you will not need to tell me the names) but it is in order to make sure that we know which ones will go forward with the operation. Once the patient goes ahead with the operation then they are no longer eligible for the study and more information sheets can be given out. Once I have any participants coming forward, I will let you know so that you are aware of what is happening from my end.

For example: give out 8 leaflets and write down their names

A B C D E F G H

If D and G go ahead and have the operation then you will know that they are no longer eligible and as a result you can give out information sheets to I and J.

As soon as someone comes forward then I will let you know so you are informed of how many people I have interviewed already.

Appendix III – Participant Information Sheet and Consent Form

Participant Information Sheet

Research title: Living with infertility: an exploratory study of men's experience

I would like to invite you to take part in a research study. Before you decide, it is important for you to understand why the research is being carried out and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask me if there is anything that is not clear or you would like more information. Take time to decide whether or not you wish to take part in this study.

Thank you for reading this

What is the purpose of the study?

Most people approach adulthood with the assumption that they will eventually become parents if they want to. One in six or seven couples, however, are finding it difficult to have a child. There is an enhanced knowledge of the experience of infertility for women but despite some exceptions, the same does not apply to the experience of men. The purpose of this study, therefore, is to explore how men who have been diagnosed with an exclusively male factor infertility problem experience their diagnosis.

Do I have to take part?

It is up to you to decide whether or not to take part. If you decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If

you decide to take part, you are still free to withdraw at any time and without giving a reason. You could do this by sending me an email, calling me or even informing me face to face.

What do I have to do?

If you decide to take part in this study then this will involve two interviews, which will last for approximately one to one and a half hours each. Both of the interviews will take place **before** you go ahead with the operation for sperm retrieval and will be two to three weeks apart. The interviews will involve a one to one meeting with you and a researcher who is independent from the clinic. The interviews will be semi-structured which means that the researcher will ask you different questions and then help you explore your answers by discussing them in order to make sure that your point of view has been understood. The questions will be about your experience of infertility and what it means to you to have this diagnosis.

The interviews will be carried out by myself, Anastasia Panayiotou-Enness at the clinic at a suitable time for both of us. I have a lot of experience working with clients and I will do my best to make you feel at ease whilst conducting the interview in a sensitive and professional way. You will also have a discussion with me at the end of the interview to see what it was like for you and if you have any further questions that you might want to ask me.

What are the possible risks of taking part?

There is a possibility that talking about your experience might upset you. If this happens during the interviews, then you can either stop altogether or you can take your time and take a break before continuing. I will also talk to you about the

interviews at the end to see how you found them. Information will be provided to all participants or a referral will be made if you wish, to some free or low cost support services if you want to discuss what has come up further.

What are the possible benefits of taking part?

I hope that taking part in this study will help you. However, this cannot be guaranteed. The information I get from this study will help in gaining more insight on the experience of men diagnosed with infertility and what they might need. It may also be useful for the counselling psychologists, psychotherapists and other professionals working with men diagnosed with infertility as it will provide them with more information on how to support this client group.

Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you which is used will have your name and address removed so that you cannot be recognised from it.

The interviews will be tape recorded and later on transcribed. No one other than the researcher, however, will have access to the tape recorder. All data will be stored, analysed and reported in compliance with the Data Protection legislation in UK. All the tapes will be destroyed at the end of the research.

What will happen to the results of the research study?

The data collected in this study will be part of a doctoral research project, which might also lead to a research publication. If this is the case, any information used will be made anonymous so that the people involved will not be recognised.

When the study is complete and if you wish to obtain a copy of the results then you can either request it from myself, Anastasia Panayiotou - Enness or contact Metanoia Institute/ Middlesex University who can then inform you of the results.

Who has reviewed the study?

The study has been reviewed by Metanoia and Middlesex University Research Ethics Committees and was given favourable opinion.

Contact for further information:

If you would like to discuss this study further then please do not hesitate to contact either myself or the academic supervisor. If you would like to participate in this study then please contact me via email or telephone.

Researcher:

Anastasia Panayiotou - Enness

Email: [redacted]

Telephone number: [redacted]

Academic Supervisor:

Dr. Jenifer Elton Wilson

Metanoia Institute

13 North Common Road

Ealing, London

W5 2QB

Email: [redacted]

Date: .....

Thank you for taking the time to read this

PARTICIPANT CONSENT FORM

Participant Identification Number:

Title of Research Project: Living with infertility: an exploratory study of men's experience

Researcher: Anastasia Panayiotou – Enness

Please initial box

1. I confirm that I have read and understand the information sheet dated ..... for the above study and have had the opportunity to ask questions.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. If I choose to withdraw, I can decide what happens to any data I have provided.	
3. I understand that my interview will be taped and subsequently transcribed	
4. I agree to take part in the above study	
5. I agree that this form that bears my name and signature may be seen by a designated auditor.	

_____	_____	_____
Name of participant	Date	Signature

Anastasia Panayiotou – Enness	----------	_____
Researcher	Date	Signature

1 copy for participant; 1 copy for researcher

Appendix IV – Interview Questions

1) How did you find out about your diagnosis of azoospermia?
2) How do you experience your diagnosis?
3) What does it mean to you to have this diagnosis?
4) How do you feel talking about your experience with me?

Appendix V – Information for the participants

Information to be given to my participants at the end of the first interview:

1. Name of therapist: [redacted]

[redacted] has worked as a psychotherapist for the past eleven years and has a lot of experience with fertility issues.

She is a Professional Member of the Foundation for Psychotherapy and Counselling FPC (WPF), Member of the British Association for Psychotherapy and Counselling (MBACP) and a Member of the British Psychoanalytic Council (BPC).

She offers therapy face to face, by telephone or over the internet.

Her contact details are: [redacted] and she is based in [redacted] You can also contact her via email on [redacted] or visit her webpage [redacted]

[redacted] has agreed to charge [redacted] per session but if you contact her please let her know that you have spoken to me and you are one of my participants. Alternatively if you wish, I am happy to make the referral for you.

2. If you wish to find your own therapist you can visit: www.bica.net. This is the website for the British Infertility Counselling Association and it contains information on how to access different therapists

3. If you do not wish to speak to anyone but would like some help you can access www.llttf.com. *This means 'Living life to the full' and you can sign up for free in order to access information on different self help content.*

4. If you would like to access different forums and get in touch with other men with similar infertility issues you can access: http://www.mensfe.net or www.dailystrength.org (American Website) which are for free or http://www.infertilitynetworkuk.com/ with £20 per year.

Appendix VI – Process of analysis

Line	Transcript	Exploratory comments	Emergent themes
206 207 208	And I guess with this, erm. The way I kind of look at it is at least I definitely know I wanted to have a child (laughing). And I would do kind of anything to have one.	Having a problem showed him how much he wants children Determination – I would do anything to have one – importance of having one Laughter – more sadness than anything else for wanting something and not sure if you can have it	Strong desire to have a child Urgency/desperation to have a child
209	Uh huh		
210 211 212 213	But erm. Yeah. So that's kind of. I think I'm kind of, it hasn't really erm. I'm not sure how other kind of men handle it and deal with it. I guess it can be, there is definitely a big part of erm. Not feeling like a man.	Wonders about other men and how they handle it Issue of not feeling like a man A big part of not feeling like a man because you can't reproduce	Destabilisation of masculinity
214	Uh huh		

215 216	Erm. Because you can't do that. Erm. But luckily that. I never had that feeling too much.	Sometimes but not too much – the feeling of not feeling like a man	Destabilisation of masculinity
217	Uh huh		
218 219 220 221	I guess other men, I don't know how they see it. Erm but it's never really been that for me it's kind of erm. Yeah. I don't know how what it's been like for me. It it's kind of like okay it's just almost like a test.	Wonders about other men a lot – not sure about the impact for them Repetition though about how others are finding it – isolation He doesn't let himself think too much about what it has been like for him – avoidance It is a test for him	Avoiding disclosure The inescapable call to accept the 'out of design'
222	Uh huh		
223	Erm…And a hurdle in life to kind of overcome.	He thinks of it as a hurdle for him to overcome	The inescapable call to accept the 'out of design'
224	Uh huh		
225 226 227	Erm. And really it's a bit frustrating kind of like it's that I want to move on to that chapter of my life and kind of and, and I have go to by this kind of, kind of things are out of my control.	Frustrating that he needs to go through this Out of his control Ready to move	Lack of control Having children as the next life stage

		on to the next chapter of his life but he is stopped – lack of control Inability to move to the next chapter of his life	
228	Yeah		
229 230 231	In terms of that kind of that kind of thing, but I guess with any, with those any, with even like with natural conception, it's essentially out of your control anyway it's just kind of.	Natural conception is out of your control in a way	
232	You don't know how long it's going to take.		
233 234	That's it, that's it so kind of erm. I think I am a bit of a control freak so erm. I like to kind of, I like to plan.	Contradiction → things are the way they are vs. He likes to plan Being a planner – I wonder how difficult this is for him as it is out of his control	Lack of control
235	Uh huh.		
236	I like to know what I am doing, and when I'm doing it.	Likes to plan	Lack of control
237	Uh huh.		
238 239	Erm. So. This is may be puts me out of my comfort zone because it's not part of my timetable.	Out of his comfort zone – not part of his timetable – lack of control	Lack of control
240	Yeah.		
241	And I think I kind of, it will never have been erm. So, yeah.		
242	Uh huh		
243	And then you kind of I guess we are here and it's kind of	Latter stages	

244	coming to the latter stages now.	now of the process – trying to make the situation better?	
245	Yeah.		
246 247 248	Of the whole kind of process and we will see where it goes from here. Because it's not 100% that once I have the operation they will find sperm.	Uncertainty – does not know the outcome It does not mean that with the operation they will find sperm – reality of the situation	Facing the unknown
249	Uh huh.		
250 251 252	And I will be able to have a child of my DNA. So I'm almost, I have almost kind of resolved my mind to the fact that I might have to get a sperm donor.	Already thinking that it might not be possible – starting to think that he might need to think of other options preparing himself – planner – ways of managing Realisation that he might not have a biological child – reality of diagnosis Use of 'I' here – lonely/individual process	Being pragmatic
253	Right. So that is something you have discussed.		

254 255	Something I have discussed. I think that I. Do I have a problem with it and I do and I don't.	Sounds like he has said to his wife what he wants Puts emphasis on 'I' – individual process, wife not that much involved	
256	Uh huh.		
257 258 259 260	Obviously yes, if there was great circumstances then I will have a child that would be biological, biologically mine erm. But at the same time, if even if it was by a sperm donor I will still be the father.	Looks for silver lining – I will still be the father He is ok with the idea of sperm donor	Strong desire to have a child
261	Yeah.		
262	So that's the kind of way I am looking at it.		
263	Uh huh.		
264 265 266	Erm. Because I'm more interested in being a parent rather than kind of being a biological father. I think there's a difference. A biological father doesn't mean it's a good parent.	More important to him to be a parent than a biological father – importance of having a child for him – what it means to him	Strong desire to have a child
267	Yeah.		
268 269	So that's the way I'm kind of looking at it. And I have less of a problem with it than my wife.	Wife has a problem with the idea of donor insemination	
270	Oh really.		
271 272	Yeah, she is kind of, she want to kind of, kind of like, she's like no but it has to be yours, it has to be yours.	Repetition – wife has strong	The pressure caused by others'

		views about this and wants it to be his What does that mean for their relationship? Disagreement on alternative options	expectations
273	Uh huh.		
274 275	But I don't think she, I think she understands but she doesn't… May be because she hadn't been part of the process.	Wife does not understand but has not been part of the process – lonely process	Feeling isolated
276	Uh huh.		
277	Erm.		
278	What do you mean by the process?		
279 280 281	As in when I go for tests and that kind of stuff erm. Quite a long. I'm quite independent and have never really gone to anybody with my problems.	Private person – deals with problems on his own Is it independence not going to someone with your problems Is his wife an 'anybody' – even with her he has kept her out of it	Overstating self sufficiency
282	Right.		
283	I have always kind of dealt with my problems within myself.	Deals with problems within	Feeling isolated

		and on his own – lonely process	

Appendix VII – Major themes and subthemes from all the data

Major theme 1: The emerging notion of fatherhood	
Subtheme 1.1 The imperatives of fatherhood	
Michael	• We want children. we want children...children is what this is all about (i2, l. 113 – 115, p. 4) • I've always been broody, probably one of the worst people around. Just say you had a child in here just walking over there I would just want to cuddle it (I2, L. 172-174, P. 6) • Even though we are a couple, we're married, it's still not enough I need something else in my life. She's done wonders I'm not pushing her away or anything but I need more. (I2, L. 235-238, P. 8-9) • well that's the next thing isn't It, I've got a one bedroom flat but don't own it but we've got a one bedroom flat we're just about to get married surely the next thing is (I1, L. 623-626, P. 20) • I think if I knew about this when I was younger I wouldn't have been interested in children because obviously I was younger. Now I've come to that stage in my life... I'm married now so that's the next stage (I2, L. 1363-1368, P. 44) • When I have a child it's going to be a million times harder cause they're going to be on your case all the time, but it's sort of helping me, I can care for something else. (i2, l. 220-223, p. 8) • I've always wanted to... when I was 16 my brother was born... I had him all the time, my stepfather was always working away so he wasn't always there and the first words he said to me was 'dad'. I was like no I'm not your dad I'm your brother but it felt nice. (I2, L. 240-251, P. 9) • She spent a year training to be a midwife, and she goes I'm only doing it to get the frills of babies away from me, she was

	getting broodier and broodier and broodier. (I1, L. 690-693, P. 22)
Simon	• We would like to have our own kids yes. And in terms of work we are, we are okay. Money wise, we will be…earn enough to have a kid. Yeah, we would like to have our own kid yeah. Having a kid is the next step. We decided erm, that erm we are ready for a kid. (I1, L. 625-635, P. 21-22)
Peter	• A bit unusual for a woman I know but she was never really had major urges to have kids. Erm. So we left things quite a while. Subsequently she is pushing the kind of, the sort of time boundary. I think she is kind of getting the urge. She doesn't feel a drive to give birth as such. But I think she has got that kind of want something to love kind of wants a child kind of drive. (i1, l. 45 – 52, p. 2) • she was perfectly, you know, she was completely non-plused as it were about having children, she just kind of was like, oh I don't really care about it, I don't really need to worry about it and left it at that. Erm. And we were talking about it for a while or we started to talk about it and I have been saying oh I'm not really interested kind of thing and then I think got to the point where she was; that she then made a definite decision that she said she wanted to do it. (i2, l 526 – 535, p. 17-18) • In terms of my experience of the process...I am being driven by my partner she wants to do this. I am happy to do it. (I1, L. 124-127, P. 4)
Seth	• I definitely knew I always wanted children. There was never a question if I wanted children or not. I definitely always knew that I always was going to have children and that kind of thing and I wanted. That was definitely going to be part of my life. (p4, i2, l. 3162-3165) • And I would do kind of anything to have one. (P4, I1, L. 207 – 208) • I'm conscious that I want to have children sooner rather than later. (p4, i1, l. 910-911) • I haven't got a timetable in my head but I know that I am wanting to have them quite soon in terms of having a child.

	Either way. Erm. As in like whether it's kind of from a sperm donor. I know kind of I want to make that kind of. That step soon (p4, i2, l. 217-225) • It was like a life achievement that I kind of ticked off my box. And then we're like okay now I can kind of, I can almost kind of go on to the next kind of chapter...children and kind of becoming parents (P4, I1, L. 145-151) • Erm. And really it's a bit frustrating kind of like it's that I want to move on to that chapter of my life and kind of and, and I have go to by this kind of, kind of things are out of my control. (P4, I1, L. 225-227)
Payton	• And I lose my generation…traditionally we have the male side carrying the tree...I'm not going to have that.. yeah…so it's a big thing for me (i2, l. 126 – 131, p. 5) • It's a big thing for me because one thing is…it's a big thing I didn't have proper family because me and my wife to take our relationship…to strengthen our relationship we need a child. (i2, l. 116 – 119, p. 4)
Subtheme 1.2 Envisaging a life with children	
Michael	• I know the priorities will be nappies, milk, I think she will initially breast feed first but then I will still have to do the milk duties as well because she can't be up 24 hours a day (I2, L. 368-373, P. 13) • she'll probably do night shifts I'll do day shifts I dunno how it will work (I2, L. 378-379, P. 13) • What we're going through watching friends and family having children it's hard but it's also that's us one day, that's us one day. (I2, L. 160-162, P. 6) • I'm quite happy to do the father daughter thing, that's the sort of thing I'm looking forward to so I've had dreams of it and can see myself already doing it (I1, L. 662-665, P. 21-22) • I only want one child, every man says I want a boy for the name, nah I want a girl, every dream I have, I seem to have I want a girl. (I2, L. 164 – 166, P. 6)

Peter	• I would need the misses to kind of keep a lid on me occasionally because I might have a bit of a tendency to be too strict. Erm. As long as I've got her there to kind of keep me a bit more reasonable. Then I will be good (i2, l. 670 – 676, p. 22) • And I think it will be a lot of fun actually. If no other reason then I get to become a big kid again myself. (I1, L. 72-74, P. 3) • I think I would enjoy having children. Because, yeah, I get on pretty well with kids. (i2, l. 668 – 670, p. 22)
Seth	• I don't want to be an old parent...And that or be old when my children are may be turning 15, 16 and that kind of stuff... Erm I want to be able to kind of like be active and be a kind of erm. Be kind of obviously I think all parents will be kind of emotionally there but at the same time I want to be physically there and be able to do things with them and not feel inhibited by kind of, kind of old age. (p4, i1, l. 913-922) • I want a child because I think and I hope I will be a good parent and guardian in the true sense. A guardian in the true sense of the word and kind of bring in a new life into the world and kind of and that person being a productive part of society. Erm is the most important thing for me. (p4, i2, l. 3141-3146)
Subtheme 1.3 Ambivalence in becoming a father	
Michael	• the goal is obviously at the end of this to go through what ever grief and pain and tears for that I'll do it (I1, L. 669-671, P.22) • I'm willing to go through ten –twenty more operations if I need to, I would do absolutely any, I would chop my arm off to have a child, that's what it is. (I2, L. 404-407, P. 14) • don't get me wrong I can't wait to be a dad but that's freaking the hell out of me as well (I1, L. 620-621, P. 20)
Simon	• We decided erm, that erm we are ready for a kid. And the thing is you are never ready. Until you get it. Erm, but yes we decided that we are going to try and so we tried. (i1, l. 635 – 642, p. 22)

	• But I have made a decision that we are ready, we are. (pause) I don't know. (pause) We are not ready to have kids. We don't know that. (pause) We are trying to have kids. And so we made a decision that we are going to change our life.
Peter	• I am, from my own opinion still not particularly swayed about having kids either way (I1, L. 54 -56, P. 2) • I'm not sitting here saying I really must have kids...really want them. (i1, l. 67 – 69, p. 3) • I'm not one of those people who just must have children at any cost so therefore there's all of these other things which you would have to do first. (i1, l. 164 – 167, p. 6) • Again as I say I have never been one to really think must have children. (i1, l. 203 – 204, p. 7) • I wasn't overly fussed because I have not really been looking at having children. It doesn't really bother me. (i2, l. 238 – 241, p. 8) • I am you know more than prepared for what we are about to enter into and understand because of having younger siblings and exactly what I am letting myself into. (I1, L. 127 – 130, P. 4-5) • Well I was never interested before because when I was younger as I say, I am, I am a thinker, I am someone who looks at all the possible consequences so unless I am completely prepared for something... I wouldn't enter into it lightly... And you are never really completely prepared for children (i1, l. 147 – 155, p. 5) • But I genuinely believe that once, if and when and once as it were that changes and we have children then you know I will wonder why I didn't do it sooner. (i1, l. 135 – 138, p. 5) • My partner wants to do it. I can see that if I don't do something about it in the next number of years, I will look back and go why didn't I do that. (i1, l. 1234 – 1237, p. 39) • I'm not so fussed about it. I think at the very end of the process if it turns out it doesn't happen, there will be some disappointment on my part.(i2, l. 376 – 378, p. 13)

Major theme 2 The disempowering impact of infertility	
Subtheme 2.1 Confrontation with uncertainty	
Michael	• The medication, but the medication has been off, so I need the medication to keep me going. But I can't have the medication if I'm trying for a baby because, well it's the Nebido because it's pure testosterone and what it does it doesn't produce sperm. It doesn't help it blocks it, so I have to come off it to make my body work. (I1, L. 133-144, P. 5) • with the nebido there's a lot of side effects with mood swings... terrible, when I'm on it I'm probably the best way was when I was taking drugs I was high so it was sort of like a menace I've never had it in my body so it shoots up....It gave me a lot of mood swings which one day I am the nicest person on earth...basically I'm Jaclyn and Hyde and there was lot more of the Hyde business they were some of the biggest issues just trying to deal with it. (I1, L. 80-93, P.3) • once I'm coming off IVF or after if I do have children I will have to have this for the rest of my life... erm probably just to keep the sexual side up (I1, L. 101-105, P.4) • There must be something, obviously there's always something new coming out and I'm willing to take anything new but I don't want to be taking the injections for the rest of my life because they're not the nicest things to take. (I1, L. 302-306, P. 10-11) • It is hard to deal with but as long as I take the medication that's what the medication is there for. As long as I carry on taking the medication I'll be fine. (I2, L. 1238 – 1241, P. 40) • The blood test before said they are but are they live? This is all it's about...we don't know if they are live or not. (I1, L. 146-148, P. 5) • Does that mean the fluid in its self you know from the tube, obviously that might be producing the sperm going with it or is

	there a blockage down there why they're not working and she's not falling pregnant. (I2, L. 1202- 1206, P. 39) • This is the problem I don't know how intent as there's so much research going on and there's still a lot more to be done (I2, L. 67-69, P. 3)
Simon	• Because we can't change it. I can't change the fact that I can't have erm, I don't produce sperm or if I produce they don't come out. Erm, so I can change nothing. (i1,l. 1141 – 1144, p. 39) • Because time goes by and you experience more and more and more and there is a lot of things I can't control that I thought I could. That's why I used condom and I thought I would need it but it seems I don't (uncomfortable laughter). Er. For that stuff to get pregnant or not. Erm. Yeah. (i2,l. 731 – 738, p. 24) • Because I can't control nothing. I can't erm. I am just waiting. I am just waiting. (i1, L 658 – 662, P.23) • And I know the problem, I know the solution. What can go wrong or what to do. And at the moment what I need to do is. Wait. And because I am all this situation, I can't control it. There is no point of be worried or concern, or, or unhappy or sad, or whatever. It's what it is. (i1, l. 1632 – 1640, p. 55 – 56) • We have been trying for almost two years and we know the reason. So problem solved. And now we are trying to solve it. And I can do nothing about trying to solve it. It's in the doctors hands. And erm. That's it. (i1, l. 1172 – 1176, p. 40) • We can't and erm. It's just now waiting for the things to happen. And I can do nothing about that. It's waiting. (researcher) So does if feel quite hopeless in a way or helpless not being able to do much until you just kind of have to rely on someone else to give you…(participant) (laughs) Yes, yes. Because I can't control nothing. I can't erm. I am just waiting. I am just waiting. (i1, L. 649 – 662, P. 22) • I can't stop my life... So there is no point.. But erm...yeah just waiting.. That's the story... For the…what's happening now…

	it's the waiting. (i1, l. 1235 – 1250, p. 42-43) • It doesn't make a difference because we know it's my problem. Erm... the only thing that makes a difference is because she is getting older... She is 35 and we don't want to wait until she is 40... Because it's only five years ahead. (i1, L. 327 – 333, P. 11) • But it's a waiting game. Of course it's a bit difficult... Because erm time flies. (i1, l. 395 – 398, p. 13 – 14) • Because the problem on these is there is always pressure because we have started to try to have a kid at the beginning of 2011. So 2011, 2012, we are in August 2013 and operation, IVF blah, blah, blah will be 2014 so three years. It's a lot of time. And that's the problem when you don't know, then you know, then you wait and. Then treatment and then waiting again to make sure she's pregnant. That's what is tough. (i1, l. 1786 – 1798, p. 61) • Because time goes by and you experience more and more and more and there is a lot of things I can't control that I thought I could. (i2,l. 731 – 734, p. 24) • It is tough. It's a bit hard because we are waiting... For something we do not really know when it will happen. Because we don't have a date. We don't have a date. (i1, L. 367 – 373, P. 367 – 373, P. 12-13) • Erm and the only thing I have concern is with outcome If it all goes well, if I don't struggle the day after Because they are kind of mixing with my and touching my erm. Private…(chuckles) Area. (i2, L 37 – 46, P. 2) • Erm. I am just, I am just concerned with erm with outcome... If it's going to be successful or not. And if I am going to suffer a bit. And then if everything works well after. (i2, l 216 – 222, p. 7-8) • It's hard. Because we are trying to have our kids and it doesn't work. Something is wrong. And....we never. We didn't think it was her or me, we just thought there was something wrong (i1, L. 144-152, p. 5) • It's not difficult, it's not tough. What was tough was the not

	knowing, that why can't we have a kid. We have been trying for almost two years and we know the reason. (i1, l. 1170 – 1173, p. 40) • The only thing here which is difficult is we have almost two years we are trying to have a kid and we didn't know the cause. We know the cause, we are trying to. We have done everything we can. (i1, l 1414 – 1418, p. 48) • This is I think what I can say about this infertility issue and on balance is. The problem is when you are trying to have kids. It doesn't matter if it's the men or the female. Erm. The problem is when you don't know. What's going on? Is it me? Is it my partner? It's both. But when you find out and then it's done. You know the problem. The only thing to do next is find a solution. (i1, l 1657 – 1668, p. 56- 57)
<u>Peter</u>	• We are realistic in the fact that the odds may not favour us because the age of my partner... Erm because she is now passed 40. (I1, L. 106 – 110, P. 4) • But time has beaten us to it now. So now we just have to proceed and kind of make the best of it. (i1, l. 167 – 169, p. 6) • But what they have said to me is even if they get it sorted it can take up to a year for that to actually come through which is part of the reason having the IVF procedure... Because obviously my partner is not getting any younger. (i1, l. 372 – 378, p. 12-13) • Realistically we should have started quite a lot sooner because then we would have found out and I could have had all the stuff finally done and possibly conceived naturally (i2, l. 538 – 541, p. 18)
<u>Seth</u>	• Erm. And really it's a bit frustrating kind of like it's that I want to move on to that chapter of my life and kind of and, and I have go to by this kind of, kind of things are out of my control. (P4, I1, L. 225-227) • I think I am a bit of a control freak so erm. I like to kind of, I like to plan... I like to know what I am doing, and when I'm doing it... Erm. (pause) So. (pause) This is may be puts me out of my comfort zone because it's not part of my timetable.

	(Se, I1, L. 233-239) • May a little bit of anxiety in terms of kind of…I think it kind of unknowing. I have never really had any operations. (p4, i2, l. 99-101) • It's the first time something is like this is kind of taking place for me. (p4, i2, l. 108-109) • Because it's not 100% that once I have the operation they will find sperm. (P4, I1, L. 247-248) • It's just that this is kind of on the back of, on the back of the kind of the situation and it's kind of, it's almost kind of it's erm. Overhanging. It's overhanging above us (p4, i1, l. 773-775) • How do I feel? Instinctively I want to say weak. That was the first word that came to my mind weak... Erm. Those times. I no, I think I can remember one day I just thought negative. Erm. Is the best word I think. Negative and just kind of, deflated. And just kind of like just there's no kind of, kind of it's just all you are thinking about is the here and now and not looking to, you are not looking towards the future and you just kind of you are just stuck in your own kind of self pity if you like. (p4, i2, l. 3238-3260) • I felt deflated and to kind of in that way kind of in a dark place if you like. Erm. (pause) Just worried about the future and what the implications. Yeah and what this means and where we go from here. (pause) Erm. And kind of just kind of thinking like you have no options...It's definitely kind of worried about the future. (Se, i2, l. 3291-3310)
Payton	• I want to have a baby soon but I have to wait….I can't do anything (i1, l. 541 – 542, p. 18) • suddenly I got really shocked then sad and I had to deal with it and I spoke to the doctor 'how can I do' (i2, l. 40 – 41, p. 2)
Subtheme 2.2 The debilitating sense of differentiation	
Michael	• terrible, it's been hell because it's thinking that I'm not a human being, I mean the amount of times I have broken down thinking there's something wrong with me I'm not a

	human being (I2, L. 1217-1220, P. 39) • when I first found out I got the syndrome and they showed me all this weird and wonderful thing I thought to myself I'm not a human, there's something wrong with me, why has there always got to be something wrong with me (I2, L. 1386-1390, P.44-45) • there was something wrong with me I knew then there was something wrong with me (I2, L. 840-841, P. 27) • knowing that other people out there can have them (I2, L. 169-170, P. 6) • What we're going through watching friends and family having children it's hard(I2, L. 160-162, P. 6)
<u>Simon</u>	• Erm... Yeah just erm... it's a pity we can't have it on the normal procedure. Which is quite nice the normal procedure. But erm. We can't and erm. It's just now waiting for the things to happen. (i1, l. 644 – 650, p. 22) • The only thing which is difficult in the whole story is it is hard to find out that erm. You can't have a kid on like everybody else. Normal, naturally just doing love and after nine months you have a kid. That's what is hard on this. (pause) It's finding out that you can't have a kid naturally. (Si, i1, L. 880 – 886, P. 31) • We can't have like normal ways because I can't have kids normal. (i1, l. 1054 – 1055, p. 36-37) • It's just we know that we cannot have a kid. Erm. Normally. Like normal people (i2, l 1134 – 1139, p. 37)
<u>Peter</u>	• I mean, I'm hoping they find something and they can just fix it there and then because great… (I1, L. 370 – 372, P. 12) • To be honest it's nice to know there is a problem only because then hopefully it can be fixed. (i1, l. 468 – 470, p. 15) • Not at all. This is one of those things that they've found a problem hopefully they can fix it. And we are going through a process to work around it. (I1, L. 1181 – 1185, P. 38) • And I know it's part of getting older because you have more responsibilities and stuff, so this issue came along and I'm like well fine. It can be fixed, dealt with just get on and do it I don't

	have to worry about it. That's probably why I'm responding like this. (I1, L. 1214 – 1219, P. 39) • I am in a position now where I think well if something's wrong it needs to be fixed. (i2, l. 241 – 243, p. 8) • Then if they fix me if you like, if they can find out what's wrong and actually sort that then basically that opens up a very slim possibility of something happening naturally. (I1, L. 118 – 122, P. 4)
Seth	• Obviously kind of everyone that's going through this is totally kind of new and and erm. I think kind of isolated. Because there is a so little about it (p4, i1, l. 1210-1216) • It's nice that because you are doing the study and there is other people out there that are dealing with this so it's not just me. Erm so that's kind of comforting (p4, i1, l. 1362-1366) • You know you are, you know you are not the only one dealing with it but at the same time you kind of like where are these people. (p4, i1, l. 1216-1218) • So it's almost reassuring it's kind of, you don't want people, you don't want people to have a problem do you but you kind of it's like, it's kind of like oh yeah yeah...it's isolation (p4, i1, l. 1587-1593)
Payton	• I was shocked because my father, we are seven of us and my father's side and even my mother's side everyone has children, my siblings everyone had children so it was a big shock (I1, L 113 – 116, P. 4) • I felt shocked because in my family no one had this problem (i2, l. 32 – 33, p. 2)
Subtheme 2.3 Carrying the burden of stigma	
Michael	• I was like I'll give you the letters I won't actually tell you what I'm having done I'll give you the letters. (I2, L. 1165-1167, P. 37) • a few of my pub colleagues know about it, a couple of them you can't tell about it as they would just spread it around everywhere but a couple of them I told them while they were

	sober because I know they're not going to say anything whist they are drunk, and I told them and it was easy I only told a section of family because they're close to me the rest of my family they don't need to know (I1, L. 888-897, P. 29)
Peter	• Because you don't rock up in a pub and within 30 seconds go by the way. I have been had this test and this has happened...you would be like well actually we'll have a few drinks first and then I might talk to you about it. (i1, l 619 – 627, p. 20)
Seth	• At the same time I don't want the reprisals...Of speaking with friends and family and that whole situation. (p4, i1, l. 1355-1357) • I shouldn't feel afraid to talk about it. (p4, i1, l. 1403) • I think definitely speaking to someone else removed from your kind of social circle and that kind of stuff is definitely easier...because there is no judgement (p4, i1, l. 1139-1143) • If they are going to ask me it could have the, it could have a detrimental effect. In terms of kind of like other people knowing and getting kind of the word being kind of spread around. And may be just going to kind of people that you don't really kind of want kind of knowing this information. (p4, i2, l. 1947-1954) • He would totally understand and he will be supportive. And that kind of thing. So I am not worried about his reaction. I'm, it's, just how do you tell someone. I think it's almost it's kind of like if you was gay, how do you tell someone you are gay? Erm, it's kind of, it's almost like that. (p4, i1, l. 1085-1091) • I'm not putting my kind of, my name to anything I'm kind of like yeah this is me everyone kind of like, this is, this is kind of like this is, this is what I am all about. (P4, I1, L. 1150-1152) • If a woman was unable to conceive or was barren erm. She will be in the eyes of others, less of a woman. I think the same for a man as well. (p4, i1, l. 687-689) • You don't want the questions and you kind of I don't know what it is. Yeah definitely obviously there is a stigma attached to it and you kind of, and in terms of kind of being less of not

	being able to. (p4, i1, l. 703-706)
Payton	• Cultural issues for the community there are more respecting so you know I don't have that status. (i2, l. 121 – 123, p. 4) • because we should have a family culturally, if someone didn't have a child they wouldn't be respected in the important festivals or celebrations... they will skilfully avoid them (i2, l. 233 – 239, p. 8) • and in our culture it's a social stigma erm if you don't have children (i1, l. 136-139, p. 5) • if she has donor we're not going to say it to anyone and they think it's our children (i1, l. 566 – 568, p. 19) • But if I talk to my colleagues and they are not good friends…they are acquaintances in my work place if he talked to them they would… they would talk sarcastic (i1, l. 428 – 433, p. 15) • They can't stop it but they will make comments.. sarcastically or in another way implying (i1, l. 298 – 300, p. 10) • I don't know how people are going to react, but normally people the reaction would be they don't respect, they won't react in front of you but normally they would degrade you (i2, l. 187 – 190, p. 7)
Subtheme 2.4 Destabilisation of masculinity	
Michael	• I'm six foot, I'm a massive guy and I'm one of the biggest wimps going, it's really weird (I1, L. 1344 – 1345, P. 43) • that is the hardest bit for that I just want to be a normal man, you know be able to do it as and when I want to be able to do it (I1, L. 1731-1733, P. 55) • I've always noticed I've had small testicles and I found it very hard cause I just wanted to be like a normal guy, you know have bigger testicles (I2, L. 808-810, P. 26) • Especially at a young age it's important because it's sort of like I'm bigger than you I can do this I can do that. They were already showing in the sack that they were much bigger and mine was just like a bit of skin. (I2, L. 828-832, P. 27)

Seth	• I'm not sure how other kind of men handle it and deal with it. I guess it can be, there is definitely a big part of erm. Not feeling like a man.... Erm. Because you can't do that. Erm. But luckily that. I never had that feeling too much. (P4, I1, L. 211-216) • And I definitely kind of think there is times when I feel like that... But they are seldom and far between (referring to a loss of masculinity) (p4, i1, l. 783-786) • Men have always been kind of because we don't give birth, we kind of almost every, every man is a sperm donor essentially whether it kind of in part during relationships or not so you kind of almost removed from it (p4, i1, l. 862-865) • It's almost kind of like an identity that I kind of carved out for myself just by exercising and that kind of stuff. (p4, i1, l. 932-934) • You lose that part of your identity. As being the kind of, kind of chest out kind of, kind of, kind of guy. (p4, i2, l. 1338-1341) • That was there before and I think that kind of helped (referring to looking masculine) (p4, i1, l. 940-941)
Payton	• it is a manly thing having children it's important like that (i1, l. 174 – 176, p. 6) • I've heard of women but I've never heard of men... yeah it's not a manly thing you know, (i1, l. 381 – 385, p. 13) • yeah they would say that there isn't man enough (i1, l 409, p. 14) • I didn't feel that I am not man enough, but if the society knew, they all talk about it but they don't know because I didn't tell anyone (i1, l 181 – 184, p. 6)
Major theme 3 Responding to the limitations of infertility	
Subtheme 3.1 Sustaining avoidance	
Michael	• But you know I'm taking, I've got to be bright cause if I don't, I just shell up, (I1, L. 213- 214, P. 7-8)

	• It was heart breaking because all I ever wanted was to have children, so we kept going backwards and forwards they put me on an injection chemical called 'nebido'. (I1, L. 38-42, P. 2) • whereas when I have the stuff the first couple of days no because it really hurts and I'm lethargic anyway but then after that I become a normal human being. But like I said the side effects, with my syndrome they told me that Klinefelters they are supposed to be pretty much hairless (I1, L. 111-118, P. 4) • if we never wanted children we would never be going down this route and we would just be carrying on as usual, but in the future if there is any other types of erm medication I will go down that route (I1, L. 1656-1660, P. 52-53) • We can move further on the ultra sounds now and obviously now going to the next procedure it's like one after the other. I don't mind it's nice to get a day out (I2, L. 920-925, P. 30) • Yeah alright we still have to pay for donor ship cause obviously you have to pay for some mans business (laughs). (I2, L. 1047-1049, P. 34) • The results I'm not bothered about because being known about it for the last 3 and half years there a 70% chance there's nothing there. so I'm not bothered (I2, L 1193-1199, P. 38-39) • what I am trying to do is to focus on the future and not try and dwell on what I've got cause if I do I'll just be in a hole (I1, L. 423-427, P.14) • It is very important but I'm not going to kill myself if it means I can't because it means I lose a life with (name if wife). (I2, L. 409-411, P. 14) • I would obviously love to have children but it's not the be all and end all. I still have a beautiful wife at home. (I2, L. 1243-1245, P. 40) • She has to beat it out of me, cause I just close up and that's how I deal with it. (I1, L. 222-224, P. 8) • it's very easy just to clam up (I1, L. 1585, P. 50) • even though it feels like pressure we take every day as we can because if you don't I would just go into meltdown (I1, L.

	727-729, P. 24) • At the moment I've put that to the back of my memory, erm once the weddings gone just getting work then getting myself sorted again. (I1, L. 231-234, P.8) • I went down the pub and got absolutely smashed. Because I thought that was the only thing I could do (I1, L. 882-886, P. 28) • I'll just go off and drown myself you know drinking, just drown my sorrows. (I2, L. 141-142, P. 5)
<u>Simon</u>	• We, I talk with my partner because we are both in all this but I don't need to feel the need to even to go to a friend I know and if this is a problem for me and I am worried, it's not true. I'm not worried. I just need to live with this and that's it. (i1, l 1408 – 1412, p. 48) • Of course the fact that we can't have a kid directly. Affects the relation. But it did not affect on a negative basis. It's just the fact, it's just we know that we cannot have a kid. (i2, l 1130 – 1135, p. 37) • And I can choose what to think at the moment. I try to put things on a special box. And that is the type of thing that I don't think now. Because that is totally dependent of the outcome of next week operation. (i2, L. 632 – 641, P. 21) • And if the sample is there. Because if it's not there then I will need to take the box from the shelf open and talk about what's inside the box. Erm. Yeah. That's pretty much it. (i2, l 677 – 684, p. 22) • What I try to do now is put things on a box and only think about closed things when I need to. (i2. l. 768 – 770, p. 25) • I have a problem at the moment I try not to think about future problems... Just the problem at the time. (i1, L. 495 – 498, P. 17) • I don't really think about that (laughter) to be honest. That's a different story. I don't know, to be honest I don't know yet. I haven't thought about that...One problem at a time... Yeah, keep it simple... Yeah. Keep it simple... I really need to get with a problem at the time. I know that that discussion if. It

	depends, because it depends on the outcome. Of next week. So I don't want to spend time thinking or discussing something that I don't know. So in a way it kind of feels pointless because obviously there might not even be a need to be having that conversation in the first place.(i2, l 534 – 571, p. 18-19) • If I need to think about something. I will. If I don't I will avoid it.... Erm. Like if we are going to adopt or not. Erm. We have a brief discussion about that and we haven't spent much time talking about that because we don't know what is the outcome of the erm next week so on this type of things I try not to talk or think about because I don't know what is going to happen here (i2, l 916 – 933, p. 30) • And if I start thinking about too much about this I will be a bit stressed. And I don't know what to do with it. (i1, l. 504 – 507, p. 17) • So. Just a question of waiting and see what happens. It's like I told you last time, there is no point for me to suffer in advance. It's just a bit of erm wasted time. So I just try to…not think about it. (i2, l 227 – 232, p. 8) • If I don't need to think about something I would not and I would try just to live the day to day without really getting concerned. And then if and when we will talk about it. Yeah That's my strategy. Yeah. Keep the problem away. Until it actually comes and it's really a problem yeah. And then I have to deal with it yeah. (i2, l. 964 – 980, p. 31-32) • I said let's wait and see what happens...Because there isn't much point to continue every week to talk about this... What happens if, what happens if. We don't know so what the agreement is to just wait and see. (i1, l. 533 – 540, p. 18-19) • She is probably more worried because she worries more with this waiting. But erm. Because I can't control the waiting and she can't control the waiting and even if we talked today during dinner about the operation it will not change nothing. I will still need to wait. And we already talked about that last week… It will not change nothing at all. It will not make it

	quicker. It will not make it easier so. (i1, l. 800 – 816, p. 28) • There is no point to say this, it will not change nothing. It will not make it easier as well. (i1, L. 983 – 986, P. 34) • If I am having this type of conversation with friends. And we will just be talking about a problem that I can't solve. He can't solve. And I will feel it will be a waste of time. (i1, l. 1509 – 1519, p. 51-52) • But it's hard to find out this. That it's me.. The cause...Yeah...it feels like it because I know it's me (laughter) and it's a bit hard but it's life. Without, it's the first time I tried to have a kid. (i1, L. 153-160, P. 5-6)
<u>Peter</u>	• So, we are doing it now. And that's sorted as far as I'm concerned. (I1, L. 1239 – 1241, P. 39-40) • It can be fixed, dealt with just get on and do it I don't have to worry about it. (i1, l. 1216 – 1218, p. 39) • To be honest I don't really need to know. It's not that I'm squeamish because I have been in and out of hospital enough times for various things so I'm just going to let them get on with it. (i1, l. 311 – 314, p. 10-11) • Yes, so I don't know I haven't really asked because as far as I'm concerned you know they will tell me what I need to know when I need it. (i2, l. 130 – 132, p. 5) • I will only worry about children when as I said she has a baby on the way. (i2, l 681-682, p. 22) • That's why this isn't really high on my list of the things to worry about at the moment. At the moment as the baby is involved…when she is actually pregnant. That's when it becomes...It goes up the priority list. But the moment.... I have got other things more immediate at the moment. (i2, l 1269 – 1289, p. 41-42) • I don't have a problem with any of the tests because all I have had to do is turn up. You know, provide samples, be it blood or whatever and they have done various tests mainly adminy type stuff you know...They are no problem. It's like going to the doctor to get jabs for your holiday. It's not difficult. (I1, L. 433 – 444, P. 14 – 15)

	• It doesn't really bother me. I am in a position now where I think well if something's wrong it needs to be fixed. (i2, l. 241 – 243, p. 8-9) • But then they give you all these leaflets about pain management and all this other kind of stuff and you are looking at it thinking what kind of thing am I having done, it's not going to be that bad. (i2, l. 60 – 64, p. 3)
<u>Seth</u>	• Why make it worse by kind of stressing about it. (p4, i2, l. 722-723) • There's no point stressing about the kind of things that are out of your control. But you do as much as you can that's in your control. (p4, i2, l. 1649-1651) • It was a shock and it was erm. I think I handled it quite well. (p4, i1, l. 32-33) • I am not thinking it worries me on a day to day basis. But it definitely kind of, it's definitely a factor. Erm. It's definitely a factor. But then, the positive in me comes out. And you are well this is the way it's going to be kind of like if you can. (p4, i2, l. 3322-3329) • I removed myself from it as in it was like okay, everything is the way it is meant to be. (P4, I1, L. 337-338) • I don't think it's really affecting my day to day kind of how I am, my routine. Everything is pretty much the same. (p4, i1, l. 770-771) • And it doesn't bring me, it doesn't bring me down. (p4, i2, l. 734) • You almost kind of you put it to one side because I think for me anyway, it's kind of there's no point in keeping it in front of you all the time and having it on your lap and worrying about it all the time because you can't do nothing anyway. Erm. You can do what you can do erm. You think about it when you need to think about it in terms of planning and that kind of stuff. But then otherwise you kind of, you don't kind of, it doesn't really. You don't really need to worry about it and be anxious and that kind of stuff because it makes no difference anyway. (p4, i2, l. 1978-1988)

Payton	• we didn't think too much and paused for everything until the operation (i1, l. 360 – 361, p. 12) • No stress. We don't discuss much and we are waiting for the Dr's operation (i1, l. 511 – 512, p 17)
Subtheme 3.2 Maintaining a pragmatic approach	
Michael	• There's people out there that can't have children full stop (I2, L. 1025-1026, P. 33) • I don't take it straight away then I'm like I haven't been hard done by in life. I was born with a crappy syndrome big deal. I didn't know about it, I survived 27 years of my life not knowing about it I can survive another 27 years or 50 years knowing about it (i2, l. 1230 – 1236, p. 40) • Her best friend works in a cancer ward she's a nurse over at (name of hospital) one of the main trauma centres and we was in the car with her a couple of days ago and she said she was dealing with a 15..no..9 year old who had cancer. Sorry not cancer, leukaemia who's obviously on the same ward, and that's a killer I said mine's nothing. (i2, l. 1253-1262, p. 40)
Simon	• But it's not. (pause) I am not concerned at the moment. I am not concerned at the moment. I am sure I will be more stressed the week before. When the date comes to the operation. Because then things start to happen. I will know when the operation. I will stay at home, I will have the results if they have retrieved sperm or not and then after the operation things will be more tough. (i1, L. 1252 – 1262, P. 43) • And I know the problem, I know the solution. What can go wrong or what to do. And at the moment what I need to do is. Wait. And because I am all this situation, I can't control it. There is no point of be worried or concern, or, or unhappy or sad, or whatever. It's what it is. (i1, l. 1632 – 1640, p. 55 – 56) • Will be difficult the, after the operation until we get a result. And then it will be difficult there will be pressure. But if we

	can't get pregnant by IVF, erm. We need to live with that. (i1, l 1422 – 1428, p. 48-49) • I am not worried. There is no point to be worried. Just live your life on a daily basis... So what can you do, just do. You plan, you whatever but there is no point to suffer in advance so. So at the moment I know what is the next step so I am okay. (i1, l. 1765 – 1778, p. 60) • The next step is operation and if... and after, if everything works well in terms of the operation and eggs treatment and IVF...if it's not working... Erm. Because the thing is when you get, if you have sperm they can freeze everything... And then we get like three chances on the public service... For free, yes. And after the three chances erm. If it's not working we said we would not try more... Not because of the money but erm if it's not working we are going to adopt. That is where we are at the moment. Probably...Things change I don't know. But at the moment that is where we are...because chance statistically you get like 30 or I don't know, I don't, have exactly the figure but if you do not get on the first. Erm the treatment is always the same, nothing change, the sperm is the same. So if it does not work three times. (i1, L 550 – 580, P. 19-20) • We had ...we talked about when we started and when we went to the doctor and we talked and we talked about possibilities and IVF erm yes, sperms from someone else, adoption and erm we discussed erm after the doctor, first IVF, if IVF doesn't work we are going to adopt and we didn't spoke about this because there is no point. Er...I went to Dr (name), operation, I'm going to be booked somewhere. Somewhere, not somewhere but some date and we discussed that day, what is going to happen next and that was it. (i1, L. 755 – 767, P. 26 – 27)
<u>Peter</u>	• I come more from the practical side than worrying about whether it makes me less of a person or a man so to speak. Yeah. Because no one wants anything wrong with them. But at the same time, it's not a part of me that I needed to use

	before. (i2, l. 455 – 463, p. 15) • I mean you have to talk, you have to pass on information about this you know and I have been getting paper work to sign, I tell her about the paperwork I have got, what I'm signing for, what's been paid for and then if there is any questions around that or if I have got to ring the hospital I would say to her you know I have to ring the hospital because I have these questions...So we talk about it...but I don't think we ever just sit down and out of the blue just start talking about it. (i2, l. 778 – 793, p. 25-26)
Seth	• I kind of almost resolved myself to that fact... This is kind of, I have always kind of always got to have a backup plan... And kind of okay if this doesn't work out, what's the next option. (P4, I1, L. 422-427) • This is what's meant to be this way. It's, it's by design. It's not ideal. But you make the best of it and you think about the next step... it's kind of definitely it's pragmatic. (p4, i2, l. 3067-3078) • Erm because I am quite happy. I am probably I am saying I am happier about the situation than she is. Obviously it's not ideal. But I am in a better place because, because the thing that I just accept that things that are the way things are. Erm and it's by design. But it's not our design. Erm so I am quite kind of happy with that and that's my balance. (p4, i2, l. 2088-3000) • I resolve things and am quite happy to; that's it. I see things in the way I see them and it doesn't really kind of; I have got that balance kind of. Okay in terms of the outcome, I will go back to; this is the way it was meant to be. This is not my kind of; ultimately this is not my choosing...And that's where I kind of, that's my balance. (p4, i2, l. 3046-3060) • It's just almost like a test.... And a hurdle in life to kind of overcome. (P4, I1, L. 220-223) • In everyone's world there are big hurdles... So yeah this is something that I am, that I have to kind of deal with (p4, i1, l. 740-743

Subtheme 3.3 Negotiating alternative options	
Michael	• It might not be mine, I've already sacrificed saying that there is a chance I may not have children by me, and I've already said that if she falls pregnant it will be via a donorship. (I1, L. 189-192, P.7) • Initially I was petrified, having another person's child but now I'm thinking do you know what that's what they do it for. Because they want to give some happy couple a chance to have children (I2, L. 1051-1054, P. 34) • It was hard, it's like being cheated on, like if that's the case I'll say why don't you go and have a one night stand. (I2, L. 1078-1080, P. 35) • we've already said we are going to try a donor if not we will try and adopt.(I1, L. 184-185, P.7) • at the long run...it will be my child if not it will be a donor or we'll go down the adoption route (I2, L. 116-117, P. 4) • As I've said as long as we can profile it so technically have dark hair and blue eyes and so and so. (I2, L. 1054- 1056, P. 34 • But as long as it's on a level to what I've got then I'm fine. I don't really care if it's not my child because the minute that baby is born it's my child. I will raise that child as long as it's got the same sort of… well it could be blonde hair or dark hair because she had blonde hair when she was a baby but she's darkish now. As long as it's close enough to me it's not going to be exact but I'll raise it as my child (I2, L. 1060-1071, P. 34)
Simon	• If we can't have a kid with my sperm and her eggs, assuming that the lab and the hospital don't change my sperm with anyone else, erm… so yes, if we can't have with IVF with my sperm and her eggs we are going to adopt... As soon as we know we can't get it with our things, we will adopt. (i1, L. 473 – 481, P. 16) • So we need to try other alternatives and at the moment we are exploring this one. If it's not working, if it doesn't work, we

	will need to explore another one. Which will be my erm. Perspective erm, adoption. (i2, l. 1139 – 1146, p. 37) • We thought about that if they can't collect sperm we will not try IVF with other sperm... That's out of the question... We discussed that... It was the agreement. (i1, L 461 – 469, P. 16) But at the moment I don't want to get a donor, not at the moment I don't want to get erm. (pause) A donor. For me that's very simple...What I don't want and I am not saying I wouldn't love the kid if she would get pregnant by other sperm. But I just don't want that. It's very simple I don't want that.... I don't even want to be in that position...To think about or when she is pregnant I will...thinking about she is pregnant and that's not my sperm. So I would prefer not to be in that position even if it, even if it's more difficult for her because she really likes to have kids with her eggs. (Si, i1, l. 1715 – 1756, p. 58 – 60) • Except if she does have a very good argument (chuckle) that can change the way I see things. But we haven't discussed that yet... So things can change. Because we haven't really discussed that.... I don't have any argument to say that I don't want because of this. I don't want because I don't want. Which will be a very (chuckle) a very short discussion with her so I really need to think about the argument. (Si, i2, L 1148 – 1180, P. 37 – 38)
<u>Peter</u>	• Because I am. I would never say never. In life because. I'm too much of a realist to know that there are certain circumstances of where you would entertain all kinds of things. So may be that would change depending on how this goes, depending on how our opinions change over the months that this is going to take to do this (I1, L. 227 – 237, P. 8) • So once you come into those options then may be adoption becomes more viable. (i1, l. 256 – 257, p. 9) • Basically we touched on the idea of adoption and things like that but as I said before, I don't know that I would be as

	amenable to adoption. Because I don't have that kind of strong parental urge That I don't feel like I need to take on other children (i2, l. 412 – 418, p. 14) • Adoption things like that, I don't think would suit me... So I feel that I would need that kind of genetic factor to actually kind of engage with the child. (I1, L. 57 – 63, P. 2-3) • If the child is mine then I think there would be a stronger bond there. (i1, l. 239 – 240, p. 8) • If it's my child, it's a different ball game. Because...Because there is a lot more connections there isn't there. (i2, l. 423 – 426, p. 14)
<u>Seth</u>	• I have always thought about adoption anyway. Erm. And I always felt, always kind of like to think that if I had a child and may be and I wanted to have another child adoption would be. Even if I could have a child biologically adoption would be a kind of a genuine route. (p4, i2, l. 3322-3334) • I kind of almost resolved myself to that fact... This is kind of, I have always kind of always got to have a backup plan... And kind of okay if this doesn't work out, what's the next option. (P4, I1, L. 422-427) • Over adoption yeah. That would be kind of that would be the first step...That would definitely be the first step. Because luckily touch wood, my wife is fine in terms of being able to reproduce so erm. So hopefully that kind of like shouldn't be any problem. (p4, i1, l. 874-879) • But then I have always kind of like worry if I was to do that. How would you, how would there be a difference in terms of kind of deep down how. Yes would there be a difference in kind of like well this is biologically your child and this isn't. Like. How I am. Because you. Anyone can say no I've feel the same. But then how do you know until you kind of are in that place. Erm. And I would like to think it wouldn't make a difference. So kind of like that's definitely kind of a worry erm. And even kind of going through the kind of, the sperm donor route, it's something, it's a concern. May be later on. But because I think, there's a lot less concern because I think

	because the pretence is there. People don't know erm. This is your child. Erm. It doesn't make a difference to you. (p4, i2, l. 3356-3385)
Payton	• the first alternative would be from a sperm donor (i2, l. 348, p. 12) • I will always look for alternatives... I will be calm then look for alternatives... once I get a problem that's unexpected I will be calm for a while then I look for alternatives (i2, l. 83 – 91, p. 3)
Major theme 4 Placing infertility in a relational frame	
Subtheme 4.1 The sense of pressure by others' expectations	
Michael	• So my mother in law is like its resting on us two. (I1, L. 721-722, P. 23) • Mm (nods) I especially told my mother in law this because obviously she deserves to know because you know she desperately wants a child (I1, L. 940-942, P. 30)
Simon	• Because we have friends, couples younger...Who have kids already... We have friends who are a bit older who have kids and they just ask normal question like what is your time now. What is your term now whatever... And we say that we like, it will be soon, just keep trying. (i1, L. 1020-1029, P. 35 – 36) • She asked when do I have a grandson and I said erm soon. We are trying... There is no point to talking too much about that. (i1, L. 1080 – 1084, P. 37) • My mother in law she asks my partner. But we. We…What they know er is that we are trying.... she is a midwife. So she is always asking about that stuff... Erm. But what we say is that we are trying. (i1, l. 1098 – 1116, p. 38) • And if you have someone asking about that, the only thing that will make is it will make you upset. And (laughing) and it's a lot easier for me to be not upset (i1, l. 1146 – 1150, p. 39 – 40) • And if we tell our parents, it will, they will be worried probably

	more worried than we are. And then they will ask every time they call they will ask, do you have news, do you have news, do you have news. They will not change nothing. It will make it worse. (i1, L. 986 – 993, P. 34) • Because if I tell, if I tell my mother she will be worried. If I tell, if we tell her mother, she will be even more. She will ask even more. Because she knows a lot more about the subject and it will be even more. Because the problem is as I said we are just waiting for an operation but when you have someone every week or every day asking where are you with er, the operation... Er, where are you with. What's the plan, what is going to happen next I am so worried about your situation. It will make it difficult. (i1, l. 1128 – 1139, p. 39) • And if you have someone asking about that, the only thing that will make is it will make you upset. And (laughing) and it's a lot easier for me to be not upset and for them as well. And erm so if they know, if my partner and her family, if they know, they never refer. And but I am, I think she did not told them so. Yes. It's a lot easier. Because if people they don't know, they don't ask. (i1, l. 1146 – 1154, p. 39 – 40) • It's not hard because I have not told erm people otherwise it would be hard. Because they don't know they don't ask so it's a lot easier. (i1, l. 1192 – 1195, p. 41) • Because I have my life. And erm. I don't need their questions. Erm. When I want to talk I talk. And when I don't want I don't so questions will not solve nothing. The only thing it will make me is upset. But the reason I haven't told my mother is because she will be worried. She will become worried and asking and I have nothing to say. Because er. Nothing, it is a lot easier just to keep it away from them. And it's not a lie. It just makes life easier. (i1, l 1347 – 1371, p. 46 – 47) • Because when people don't know they don't ask... If people don't know, they don't ask. Its life it's much easier. (l. 1484 – 1495, p. 50 – 51)
<u>Seth</u>	• Obviously because she doesn't know like the whole ins and outs at all (referring to his mum).... my mum, my family's going

	up north to visit some of my family up there and erm. My mum wants my wife to go. With her because there's a Chinese woman there. (p4, i2, l. 545-568) • In terms of children it's more pressure like that as well... Erm. Because you always as soon as you are married it's kind of like okay so when are you having a child? Erm... So that puts on that puts pressure on (P4, I1, L. 584-590) • Just kind of old fashioned and in that respect kind of okay you are married start having children. (p4, i1, l. 600- 601)
Payton	• When they ask questions like ah when are you going to have a baby? We plan to have a house first then we are going to (i1, l. 233 – 235, p. 8) • Some ladies ask me not friends some ladies ask me you know if you are delayed and when your time will be, you will be older and your child will be too young and it is very difficult to handle. (i1, l. 242 – 245, p. 8) • if they knew we can't have children….initially for the first three or four years they might think we are delaying it because of our career and we are going to buy a house and after such period they will ask such questions 'where's the baby' we are getting old and should have a baby, they start to ask questions... yeah own assumptions and they will talk about it (i2, l. 198 – 208, p. 7) • they all say to her don't wait for a baby because if you have a baby you can easily manage you know, you can have a baby quickly and have a second baby after... they say before you're 30 you should have a baby otherwise your body will not cope, sometimes you won't get pregnant, and if you are younger you will easily get pregnant (i2, l. 559 – 571, p. 18-19)
Subtheme 4.2 Instability in the relationship with partner	
Michael	• well I thought if I can't do it why should I hold her back, (I1, L. 948-949, P. 31) • I have told (name of wife) obviously before we got married so leave me leave me leave me...if you want children go have your children and if you want to come back to me. (I2, L. 181-

	185, P. 7) • At least I can say two of us made this child. You know every woman says I hate you for getting me pregnant putting me through this pain so I can always come back by saying this to her I went through the pain for the first three years. (I2, L. 399-404, P. 14) • Not as much as she would like cause with the syndrome I can be like yeah I'll do it seven days in a row, I wouldn't be able to alright 3 or four days, or 5-6 weeks easily and to any women that is horrifying. (I2, L. 1097-1101, P. 35)
Simon	• We decided that I don't want to have kids without my sperm. And we decided to adopt. But like I said er. Things change. This is what we decided two months ago. I don't know when, or if, if we find out that we couldn't get pregnant by IVF. That my partner she will still agree. With adoption solution...Because she knows that she can still have kids. With her eggs. Yeah. But because I can't with my sperm, I don't want to have a kid from other sperm. So in that time, that's a different question if she will still be happy to go with adoption but erm. There is no point for me to be worried. (i1, l 1680 – 1704, p. 57- 58) • At the moment yeah. I hope she continues to be in that opinion. Are you worried about that that she might come back and say that actually she does want to have? (researcher) Yeah sometimes... She can change idea I don't know. At the moment we are okay. She wants, she is supportive with the operation with everything and she is, she is in the opinion that if we don't, if it's not okay, we will adopt. But who knows. Tomorrow or the day after. She wanted to be a mother yeah. (i2, l. 499 – 516, p. 16-17) • Even if I get an ultimatum saying we can only continue the relationship if I have her kids. And erm my kids. If she tells me that. I say alright you need to find a donor and go with your life because I don't want to do that. (i1, l 1723-1728, p. 58)
Seth	• Me and my wife are in a very good place. I guess in terms of

	our relationship... We are very happy (P4, I1, L. 408-411) • I consciously try to be there... So when it comes to that stage I think erm yeah I will kind of like, yeah it will just kind of I will make her to talk about it to me and so. And so I don't know, I don't know the best way about it but I kind of, I think with my partner I will get her to kind of force her to talk about it because she kind of. I think she finds it hard to express herself with words. (p4, i2, l. 291-303) • She has come to one but I was, yeah I didn't really kind of didn't really want her to be in the room with me. Erm. And I am not sure why that was just kind of I was, I felt kind of safer. (p4, i1, l. 1607-1610) • With my wife I don't think she would understand. (p4, i2, l. 370-371) • She's like no but it has to be yours, it has to be yours. (P4, I1, L. 271-272) • Because I have got low testosterone I think it's a cause for having a low libido. So then that becomes an issue in terms of our sex life and that kind of stuff (p4, i1, l. 1697 -1701)
Payton	• if we can't produce to have a baby then it might change (i1, l. 495 – 496, p. 17) • It's a big thing for me because one thing is…it's a big thing I didn't have proper family because me and my wife to take our relationship…to strengthen our relationship we need a child. (i2, l. 116 – 119, p. 4) • Culturally...in our culture having a baby, marriage is for having a baby that's what marriage is for (i1, l. 134 – 135, p. 5) • not having a baby is the biggest thing (i1, l. 280 – 281, p. 10) • that's the main purpose of the marriage rather than making a relationship and finding a companion, the main reason for the marriage is having children (i2, l. 211 – 215, p. 7)
Subtheme 4.3 Oscillating between disclosure and concealment	
Michael	• (Name) who is my auntie I tell her everything. (Name) knows my cousin, I tell them all because it's easier to release it off

	my chest. (I1, L. 856-859, P. 28) • but you know talking to them made my life easy (I1, L. 919, P.30) • I want to be an ambassador to the syndrome, and I'm happy enough to tell people about it and it doesn't matter if they're strangers or people that I meet up the street (I1, L. 1560-1563, P. 50) • well men don't like to talk do they...so that's the big issue I was like that at the very start (I1, L. 1971-1972, P. 62) • a few of my pub colleagues know about it, a couple of them you can't tell about it as they would just spread it around everywhere but a couple of them I told them while they were sober because I know they're not going to say anything whist they are drunk, and I told them and it was easy I only told a section of family because they're close to me the rest of my family they don't need to know. If they ask then I'll tell them. (I1, L. 888-897, P. 29) • She has to beat it out of me, cause I just close up and that's how I deal with it. (I1, L. 222-224, P. 8) • it's very easy just to clam up (I1, L. 1585, P. 50) • cause I was having a lot of problems with it, it wasn't going back, it was going back, it wasn't going over (I2, L. 763-765, P. 25) • sorry to be a bit rude here but size as well cause beforehand it was erecting but not erecting as much (I2, L. 793-797, P. 26)
<u>Simon</u>	• And if we tell our parents, it will, they will be worried probably more worried than we are. And then they will ask every time they call they will ask, do you have news, do you have news, do you have news. They will not change nothing. It will make it worse. (i1, L. 986 – 993, P. 34) • Because if I tell, if I tell my mother she will be worried. If I tell, if we tell her mother, she will be even more. She will ask even more. Because she knows a lot more about the subject and it will be even more. Because the problem is as I said we are just waiting for an operation but when you have someone every week or every day asking where are you with er, the

	operation... Er, where are you with. What's the plan, what is going to happen next I am so worried about your situation. It will make it difficult. (i1, l. 1128 – 1139, p. 39) • And if you have someone asking about that, the only thing that will make is it will make you upset. And (laughing) and it's a lot easier for me to be not upset and for them as well. And erm so if they know, if my partner and her family, if they know, they never refer. And but I am, I think she did not told them so. Yes. It's a lot easier. Because if people they don't know, they don't ask. (i1, l. 1146 – 1154, p. 39 – 40) • It's not hard because I have not told erm people otherwise it would be hard. Because they don't know they don't ask so it's a lot easier. (i1, l. 1192 – 1195, p. 41) • Because I have my life. And erm. I don't need their questions. Erm. When I want to talk I talk. And when I don't want I don't so questions will not solve nothing. The only thing it will make me is upset. But the reason I haven't told my mother is because she will be worried. She will become worried and asking and I have nothing to say. Because er. Nothing, it is a lot easier just to keep it away from them. And it's not a lie. It just makes life easier. (i1, l 1347 – 1371, p. 46 – 47) • Because when people don't know they don't ask... If people don't know, they don't ask. Its life it's much easier. (l. 1484 – 1495, p. 50 – 51) • This type of discussion is healthy. Because you are doing a PhD. If I am having this type of conversation with friends. And we will just be talking about a problem that I can't solve. He can't solve. And I will feel it will be a waste of time. But with you I am here because you are doing a PhD. It's useful, it's useful. (i1, l 1505 – 1523, p. 51-52) • It's not useful it's not useful, it's just easier. Because erm. We have an objective. We are talking about something to do with erm. What I have experienced. To help you on your research. (i2, l 2011 – 2017, p. 64-65) • Yeah (laughing). They have been... No because they joke, they joke... Yeah. But it's fine. No it was. It was just like

	friends joking... Yeah. As a joke. As a joke. Nothing major. But I'm yeah. It's fine... We just erm. We just told a few…a few friends. And that's it. (i1, L. 1001 – 1015, P. 35) • I feel different yeah. Because I know it is to be used as a PhD. And you don't know me. (Laughing). We don't have any relation. Er. If I wanted to leave, I could leave. (i1, L. 1381 – 1387, P. 47) • Very strange, very strange. I can only do it because you are a stranger. And erm. And this is to do with research for you. And erm. And just because you are a stranger, I will do everything in my, on my erm. Reach to keep you as a stranger.(i2, l 1822 – 1832, p. 58-59) • If I am having this type of conversation with friends. And we will just be talking about a problem that I can't solve. He can't solve. And I will feel it will be a waste of time. (i1, l. 1509 – 1519, p. 51-52) • It's not hard because I have not told erm people otherwise it would be hard. Because they don't know they don't ask so it's a lot easier. (i1, l. 1192 – 1195, p. 41) • There is no need. I don't feel the need to talk about problem or to explain myself. To anyone... It's just the way I am... But I've always been like this (i1, l 1437 – 1455, p. 49 – 50) • It feels very uncomfortable...because I am talking with a stranger about my personal life (laughing)... Erm. But yeah. And if you are going to ask me if it helps me after.... I don't know. It probably helps... I don't know because I'm, you are making me to talk about things. That I don't normally talk about or even sometimes think. Erm. So probably it helps me. It's like going to a pain for erm, erm. Doctor, I don't. Yeah. Erm, and I don't need to pay For free yeah exactly. That's what I told my partner. That's what I feel. (i2, l. 1840 – 1877, p. 59-60) • I didn't came to my first. I didn't came to think that I am going to get a free appointment. With a stranger. To talk about my problems. Erm. No I came with an open mind to answer your questions... But I will say probably helps. Helps me because I

	am putting out what I am thinking about. (i2, l 2025 – 2044, p. 65-66) • You helped being here talking about this Like the free... No, it's I am joking but it's probably true. Because I haven't thought about that but it and now I don't have any other comparison. Because I have been here. And I don't, I have an experience that. So it helps probably because you made me talk about things, which is a good thing. (i2, l 2096 – 2110, p. 67-68) • I don't feel the need to. Talk. I am okay. I have always been okay without talking. (i1, L. 1327 – 1331, P. 45) • Because this is too personal. This is too personal. They know that we are trying to. Some of them they know a bit more. They know that it's IVF with what we are trying. Others they just think we are trying normally... In (name of home country), the few they know about the IVF but they don't know about the operation or that I will, next week. Nobody knows that next week I am going to be erm. Except my partner, you and my company... everything personal I never talk about it. If it's too personal no. (i2, L. 1673 – 1704, P. 54-55) • Yeah but when I want to talk about something specific about my life, I would talk with a friend Erm. But most of the time I don't talk with no one. (i2, l 1755 – 1760, p. 56) • I know a lot of people... But I only have a few close friends and I have like different levels of information that I share... With things like these…like everybody else... So I only share crucial information with a few... And er some information I even don't share with my mother or with my brother because there is no point... It will not change nothing. (I1,l. 1061 – 1074, p. 37) • We have spoke with no one else and you about this which is my first time. Erm yeah but… she is the point of contact... Nobody knows that I am going to be operated next week.. Oh no, I don't, I haven't told no one. I haven't told anyone except at work. And you. That I am going to be operated next week. No way... They know that at some stage. At some stage I will

	say it's done already... They know that we are going over tests. And yeah they probably know that I will need to get sperm retrieval. But they don't know it's a general anaesthetic. No, no, that I need to stay home and I will need to be probably one week away from work because I can't move because whatever. No they don't know. And the work they know that I'm, I have explained my work that I am trying to have a kid... And erm. Next week I will have an operation. (i2, l. 1476 – 1520, p. 47 – 49) • Which is a really nice job because sometimes people they need that and probably I don't know if I was needing that. I don't know if I was needing to but it helps me, yes it helps me or it helped me because I had to put and I am still putting out my what I normally don't. Just keep it in for me. And I also don't spend much time thinking about it but here I need to put it and I need to explain it to you in a foreigner like and my second language. Which is different as well... I never really explained my personal issues in my second language. (i2, l 1961 – 1979, p. 63)
<u>Peter</u>	• So how was it to find out for you? To find out there was a problem? Erm...I actually don't think it's been a problem. I am sure if I sat down and actually talked to someone for long enough and answered the right questions, it would be some impact, but it's nothing that I have noticed. (I1, L. 445 – 452, P. 15) • Without going into too much detail, I mean my family don't know we are doing this. And I know that contradicts what I have just told you. But to be honest, I don't want them questioning me about it(I1, L. 570 – 575, P. 19) • I don't really want that kind of sort out mentality thing working again with lots of people asking lots of pointless questions. (i1, l. 600 – 602, p. 20) • I mean I would talk, I have got some close female friends who I would tell if the subject came up. But I don't see them enough to have that kind of conversation because you don't rock up in a pub and within 30 seconds go by the way. I have

	been had this test and this has happened... we'll have a few drinks first and then I might talk to you about it. (i1, l. 616 – 627, p. 20) • And if I had more close friends, I would tell them even if they weren't necessarily quite as trustful. I would probably still tell them because they are close friends. (i1, l. 1139 – 1142, p. 36) • And certainly if they hadn't changed, erm, that means there is very few people that I would necessarily just start talking to about things like this. (i1, l. 1152 – 1154, p. 37) • You have got to let it out somewhere. (i2, l 932, p. 31) • You and I sitting here and talking like this I would actually tell you. Erm. In part because it would be cathartic. So. Because yeah. Its, it's a benefit talking to strangers. (i1, l. 539 – 546, p. 18) • It's making me chuckle. It's quite a cathartic thing. (i1, l. 1645, p. 52) • It's just nice to talk without kind of, just whenever you talk to anyone there is always sort of boundaries and things you would adhere to but you have gathered that from what I have told you already... In terms of why I wouldn't, wouldn't tell people So it's quite cathartic, it's quite nice. (i1, l. 1656 – 1663, p. 52) • If you go back to the what little I know of psychology, they say it's always easier to talk to strangers because of. Because of the less kind of emotional investment and everything else. The judgemental factors you have got there and that's why it does work. Erm. But it just makes a change to talk very freely (i2, l 1240 – 1249, p 40-41)
<u>Seth</u>	• I think it makes it more kind of a, speaking about it to friends and that kind of stuff makes it more of a reality...within your circle (p4, i1, l. 1110-1113) • Every time you see that person, they know, they know and it's just like oh do I have to go and deal with that question and that kind of stuff. And now then it becomes kind of like a daily thing... Because you, if you… whenever you see your friends

	and that kind of stuff... And family it makes it kind of like part of your every day kind of situation. (p4, i1, l. 1275-1284) • I would never discuss anything kind of that personal. That personal and a lot of things that are going on at home, that, that kind of I don't want to talk about, I don't want to share (p4, i2, l. 913-916) • I wanted to be able to speak about it... And you kind of because, I think may be because erm. Because it's almost like a secret... you just. You want to just blur it out and you want to say, and you want to kind of like say yeah this is how I am feeling and that kind of stuff erm. And bounce it off someone. Erm. So you kind of part of me wants to kind of like. I do want to speak about this. (p4, i1, l. 1342-1353) • I think kind of sometimes you want to kind of put it out there kind of this is what I am going through... But you don't want the reprisals. (p4, i1, l. 1807-1810) • There is not going to be any comeback whether it's kind of…because it could be good. That you kind of have that support and at the same time it could be made to kind of getting questions kind of thing and how is it going and that kind of stuff (p4, i2, l. 1895-1900) • Emotionally I kind of I can sort out my problems myself. (p4, i2, l. 278-279) • If other people knew I don't think it would have any better effect on me. The negatives outweigh the positives because I am handling it fine myself at the moment so. So, I don't really need that kind of support. (p4, i2, l. 1990-1999) • I'm almost kind of yeah that's kind of a self resolve and resolving myself and it's kind of I don't need to talk about this. (p4, i2, l. 945-947) • if I'm being with it okay, I'm fine then number one I don't need to tell anybody erm. Because it doesn't make a difference to them. (p4, i2, l. 1943-1945) • the big problems I have always kind of I have always kind of really resolved them myself and within my mind (P4, I1, L. 286-288)

	• I think they will be understanding and they will be supportive but at the same time it's easier, yeah that's a good way, it's easier dealing with it myself... Because then you don't have those questions. (p4, i1, l. 1095-1099) • my tears are hidden by me pitted smile (p4, i2, l. 739-740) • You can still joke around and be normal.... these things are happening internally. (p4, i2, l. 755-759) • I make a statement rather than kind of this is how I feel. I think there's a big difference erm because this is how I feel is kind of it's, it's very personal. It's just as personal as it gets I guess. So that's kind of. I think that's definitely how I do things, I make statements rather than, kind of erm kind of making any declaration and kind of how my emotions and stuff. Erm. So yeah. In terms of kind of. In terms of these kind of stuff…Yeah. I don't think you know I could go to them but I never. Because it's kind of, I like, it's kind of, it's almost like an ongoing joke this kind of like I'm not a, I'm very kind of reserved. And I'm, I'm wary about new people coming into my… My group. And whether it's family and that kind of stuff. I am definitely a lot more reserved and it takes me a while to, to warm to people. (p4, i2, l. 1052-1088) • I think it's easier for a woman to talk about these kind of things anyway. Erm. And men have a hard time even more so of having kind of expressing themselves...In that way erm talking about kind of feelings and stuff. (p4, i1, l. 1373-1379) • It hasn't been difficult. Erm and almost kind of yeah, almost kind of a welcome change kind of...And kind of like just kind of put it out on the table. (p4, i2, l. 1849-1857) • I think you are doing a service. Yeah. Even kind of something positive has come out of it in terms of kind of how may be. I think maybe I don't know how it was with the other kind of people you spoke to but it's definitely kind of been a positive experience for me. (p4, i2, l. 3468-3474)I think I'm not sure how it feels kind of for partners erm. I think erm. I think the partners must go through it. I think it's harder sometimes for my wife...Because she is removed from it and it's just kind of

	like, she kind of knows but she doesn't really know what the kind of like what's going on... Erm. So it's kind of like, it's they are not, it's almost kind of like I have the con… a certain amount of control of the situation because I know I am going to an appointment and that kind of stuff and it's less for her. (p4, i1, l. 1593-1605)
Payton	• I felt good about it... It's good to share it and you are a stranger…you are not going to make any judgement (i1, l. 683 – 686, p. 23) • But if I talk to my colleagues and they are not good friends…they are acquaintances in my work place if I talked to them they would… they would talk sarcastic (i1, l. 428 – 433, p. 15)