Dutch men experiencing infertility, infertility treatment and involuntary childlessness

THESIS

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By

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Abstract

Infertility is both a medical and socio-cultural problem. The individuals affected by the infertility consider it has a stressful experience. Furthermore, there are limited studies that have dealt with the experience of men and how they cope with infertility. Among the couple men contributes almost equally to the cause of infertility. In addition, they are also involved in the decision making process and support of their female partners during treatment. Men confronted by infertility and involuntary childlessness often needs attention as their female partners. Despite this growing need, the main focus of infertility treatment has been the woman’s body regardless of who is the cause of infertility.

The understanding of infertility is mainly confined to its medical model. However, there is much more to understanding infertility than its medical model. The psychological and social needs are sometimes not adequately addressed within the framework of such a medical model. The wide acceptance of reproductive technologies needs infertility to be interpreted within broader perspectives. Anthropological research is required more to advance current understanding of infertility within this broader view and to encompass men inadequately investigated until now. A deeper understanding of infertility experience and coping strategies among men will guide future public policy and determine directions for effective support of men and their female partners.

The current study is an attempt to gain insight on how men experience and cope with infertility. The findings from this study highlight the need to focus on men’s experience and coping strategies with infertility. The findings suggest that men react in a different way when confronted with infertility and there is a need to have a deep understanding of their experiences. Reactions of men and their female partners towards infertility affect the functioning of the couple as a unit as they face decisions regarding how to deal with infertility. Men react to infertility mainly in the light of their partners’ perceptions, reactions and their wish to become mothers. The experience changes overtime based on the diagnosis of infertility in men and the type of medical interventions to be offered.
DECLARATION OF ORIGINALITY

I declare that this is an original study based on my own work and that I have not submitted it for any other Course or degree

Signature..........................
**Abbreviations**

AID- Artificial Donor Insemination.

AIH- Artificial Insemination using husband’s sperms.

IVF- Invitro Fertilisation.

IVF-D- Invitro Fertilisation using donor sperm.

ICSI- Intra Cystoplasmic Sperm Injection.

HBO- Hoger Beroeps Onderwijs (Higher Vocational Education)

HSG- Hysterosalpingography.
Acknowledgement

The path to completing this MA thesis has included the discovery of new friends and colleagues, and a renewed appreciation for the old. I have many people to thank.

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Corlien Varkevisser and Trudie Gerrits are responsible for introducing me to the world of research in medical anthropology. I am most grateful to them for their patience and thorough instruction on proposal writing, data collection and analysis. Their enthusiasm for research and stimulating discussion has had a lasting effect.

I thank the men and women, who participated in this research, and to whom this thesis is dedicated. I thank them for telling me their stories in a very honest and open way. Their participation is highly valued.

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Chapter one

Introduction

Infertility: an issue for men

Infertility has been considered one of the major life crises among men and women desiring to have children (Bliss 1999, Greil 1991, Van Balen 1993: 54). In previous studies on infertility it has been reported that infertility is more distressing and more involving for women than for men. Questions have been raised as to whether and why men experience and cope differently when confronted with infertility and involuntary childlessness. The psychologist Caren Jordan (1999: 344) argues that there is a large body of evidence that infertility evokes more general psychological distress for women than for men. However, she points out, this may rather be the result of the fact that researchers more often frame questions around women’s experience and that women are more likely to participate in infertility research when asked. In addition, she states that the common finding that women are more distressed than men may be overstated.

Fertility issues are a concern for both men and women. They all have the desire to have children, as they are involved in the procreation process. In his discussion on ‘gender and reproduction’ Helman (2001: 126) points out that, although pregnancy and childbirth, from a biological point of view are female events, most men are also deeply involved in the birth of their children. Their involvement is recognised by a series of rituals and tasks that men in most societies carry out during their wives’ pregnancy and delivery. The assumption in this thesis is that male involvement applies to infertility as well. Infertility is not only a physical condition. It is an emotional and social condition with accompanying feelings and psychological problems attached to it. In addition, with the advance of new reproductive technologies, men and women are likely to experience infertility in a different way than in the past. The evaluation and treatment of infertility requires a lot of time, resources, and decisions to be taken. Despite the fact that the main focus of these technologies is the woman’s body. It requires the full participation of both partners in all steps of treatment. This is one of the main issues to be discussed in this thesis.
From the biomedical point of view, infertility is defined as the inability to conceive a pregnancy after one year of engaging in sexual intercourse without contraception (Taymor 1978: 15-21, Davajan 1991: 18). Individual women who never conceived fall under the category of primary infertility. Secondary infertility occurs when they have had at least one conception.

When couples in western countries, including the Netherlands, are confronted with infertility medical treatment is mainly the first solution considered (Van Balen 1997:19, Stanton 1991:5). Medical intervention is primarily focusing on women's body and since women ultimately conceive and become pregnant, the inability to conceive and become pregnant is perceived almost exclusively as a women's problem. However, statistics confirm that in fact infertility affects men and women almost equally: approximately 40% of infertility problems are male related, 40% are female related, 10% are a combination of male and female problems, and 10% are of unknown cause (Davajan 1991: 18, Sandelowski 1993: 14-15, Taymor 1978: 15-21,). Although generally one member of the couple is identified having the specific medical condition that leads to infertility (with the exception in case of combination of both female and male factors), it is the couple that is considered infertile, and has to undergo treatment together.

Currently Invitro Fertilisation (IVF) and Intra Cystoplasmic Sperm Injection (ICSI) are widely available in the Netherlands and many infertile couples are utilising them, after having tried on, in combination with hormonal stimulation, artificial insemination with husband sperm (AIH) or donor sperm (AID). These are nowadays the most commonly used assisted reproductive technologies for treatment of infertility. ICSI is used in case of male infertility. Where there is severe male infertility, a single immobilised sperm is injected directly in to the cytoplasm of the oocyte (Trounson 1994: 269). However, not all who have utilised these treatment were able to fulfil their desire to become parents. The success rate of these treatment options is still very low. The success rate for IVF is about 15 to 20% and for ICSI is about 30% (Van Balen 1997: 2, Gupta 1996: 253, Hill 2001: 249-251). It is estimated that nowadays about 1% of the first-born children in developed western societies are conceived through IVF or ICSI (Van Balen 1997: 2).

** Literature on social-cultural aspects of infertility will be presented in chapter four to six, in combination with the presentation of study findings. **
The cost of these technologies has been the subject of discussion (Gupta 1996: 268). Although in the Netherlands almost all people are insured including IVF and ICSI treatment, only the first three attempts are covered by the health care insurance. After these three attempts, the couples have to cover the costs on their own (Sciortino & Hardon 1994).

Because of the increased diagnostic procedures and therapeutic possibilities of assisted reproduction, the failures, the (sometimes) high costs and time spent in the treatment, couples are found to get exhausted with the treatment process, which may hurt their feelings and evoke strong emotional responses. Various researchers have described a number of psychological problems like depression, anger, and anxiety among infertile individuals (Reading 1991: 183, Jordan 1999: 354, Van Balen 1994: 157-164). These problems may be attributed to the problem of infertility itself, but also be enhanced by the medical interventions. These authors have suggested that infertility consultation should offer an individualised treatment model that takes into account the special somatic and emotional features of the individual.

According to Adler (1991: ix) the experience of infertility is potentially one of the most painful events of life to which people must adjust. In her discussion ‘Infertility: Perspective from stress and coping research’ Adler argues that infertility is a complex experience affecting the man, the woman and the couple. She points out that it brings people into contact with the leading edge of biomedical technology, where uncertainties abound and procedures are costly, painful and intrusive.

1:3 Motivations for Doing the Research

In the Netherlands up to now no qualitative study has been done which focus on how men experience and cope with infertility and involuntary childlessness. The study, of which the results are presented in this thesis, is about men who want or wanted to have children, but were not able, or were only able after a series of (medical) interventions. In this thesis, I am discussing what I have come to know about the experience of men in Dutch society who have been confronted with infertility, infertility treatment and involuntary childlessness. The personal stories from men and some of their female partners were my primary source of information. By presenting their stories I hope to be able to give insight in their experiences and coping strategies and the extent to which
these are shaped by the wide availability and acceptance of reproductive technologies, cultural norms (i.e. perceptions of one’s masculinity, the significance of biological fatherhood), the relationship with their female partners, and the interaction with friends and relatives.

I have also been motivated to carry out this study by the fact that I am a medical doctor with commitment to provide good care to patients, and feeling the responsibility to add something to the body of knowledge. Infertile couples need support and consideration from the treatment team, friends, family, and each other. I hope the knowledge I have gained from my study will give additional insight into men’s experience of infertility, which may contribute to a better understanding of and response to their needs.

1.4 Research Objective and Questions
The present study is an attempt to explore and describe the experience of infertility, infertility treatment and involuntary childlessness among men in Dutch society. My main research question is how do men experience and cope with infertility and involuntary childlessness and what are the factors, which influence these experiences and coping strategies. Research questions of this study were:

1. What do men see as the value of children?
2. What does infertility and involuntary childlessness mean in the life of men?
3. What bio-medical investigations and treatment men and their female partners have undergone and what were the cause(s) of infertility found?
4. How do men experience the process of medical treatment?
5. How do men perceive various (biomedical treatments) options especially those that would exclude their biological fatherhood (i.e. AID and or adoption)?
6. In what way do the explanations that men have about the cause of infertility interact with the way they cope with it?
7. Do men search for any emotional and psychological support during the process of treatment? If yes how?
8. How do men cope with infertility and involuntary childlessness after medical treatment has failed to solve their fertility problem?
9. How do men and their female partners communicate with and/or support each other when confronted with infertility and involuntary childlessness?
10. How do men interact about their fertility problem with their friends and relatives?
11. What do men see as different in the way they themselves and their partners cope with infertility and involuntary childlessness, and how do they explain these differences?

1:5 Organisation of This Thesis

In chapter two a detailed description of the methods used in this study is given. Discussed are the selection procedures (sampling), the data collection technique, ethics, the role of the researcher and the limitation of this study.

In chapter three the participants are presented, including some sociodemographic data and a summarised profile based on their stories.

The main findings of the study are presented in chapters four, five and six. The narratives from the participants are described to get an understanding of their experiences. In chapter four I describe their search for a diagnosis, their experiences with and their thoughts about treatment and adoption. In chapter five I present the value of children from the men's point of view, and discuss some cultural factors, which influence their desire to have children. In chapter six I discuss how men perceive various sources of support available to help them cope with their infertility problem.

In chapter seven I summarise the study findings and try to draw some conclusions on how to better meet the needs of infertile and childless men.
Chapter two
Methodology

This chapter provides detailed description and discussion of the methodology used in this study. Considering the exploratory nature of this study, a qualitative design was implemented. The primary source of information to understand men’s experiences with infertility and involuntary childlessness comes from the interviews, which I carried out with men, some of their female partners and other key informants. I have also undertaken a literature review on infertility issues in the Netherlands and other western countries from different disciplines such as anthropology, sociology, psychology and medicine.

2:1 Sampling

Informants were recruited from a variety of sources. In the original research proposal I planned to access informants from a hospital that deals with infertile individuals and through snowball sampling. Recruitment of informants from the hospital was not possible: the study had to be approved by the ethical committee in order to get access to patients and getting approval or disapproval would take at least six weeks. This was too long a period for me to wait because of the time constraints. Instead of this, I placed an advertisement at the waiting room of the clinic requesting those who were willing to join the study to contact me by phone or through email. In this way, I succeeded to get in touch with two men.

I also contacted FREYA, an infertility support group. I explained the objectives of my study to the contact persons and requested them to ask men they knew if they would be willing to be interviewed. They agreed and subsequently I have sent an email to the email list of all FREYA members with my request for informants. Five men were identified using this method. Although in my invitation I did not state that my study deals only with men identified to have a reproductive impairment, all men who responded either by phone or email had a reproductive impairment themselves. This may have an impact on the findings, and this will be taken in to account in the analysis of data.

Another way to get in contact with informants was through a key informant, a psychotherapist who is specialised in dealing with infertile individuals and through
my supervisor. In this way I was able to get five informants. All informants were encouraged to contact me by telephone or email. I was also given their telephone numbers and email addresses.

I preferred to hold the interviews in English because the risk of losing richness of the data by using a translator was simply too great. Therefore I selected English speaking informants, which implies a certain selection bias: all interviewed men are highly educated. Another reason not to work with a translator was because of the sensitivity of the topic: the presence of a third person during the interview could have hindered participant’s privacy.

2:2 Data Collection

Based on the review of literature, an initial interview guide was developed. My approach was open-ended, therefore an interview guide (See Appendix) was only supposed to be a tool to make sure that the same topics would be covered with each participant. However, the interview guide was only intended as that, a guide, so as not to hinder the open-ended nature of the interview. A ‘ground tour’ question, asking the participants to describe their experience of infertility in their own words, was followed by several sub-questions. Throughout the interview, participants were asked to clarify certain statements and probing questions were asked for more details.

In total I have conducted in-depth interviews with twelve men. Eleven interviews were held in the participant’s home and one in a restaurant. The average length of the interviews was two and a half-hour. The men were more than willing to share their stories and intimate details with me. They all expressed in one way or another their appreciation for the opportunity to participate in the study.

I also had interviews with four female partners. Two of these were interviewed separately after I had interviewed their husband, while the other two were interviewed together with their husbands. Comparing men and women, while the men were already very open, women seemed to be more talkative than men. In the interviews in which I interviewed members of the couple together, women were dominating throughout the interview.

Besides, four key informants were interviewed based on their expertise on areas relevant to infertility. I interviewed a researcher who has conducted several
quantitative studies among infertile Dutch couples, two gynaecologists, the head of the sperm bank in one of the academic hospitals and one psychotherapist specialised in the treatment of infertile individuals.

2:3 Ethics

Each participant was informed of the purpose of the research and the procedures in place. Additionally, participants were informed verbally prior to the interview that participation was voluntary. Almost all interviews were taped. I asked them permission for this assuring them that everything would be kept confidential, and that their privacy was guaranteed. Audiotapes and additional identifying information, such as field notes would only be viewed, other than by the researcher, by the thesis supervisor if necessary. To ensure anonymity, participants were assigned nicknames in this thesis so nobody knows their true identity except the researcher.

2:4 The Researcher as Instrument

The role of the researcher is a critical aspect for the success of implementing an anthropological study. The researcher does not take an impartial back seat, but rather becomes an integral part of the research. The responsibility of the researcher to the participants is very important especially since qualitative research is interpretative. Therefore, it is imperative that the researcher is aware of personal biases and values during all stages of the investigation. Most of the time during the course of or after the interview, participants asked me why I became interested in the topic. Genuinely I explained them that I am a medical doctor and having worked in a hospital in Tanzania I have had a professional contact with infertile individuals and participated in the treatment. In that time my perception was that infertility was a medical problem and not of concern for social scientists. However, the study in medical anthropology has changed my perspective and I explained my informants that in this study I am not intending to focus on medical aspects but rather I am interested to hear more about other aspects.

My informants were eager to share their experience with me and I learned a lot from them. At the same time they were asking me questions about my own society: *How does it feel like when you do not have children in your country?* This was a
question I was asked almost by all participants, and to get more clarification about certain issues sometimes I used examples from my own society.

The key similarity I have with the male informants is that we are all men. The main differences between informants and me are that I am not married, that I am black and that I do not come from a western society. However, I did not have the feeling that any of these differences has had any negative impact in establishing rapport. Usually we started by discussing other issues like the weather, the transport system in the Netherlands and informants were eager to teach me a lot based on the fact that I am an outsider to the Dutch culture. It was a surprise to my informants to see someone coming far from Tanzania who wanted to hear their story. Informants were more than happy to share their experience with me.

When the interview was over I had the chance to exchange more information about my society as well as my experience as a doctor in dealing with infertility. We suddenly had extensive discussion on their experience. It was an opportunity to gain additional information because some of the issues, which were raised, were not yet discussed during the formal interview. Talking about their experience allowed some informants to understand that being dishonest about their infertility negatively impacted other aspects of their life as well. Having the opportunity to talk freely about their infertility without being judged gave them the courage to discuss it openly with me. Also, they said, they found it such a positive experience that they intended to stimulate others to be interviewed as well. Although, this may seem a positive signal, in fact this never occurred. In addition, two participants asked me to visit them again in order to discuss much more in details.

2.5 Limitations of Study

As I have explained from the beginning, this study was exploratory in nature and qualitative by design. The number of men I interviewed and their partners is limited and not representative of all infertile and involuntary childless Dutch men. Therefore, the findings cannot be generalised to all men who have been confronted with infertility in Dutch society.

In addition, some biases may have been occurred through the way of selecting informants. First, men were selected based on their English speaking capacity, which implies that they all have a rather high level of education. Conducting the interview in
Dutch was not possible due to the language limitations of the researcher. Given the nature of the phenomena being studied, the researcher would have a better ability to describe, analyze and interpret the data if the participant and researcher could communicate in a common language.

Secondly, this study mostly includes men who offered themselves to participate and therefore they may be in different position regarding their infertility experience than those who did not participate.

Finally, this research is simply and mainly based on the voices of the twelve men I spoke with, as there was not opportunity to verify the participants’ perceptions with anyone else, other than using their own reports (with exception of their four female partners I interviewed). In addition, I interviewed two gynecologists, the head of sperm bank and one psychotherapist. However, the study is valuable because it is giving a deep insight in the experience of these men, which may apply to other men as well, and highlighting issues relevant for future research.
Chapter Three

Description of participants

In this chapter both sociodemographic characteristics of the participants and information about their fertility problem are presented. In addition, a descriptive profile of the participants is provided.

3:1 Sociodemographic characteristics

The male participants interviewed for this study ranged in age from 29 to 52, the average age was 38 years. The participants had been married in a range of five to seventeen years, the average length of marriage being seven years. At the moment of the interview, two participants were divorced. Almost all participants had followed higher vocational education (HBO) at university level.

Table 1: displays the participants’ background information: Age, marital status, the cause of infertility, treatment offered and the number of children.

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Marital status</th>
<th>Diagnosis</th>
<th>Treatment</th>
<th>Number of children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hans</td>
<td>29</td>
<td>Married</td>
<td>No sperm</td>
<td>V/ectomy</td>
<td>3 AID, None</td>
</tr>
<tr>
<td>Roy</td>
<td>47</td>
<td>Divorced</td>
<td>No sperm</td>
<td>Normal</td>
<td>3 AID, 1 child AID</td>
</tr>
<tr>
<td>Willy</td>
<td>47</td>
<td>Divorced</td>
<td>No sperm</td>
<td>V/ectomy</td>
<td>None</td>
</tr>
<tr>
<td>May**</td>
<td>50</td>
<td>Married</td>
<td>No sperm</td>
<td>Bloc/tubes</td>
<td>3 AID, None</td>
</tr>
<tr>
<td>George</td>
<td>32</td>
<td>Married</td>
<td>Low sperm</td>
<td>Normal</td>
<td>4 ICSI, None</td>
</tr>
<tr>
<td>Patrick</td>
<td>34</td>
<td>Married</td>
<td>Low sperm</td>
<td>Normal</td>
<td>7 AIH, 3 IVF, 2 ICSI, None</td>
</tr>
<tr>
<td>Denis</td>
<td>41</td>
<td>Married</td>
<td>Low sperm</td>
<td>Normal</td>
<td>2 IVF, 3 AID, 2 children AID</td>
</tr>
<tr>
<td>Fred**</td>
<td>41</td>
<td>Married</td>
<td>Low sperm</td>
<td>Normal</td>
<td>3 IVF, 2 ICSI, None</td>
</tr>
<tr>
<td>Rob**</td>
<td>42</td>
<td>Married</td>
<td>Normal</td>
<td>Bloc/tubes</td>
<td>6 IVF, 2 children(Adoption)</td>
</tr>
<tr>
<td>Jaap</td>
<td>36</td>
<td>Married</td>
<td>Unexplained</td>
<td>None</td>
<td>6 AIH, 2 IVF, None</td>
</tr>
<tr>
<td>Reek**</td>
<td>47</td>
<td>Married</td>
<td>Unexplained</td>
<td>None</td>
<td>6 AIH, 4 IVF, 2 ICSI, None</td>
</tr>
<tr>
<td>Dan</td>
<td>52</td>
<td>Married</td>
<td>Unexplained</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

1.V/ectomy=varcelectomy, Bloc/tubes=Blocked tubes. 2. Female partners of **were interviewed as well.

3:2 Participants profiles

Hans

Hans is twenty-nine years old, childless, and married for five years. He and his wife wanted to have a child immediately after marriage. After six months of trying his wife was not yet pregnant. They went to a doctor who advised them to wait for another
six months. In one year they had four consultations with four different gynaecologists and in each consultation they received different kind of information. Finally, he himself requested to have his sperm tested and then the fact that he had no living sperms was discovered. Two operations were done on him in order to remove varicose veins. However, the sperm analysis revealed the same results after those two operations. Then AID and adoptions were the options remaining for them to be considered. He and his wife discussed about these options. Hans was positive about using donor sperm, while his wife preferred adoption. He felt ready to cope with a child from AID rather than going for adoption. They discussed about it and Hans convinced his wife and they started AID. Hans said that because he loves his wife very much even the child who will be born will be his child and it will have DNA from his wife. At the time of the interview they already had three AID but she was not yet able to conceive. Hans says he does not feel embarrassed with the fact that he is infertile. His main worry is about not having children of his own. After knowing that he is infertile, Hans initially had the feeling that there was no need of making love with his wife if he could not have children from her. Hans discusses his problem with his friends and relatives without feeling any shame.

Roy

Roy is forty-seven year old, divorced and has a daughter through AID. He met with his partner seventeen years ago. After three years of trying to conceive they went for fertility tests and it was found out that Roy had no living sperm cells. He was not happy with the way the doctor informed him about the results of his semen analysis. The doctor spent less than five minutes to discuss the result and did not give any advice to him. He cried and became sad after receiving the results. He had the feeling that the earth was burying him. Roy also complained about his partner because she did not feel the same after receiving the results. He thought that she would support him but she did not. Later, after three months, Roy found out that his partner was having a sexual relationship with another man. This increased his sadness and he cried a lot about it. At the same time Roy had problems at his work place. This, together with the facts that he was infertile and that his partner did not support him, made him very much depressed. His partner wanted to have a child and he felt she did not take his feelings into consideration. He told me that he made the decision to go for AID just to
fulfil her wish and he neglected his own feelings. Also, there was no other option left, because for him adoption was not an option because of his age. His partner became pregnant after the third AID. Due to the poor communication and relationship with his partner, Roy had an affair with another woman. His partner was suspecting this and told him that if she would find out that he had a sexual relationship with another woman she would divorce him and take away her daughter. Roy decided to keep it as a secret because he was afraid of losing his daughter. After all, their relationship ended in divorce when their daughter was three years old. Currently, Roy is living alone and he takes care of his daughter only once a week. However, his former partner does not even want him to take care of her. He has been thinking about the way they would tell their daughter the fact that he is not her biological father. Therefore, he was surprised one day to hear his daughter telling him that he is not her real father. He thinks that his former partner decided to tell her the story without discussing it with him first.

Willy

Willy is forty-seven year old, childless, divorced and currently living with another partner. He is known to be infertile (no sperms) for over eleven years. Willy and his former wife requested the doctor to test his sperm, because they believed that this is a simple test to perform. Willy was not scared after receiving the result because he had the hope that there is something, which can be done by the medical experts. He was also found to have varicose veins. After an operation to remove varicose veins, the semen analysis revealed the same results as before: non-living sperm cells. Willy describes himself as not being an unhappy man due to the fact that he is infertile. His former wife blamed him because he was not very much concerned with the problem. According to Willy, what he sees has changed in his life is the fact that he became more promiscuous after knowing that he is infertile. Willy explains that he was doing so because he wanted to prove himself that his sexual performance is still the same despite the fact that he is infertile. He believes that this problem created problems in his former relationship. He informed his former wife that he had an affair with another woman, expecting that she would forgive him. To the contrary, this brought a crisis in the relationship, which ended in divorce. Willy is blaming the medical team on how they advised them to solve their fertility problem. According to Willy, the medical experts told him that there was nothing more they could do for him. However, they
advised them to find someone who would donate sperms, so that they can get pregnant through AID. They were confused afterwards because they did not know how to go about it. He was not comfortable with the idea of using sperms from another man, although his wife wanted to do it immediately. Willy said that at that time he was not ready to use donor sperms. Willy believes that he is now ready to have children with his current partner and he is positive about AID after having lived with another woman and her child before his current partner. Willy has been taking care of that child and he had the feeling that he was her father. This made him to become very strong and he believes that he will not have any problems with a child conceived from donor sperm.

May

May is fifty years old, childless, married and he is infertile for over fifteen years. When he found out that he was infertile (non-living sperms) he had the feeling that it was better to end the relationship with his wife because he could not see any good reasons to continue with the relationship if they could not make children. Nevertheless, they decided to go for AID and they had three inseminations and there were no positive results. After those failures his wife was then examined and it was found that she has blocked tubes. They were advised to go for IVF, although May was positive about it his wife did not want it because she had to take hormones. He did not have any choice because he could not force her to go for medication. They started thinking about adoption but this option was impossible because May's age did not allow them to adopt. May believes that his life has changed a lot. He became more involved in spiritual healing and he is now partly working as a psychotherapist, a kind of work he has never done before discovering that he was infertile.

George

George is thirty-two years old, childless and married for over six years. He has been dealing with infertility for four years. They have had four ICSI, two of which were done in Germany. After those four failures they decided to take a break and now they are looking forward to start again after six months. He believes that this problem has brought them closer together and they are prepared to live without children if ICSI fails. They did not have a chance to discuss about adoption and still they do not know if that option would be feasible for them. At the beginning he was scared with the fact
that he is infertile, he did not want to discuss it with other people. His wife keeps on encouraging him to discuss it with other people. George believes that his partner is stronger than he is and that men often pretend to be stronger but they are not. Through the courage he has got through his wife he can now discuss about his problem with others. However, he has to trust someone before telling him/her that he is infertile.

**Patrick**

Patrick is thirty-four years old, childless and living together with his partner for over ten years in the central part of the Netherlands. He and his wife started thinking about having children six years ago. After a year of trying, Patrick was advised by his partner to first have his sperm tested. Because his semen looked strange compared to that of his partner's former boyfriend. Then it was found that he has a low sperm count. He does not really pity himself because of the fact that he is infertile. At the beginning he was just following what his wife was suggesting. He was not yet ready with the idea of having children. But now he really thinks that he wants to have children. Patrick does not have problems in discussing his problem with relatives and friends. He informed them from the beginning because he wants to be ahead of them; he does not want them to start looking for reasons why they do not have children while he and his partner have been living together for over ten years. They are still on medical treatment (ICSI). They have already decided that the next treatment will be their last chance. Patrick and his wife attended a course on adoption because they want to leave that option open. In case the next ICSI does not solve their problem they will immediately go for adoption. After three IVF and one ICSI failures they quitted from their jobs and travelled in different parts of the world. They wanted to have relaxed minds and try to see if they can conceive naturally. During the trip they also tried Tibetan traditional medicines and other remedies. Here in the Netherlands they also underwent homeopathic treatment for three months. According to Patrick all initiatives for alternative medication came from his wife. She usually keeps on looking for new therapies and once she finds something she advises Patrick to try it.

**Denis**

Denis is forty years old, married and a father of two children which he had through AID. He lives in the southern part of the Netherlands. He was married for four
years before discovering that he was infertile. He was very much disappointed after receiving the results of his semen analysis. He feels and sees a very big difference between him and his wife because they have children through donor insemination. Although Denis and his wife love their children, he sees that his feelings towards his children are different, because his wife is the real biological mother, while for him biologically there is another man involved. Denis is blaming the general practitioner because he strongly advised his wife to use donor sperm in order to become pregnant. Denis reported that he agreed to do AID just to satisfy his wife’s wishes, because she was very badly affected with the fact that she could not become pregnant and give birth to her own child. He also feels guilty because he was the one with the problem (low sperm count), but all medical interventions were mainly focusing on his wife. Denis is worried what will happen in the future when his children are adolescents. His main fear is whether they will still recognise him as their father. He and his wife decided to tell their first child (10 years) that Denis had problems with his sperms, so they decided to use sperm from another man. And they planned to tell their daughter in the near future. Denis believes that his wife’s problem was solved ten years ago when they decided to go for AID, while for him the problem then started and until now he is thinking about the AID. One year ago Denis went to the psychotherapist because he felt strongly affected with his feelings toward his children. His wife was surprised and felt guilty after hearing that Denis is still worrying about the AID though it is almost ten years ago. After the therapy he now feels more relieved and he is able to talk about it with his wife.

Fred

Fred is forty years old, childless, and married for over ten years. Eight years ago he was diagnosed having low sperm count. He did not have any problem in handing in his sperms because he thought that the results would be normal. After receiving the results he was not too much disappointed because the doctor told him that it might be possible for his sperm to impregnate his wife. After repeated failures of IVF and ICSI (done in Belgium) and having spent much time and money they became exhausted, very sad and disappointed. Fred finds it very difficult to give injections to his wife. They had the feeling that they are running a bit ‘crazy’. They cried together and Fred did not cry much because he wanted to make sure that as a man he becomes
strong, so that he could hold and support his wife. Fred’s sadness is due to the fact that he has not been able to give his wife what she mostly wanted: a child. He and his wife were advised about AID, but they decided not to do it. They discussed about adoption, and they travelled to South America looking for a possible child for adoption. They were discouraged by the conditions they saw among the children who were available for adoption. According to Fred, they saw most of the children begging in the streets and they were not happy with it. They decided not to go further with adoption. Meanwhile, they are considering taking care of children, especially those who have been neglected by their parents. Fred and his wife believe that this problem has brought them closer together and they need to support each other. The depression and anger Fred and his wife had over their fertility problem have diminished over the years due to the peace they have found after having been counselled by a psychotherapist, but they still have some difficulties when they see parents and their children walking around.

**Rob**

Rob is forty-two years old, married and has two children through adoption. Rob’s wife was diagnosed to have blocked fallopian tubes. Rob felt uncomfortable in handling his sperms for test. After receiving the positive results he was happy and relieved. They tried six times IVF without success. His wife blamed him because he was not much supportive. She claimed that he was busy doing other things, talking with his friends and playing tennis at the time when he was supposed to support her. Rob had the feeling that as a man he was not supposed to cry. According to him he was encouraging her all the time and wanted her to continue with the treatment. After repeated IVF failures they decided to stop. They went for adoption and they do not feel anymore the pain and sadness they were experiencing before, especially during treatment.

**Jaap**

Jaap is thirty-six years old, childless, and married for over eight years. They have been dealing with infertility for about six years now. There was no medical explanation given for their problem. All tests revealed that their reproductive functions were essentially normal. They believe that it could have been better to know exactly
what was the source of their infertility. They had six AIH and two IVF, they then decided to take a rest and currently they are thinking to have another IVF after six months. Jaap believes that this problem has changed his way of life because he and his wife became more involved in the patient support group. He started as a member, in the mean time he became a contact person. He is actively participating in organising meetings and information evenings for infertile couples. He is looking forward to become a member in the board of the group and later to become a chairperson. Jaap and his wife help other infertile couples by responding to emails, telephone calls and through meetings. They see active involvement in the group as a positive way of coping with childlessness. Still, they are feeling pain and sufferings of failure to become parents. Jaap’s sadness is also due to the fact that he is the only child from his parents. His parents they are also saddened because they are not able to become grand parents.

Reek

Reek is forty-seven year old, childless, married and living in the southern part of the Netherlands. After one year of trying to have children they decided to consult the doctor. The medical investigations revealed no abnormality. Reek did not have any problem in handling his semen for test. He regarded it as a normal procedure like doing other medical tests. Reek was not yet prepared to become a father at the time when they started trying to have children. He was thinking about the loss of his freedom if his wife would become pregnant. Because he has to take care of her when she is pregnant and participate in caring of the child, which will take a lot of his leisure time. Reek and his wife had conflicts, during the treatment process, especially when she had to take injections. After four IVF and two ICSI failures they decided to go for a long vacation. His wife later on decided to go on a sick leave. She was always thinking about their failure to become parents. She attended the psychotherapy and with time she started realising her problems and she believes that the therapy helped her a lot. Reek said that he sometimes thinks about it, but not too often. There are some moments when he becomes sad, for example when seeing a father playing around with his son. Reek believes that the problem has brought them closer together, while in the beginning it brought conflicts in their relationship. Reek and his wife were disappointed because at the end of medical interventions, when they decided to stop,
the medical experts could still not explain them what was the cause of the problem. They believe that it could have been a relief to know the source of their infertility.

Dan

Dan is fifty-two years old, childless and married for almost fourteen years. Dan and his wife were trying to have children for four years before consulting the doctor. Then, they were both examined and no problem was detected. Dan had the feeling that the complications, which resulted from the laparascopy, which was done on his wife, may have caused the problem. In addition, he believes that the operation his wife had to remove an ovarian cyst when she was twenty-one might have caused the infertility. Although, all medical examinations revealed no indication for that. In testing his sperm, Dan was not worried, because he assumed that he did not have a problem with his sperm because in a previous relationship he had impregnated his former girlfriend. Dan and his partner decided not to go further with medical treatment after the initial investigations, because they had heard that the success rates of the technologies are still very low. Dan believes that the good relationship with his wife is the most important asset they have and has made them very strong. They sometimes take care of their relatives’ children and this somehow gives them comfort. They did not want to adopt a child because they thought that it is not a good idea to remove a child from his/her natural parents or environments.
Participants had been trying to have children for one to nine years. At the moment of the interview three men were fathers: two through AID and one man had two adopted children. All of these participants had consulted the doctor for their infertility problem and all men I interviewed had their semen analysed. Their female partners had had more diagnostic tests done on them. These tests included laparascopy, HSG and serum hormonal levels. In seven of the cases it was found that the infertility was due to male factors: low sperm count, sperm deficiencies (non-living sperm cells) and or varicocele (two men had a combination: no living sperms and varicocele). In one case infertility was due to a combination of both male factor (sperm deficiency) and female factor (tubal problem). In another case infertility was due to a female factor only (tubal problem). In the remaining three couples the cause of the infertility could not be explained.

Two men have had an operation to remove the varicocele. Both operations did not have any positive outcome. The remaining investigative and treatment procedures were exclusively done on their female partners regardless of who had the reproductive impairment. The treatments offered were artificial insemination with husband's sperm (AIH) or donor sperm (AID) and use of ovulatory stimulating drugs most of the time followed by procedures such as IVF, ICSI, AID and AIH.

With the exception of the AID, the treatment procedures did not result into pregnancy. For the two participants who had children through AID, in one case conception occurred immediately after the first insemination, while for the other his partner was able to conceive only after the fourth insemination. For two participants whose female partners each had three AIDs, conception did not yet occur.

The partners of six participants had IVF. Four participants had a range of two to four ICSI. Two participants and their partners did not continue with treatment after the initial investigations.

Participants were asked to explain their experiences with all these medical interventions. Main issues regarding these experiences will be discussed in this chapter.
4:1 Experiencing Semen Analysis

Semen analysis is a simple test to start with in infertility work-up. It is less expensive and non-invasive compared to other tests, which are exclusively done on women. About 30% to 40% of infertility is associated with problems in the male reproductive functions such as oligospermia (scarcity of sperm in the semen), azoospermia (absence of sperm in the semen), high viscosity of semen, low sperm motility, and low volume of semen (Davajan 1991:19, Taymor 1978:78-80). Obtaining a specimen and performing a routine semen analysis is relatively easy. This test belongs to the first step in the investigation of the infertile couple.

Participants were requested to collect the semen specimen at home and required to obtain the semen by masturbation in to a clean jar. To maintain viability the specimen is kept warm. The examination of the semen is usually performed within the first hour after collection. Some of the participants did not feel this as a problem as Willy’s story illustrates:

I had no problems, because I thought everything would be all right. I think my view was that I am healthy. It cannot be possible that anything is wrong with me. It was like if you are driving a car and the police stops you to check if you are drunk and you have not drunk anything and they want to test you for alcohol...and it was like okay test me, no problem.

However, most of the participants I spoke with report that providing a specimen for semen analysis was extremely embarrassing. For example, Denis found it difficult to walk with the container full of his semen sample to the hospital. According to him he just decided to do the test because he thought that it would be a step in solving the problem. Although embarrassing Patrick did not see this test as a main problem. According to him, he had only to go through a short period of embarrassment of testing his sperm, compared with the many difficult interventions, which were done exclusively on his wife.

Surprisingly, in one case the man was not requested to have his semen tested. Hans and his wife visited five different gynaecologists in one year and in the first four appointments he was discouraged because no one was able to recognise their problem. Hans reported that by using common sense he himself requested the gynaecologist to test his semen.
My wife had a laparoscopy and everything was normal. We made another appointment and that was the gynaecologist number five and before he was to examine my wife I asked him to take my semen and just look it under the microscope. So I got a cup and I delivered the semen for analysis...I got the answer that I had no living sperm in my semen.

From a biomedical point of view, results of semen analysis are grouped into infertile, subfertile and fertile. This depends on the sperm count, its motility and morphology (Taymor 1978: 83). In biomedical literature it is reported that there is a lack of absolute standards of fertility or infertility in terms of sperm count, motility and morphology. This has caused controversy in evaluation of the male factor (Taymor 1978: 79, Colpi1994: 1-4).

Among the men I interviewed in this study, semen analysis created three groups, those with no sperm, with low sperm count, and those without impairment. As mentioned before most of the participants were not comfortable with the test. However, for those whose result turned out to be negative it was worse: they were disappointed. Although many men described it ‘not as a failure’. The reason why they were disappointed was because they realized that they could not have children of their own. Some mentioned that they see it as a failure because they are not able to give their wives what they mostly wanted: to become pregnant from them and give birth to a child physically:

I was very angry and disappointed when I heard the results. It was two days before Christmas.
I did not celebrate Christmas and New Year. I was so pissed-off, so angry because I could not give my wife what she mostly wanted...

On receiving the results, especially those with low sperm count, they still have hope that they may be able to impregnate their partners. According to those participants who had low sperm count they were assured that it might be possible for their sperms to work either through AIH, IVF or ICSI. Some participants were advised to try these possibilities. Fred was confident after discussing the results of semen analysis with his doctor and he commented:

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1 One of the standards of semen quality commonly used is the following. (Colpi1994: 1-4)

<table>
<thead>
<tr>
<th>Count</th>
<th>Fertile</th>
<th>Subfertile</th>
<th>Infertile</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;40 million</td>
<td></td>
<td>20-40 million</td>
<td>&lt;20 million</td>
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<tr>
<td>&gt;50%</td>
<td></td>
<td>40-50%</td>
<td>&lt;40%</td>
</tr>
<tr>
<td>&gt;70%</td>
<td></td>
<td>60-70%</td>
<td>&lt;50%</td>
</tr>
</tbody>
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It was great that there was something, because in the hospital they told me that there are few sperms and they said that it could be possible for my sperm to make my wife pregnant. From that time I had a hope that things will work out and we may be able to have children of our own.

Unfortunately, none of the participants in my study benefited from these procedures.

For those without reproductive impairment it was a relief for them after receiving the results as Rob’s wife told me:

My husband was very happy after receiving his results...he smiled a lot and said...ooh yes I have made it, I don’t have any problem.

That men usually are not comfortable with semen analysis and its results was confirmed in a conversation with a gynaecologist in which he told me about his experiences with men:

They all the time tensioned to hear about the results. There is a period of denying. They do not accept it very easily. Sometimes they say that may be the sample was not mine... They become very much disappointed, denying and they try to find out who is to be blamed...

According to some informants, sometimes the approach of the doctor in informing the participants about the results increased sadness and depression among the couple. They were not comfortable with the approach of the doctor. Patrick mentioned that a direct conversation with his doctor could have been better rather than hearing the result on the telephone:

It was only on the phone and very fast. The doctor phoned me and he said there is no much future in your sperm that was sort of very cruel way to inform me. And that was one of the emotional moments, we cried together with my partner. The doctor should have told me, let’s make an appointment...

Patients need sufficient time to discuss the results with their doctors. Roy became angry to his general practitioner on the way he discussed with him about the results of his semen analysis:

He spent only five minutes to tell me that there were no sperms in my semen and that I cannot make my wife pregnant.
4:2 Treatment: The Role of Male and Female Partner

Biomedical treatment of infertility follows the identification of the specific diagnosis. The objective of any infertility treatment is to increase the chance of conception and the number of live births. This is expressed as the percentage increase in the chances of conception per cycle. The chances of conception in any couple should be seen against the background of the duration, the specific cause and the age of female partner. In his discussion ‘Assessment of new reproductive possibilities’ Pryor (1994: 1) states that during infertility treatment the age of the female partner has been shown to be very important not only in infertility management but also in assisted conception. Pryor explains that the pregnancy rate per cycle during assisted conception decreases with age. The higher the age, the lower the rate of pregnancy per cycle. According to Pryor (1994: 2) the pregnancy rates per cycle in the age groups 30-34 and 35-39 are 29% and 25% respectively. In my study most of the participants’ partners had initiated medical treatment after the age of thirty, implying that their chances to become pregnant are relatively low.

Most participants' have undergone a series of medical interventions. They often considered it as a frustrating process. Of my informants, at the moment of the interview, some were still having hope that one-day it will work out positively. Most of them have undergone expensive and sometimes dramatic, painful procedures. Some participants reported that their female partners found it very difficult because they have to take hormonal injections every day to stimulate the functioning of their ovaries, even when the problem does not lie with them.

My male informants, regardless of their fertility status most of the time played a passive role in the treatment. With the exception of two participants who have undergone surgical operations (varicectomy), all other treatments were exclusively done on their female partners. Patrick and Denis strongly expressed that they felt guilty because they were the ones with the problem but all focus was on their wives, as their stories illustrates:

[Patrick] For the past six years, the most difficult part was for my partner. This in fact is not fair. It is my problem but she has to do all the medical things, which are more difficult. The only thing for me is to have my sperm produced. They did not do anything with my sperms. I do not consider my part to be difficult. Her part is extremely difficult...
Typically everything was focusing on my wife. The stress of taking drugs, going to doctor every week and the simple operations to get out the eggs. It was me with the problem, but my wife she had to go through all the pain and sufferings. They did not do anything to me. I was just sitting there, looking. It seems as if the biggest problem was for my wife. I felt guilt because she has to undergo all the sufferings.

Some of the participants reported that there were conflicts, during the treatment period. Four of them said that their female partners became angry towards them, because they felt were not very supportive. Patrick and Willy, for example, did not consider infertility as a big problem although they were the ones diagnosed to have reproductive impairment, while for their partners it was a very big problem. This brought tension in the relationship because their female partners blamed them that they were not concentrating on the treatment. The same thing happened to Rob who did not have a reproductive impairment. He had a conflict with his wife. She blamed him because he did not want to take free days from his job to support her during IVF:

I was not there most of the time. May be because of what I have explained before: my perception of the whole thing was different from her. I think for her it was more important than it was for me.

Despite the fact that infertility is a couple's problem, participants commented that their female partners where much more involved into the program. Six participants reported that their partners were constantly busy making appointments. May, for example, commented that his wife was much more involved than he was and that she wanted to be seen by the doctor almost every week. May commented:

She was constantly busy with it, she was mainly thinking of going for treatment. She was leading in everything and I was just following...

**4:3 Starting, Continuing or Stopping: Who Decides?**

Even when men are not the focus of the treatment, men are involved in the decision and treatment process. They are involved in giving injections to their wives, handing in sperm and accompanying them when they go to hospital for treatment. The gynaecologist at the academic hospital even stated that in his hospital, all the time wives have to come with their husbands. In the hospital the couple gets the results of the various diagnosis and the next steps and options in the treatment procedures are
explained. It is the couple, who has to take the decision. How do they do this? Verdurmen (1997:206), in her discussion of decision-making among infertile couples in the Netherlands distinguished four different types of infertile couples based on the way they make choices regarding medical help. The four types she identified were 'setting limits before hands', 'taking control themselves', 'step by step', and 'everything is obvious'. Verdurmen argues that the four types are characterised by the amount in which couples are active, rational and critical in their decision-making regarding medical help. Setting limits before hand couples are more sceptical and critical regarding medical help. Taking control themselves couples are positive about medical help, but active in decision making, they discuss things and they can set limits. Step by step couples are less active, follow a wait and see policy. Everything is obvious couples completely surrender to the specialist. They will do everything he/she suggests.

When analysing the conversations with the participants I came to realise that my participants fall under different categories, and that men and their female partners not necessarily fall under the same category, regarding the way they made decisions on medical interventions. Of the informants I interviewed, one of them falls clearly under the 'setting limits before hand' category: He and his wife did not want to continue with medical treatment after the initial investigation. They asked themselves about the risks of the procedures and they decided not to start with medication. Dan and his wife did not have any problems in deciding to stop from medical interventions. They had heard that the success rate was still very low. After asking why he decided not to go further, Dan confidently said:

It was because of our awareness that the rate of success is very low. We have heard from other people who have undergone through these artificial technologies, ten or fifteen times. It was more a question of how much time and effort and absolutely inconveniences and pain we have to go through...

According to Rob and May, their female partners did not feel comfortable with taking hormones. They had the feeling that it was too complicated to take injections frequently. They had already started with the treatment, but then decided to stop. So, in both cases the men wanted their wife to continue the treatment, but the women set their limits (taking control themselves type). According to May there was some
tension when deciding to stop with the IVF treatment but there was no way. He had to respect his wife's decisions. May explained this to me as follows:

My wife strongly refused, because she did not want to take hormones. I became frustrated, I cannot force her because she is the one who can become pregnant. So at the end I had to follow her wish that we are not going to continue with treatment.

Willy too belongs in the 'taking control themselves' category while his wife was in the 'everything is obvious' type. According to Willy, his wife wanted to go for AID immediately, but Willy did not want to do it.

Some of the interviewed men and their female partners were critical about the treatment but still continued with it (Having control themselves/step by step-type). During the treatment process they asked a lot of explanations and information about the risks associated with it. They were very conscious in taking decisions and they had a large period in between two subsequent treatments. Their desire to have children was very high, but they needed a lot of time and information to think about the treatment, which was offered. Jaap and his wife, for example had two IVF five years ago and their initial plan was to rest for six month before going for the third IVF. However, according to Jaap they are still discussing whether to continue or not. Fred and his wife, although they decided to go for ICSI they were also confronted with dilemmas:

Our fears were based on the fact that you may get a disabled child. We were asking if they make a mistake and we get a disabled baby, can this work out right for us to have a disabled baby? We discussed about it and asked the doctor a lot of questions, then we decided to take the risk. And you know you have to feel guilty if you give birth to a child with a disability.

Three participants reported that they had not considered any other option: they only went for treatment immediately. According to these men, they were pressurised by their female partners. This made that they themselves also exclusively thought about treatment. Roy for example explained me that when they were looking for solutions, his wife mainly discussed about treatment. He felt he did not have the chance to think in detail about the risks associated with treatment. These three men came to realise later on that they were doing things without careful attention. In the view of these men, they ended up in the 'everything is obvious' type while they themselves had wanted to be more critical about steps taken (step by step). They
commented that they now regret why they were not warned about the risks of taking immediate decisions. Jaap commented:

It is like when you see a very nice car and you admire it and immediately you want to buy it. Then you pick the car and just after a few days you find out that it is not the car that you really wanted. When I did the first two IVF, I came to realise that it is really a tough job. Really, I was not conscious of what I was doing. I was just giving injections to my wife; it is really painful and stressing. Later I asked myself what am I doing here. I came to realise that on the waves of my own desire I made very unwise decisions...

According to some of the men I interviewed, the strong desire of their female partners to become pregnant was the only reason to start with treatment. Patrick for example, after knowing that he has a low sperm count he was willing to live without children. He said to me that all initiatives came from his wife and he was just following. Reek’s wife also told me that her husband was not much involved in making decisions. On deciding to consult the doctor there was a conflict among them because according to Reek himself he did not want to start with treatment program, because he was still thinking whether it was very important for him to become a father or not. While for her she really wanted to become a mother.

Besides the wish of the partner, the advice by medical experts also influences and sometimes complicates the whole procedure of decision making. Denis pointed out that the strong comments given to him and his wife by the doctor brought tension among them when discussing the treatment option (AID) available to them. Denis explained me as follows:

Our doctor pretended at that time...he just said do it. It is a matter of taking a very small cell from another man and take the egg from your wife, put them together and then your own child will be born. It will be your own child, you will feel it that way, and you will experience it that way. So more or less the same... what is the problem just do it.

Deciding on continuation or stopping biomedical treatment seems to be more difficult when the next step in the search for a child implies that the man or both parents would not be the biological parent, as in the case of AID and adoption. The participants' experiences with these two options will be discussed in the next paragraphs.
4:4 Artificial Donor Insemination (AID)

AID may be an option for a number of reasons. The absence of sperm in the husband is, by far, the most common. In other cases, husbands may have a low sperm count or immobile sperm, hardly capable of fertilising an egg. The head of the sperm bank in one of the Dutch academic hospitals pointed out that in his hospital when attempting AID 40% of all patients become pregnant after 6 cycles, 25% becomes pregnant after the next cycles, 25% becomes pregnant after IVF using donor sperm (IVF-D) and the remaining 10% do not succeed to become pregnant.

Of the men I spoke with eight had a reproductive impairment and four partners had already had AID. Two were successful in having children. One of them reported that conception occurred immediately after the first AID. For the other it occurred only after the fourth AID. The remaining two participants have had three and four AID respectively. However, for them conception seems to be difficult. Of these two participants one was still waiting for another AID. The other participant did not continue with AID because it did not work out and his wife did not want to take hormones when advised to do IVF using donor sperm. The remaining four men with reproductive impairment were either still busy with other medications or decided not to pursue AID. I will explain later the reason why they decided not to do it. Those who were still on medication (mainly IVF and ICSI) at the moment of the interview, considered AID as their last resort, and were not yet sure whether they go for it or not.

For those who had decided to do it, it had not been easy to make the decision. In biomedical terms, AID is a simple and inexpensive procedure compared to IVF and ICSI. However from the perspective of the people involved AID may be more complicated than IVF and ICSI.

AID is not a treatment for male infertility, it is ‘a means of bypassing a partner whose reproductive impairment resist correction’ (Greil 1991: 31). Through AID a child has another biological father than the male in the couple, and that is the reason some couples prefer not to do AID (Baird 1995: 493).

In case of AID the mother is the biological parent. The wife has the opportunity to experience pregnancy, birth, nursing, and all the other roles of motherhood she wishes. The husband, however, will not have the biological link with his child and that makes that some men see it as a problematic issue because they are afraid that the relationship between the mother and the child will be much closer than the relationship...
between themselves and the child. Before insemination, the couple has to sign a consent that if the child is born as a result of AID process, the child will be treated by law as if it were the husband’s natural child. In reality, it is difficult for the parents to reduce the donor to a sperm cell. Brewaeys (1999:23) who interviewed heterosexual and homosexual parents, who had children through AID, found that in both groups of parents it remained difficult to reduce the donor to a sperm cell. Fantasies and questions about the donor continued to exist over the years.

The men I interviewed had different ideas about AID. Almost all men with reproductive impairment were asked about their views concerning AID. Their views varied, and they had no simple answer. The interviewed men were categorised into three different groups based on the ways in which they discussed AID with their female partners. The following three groups have been identified: ‘husband positive, wife negative’, ‘wife positive, husband negative’ and ‘both husband and wife negative’.

Three men I interviewed were in the ‘husband positive and wife negative’ group. These men wanted to have AID, but their wives were not comfortable about using the sperm from another man. According to Hans, his wife was worried that in case of conflicts Hans would say that it is not his child. As illustration, Hans described his perceptions while discussing AID with his wife:

I have the perception that there are women on the earth and they have to give birth to children and the body is made to carry the pregnancy. I could not give my wife pregnancy, but there is somebody who delivers sperms for people who need it. That is a possibility. And then later on you can have some reflections on the child because he/she has some DNA from my wife. When the child is growing, you can always say ooh she has this or that from my wife.

Patrick had the same feelings as Hans, he laughingly commented:

I love my partner very much and I know how much she wishes to bear her own child. So I want to do everything possible to make that happen. The positive thing is that we will be faced with the birth of the child, it is the child that comes from my partner, it is there starting from point zero. I am wondering how much is the DNA impact or how great it is to have a child with my own DNA. I think the characters will be made by the way we raise the child.

Willy and Denis belonged to the ‘wife positive, husband negative’ group. Willy’s and Denis’ wives wanted to have AID immediately after being informed of
that choice. According to Willy and Denis this brought tensions in the relationship. Their wives did not want them to tell about their infertility other people because during that time AID was the only option to be considered. Willy did not want to go for AID because he was not yet sure what would happen in the future. He also had the feeling that he was going too far to fulfil his desire to become a father. He needed more time to think about it and to get used to the idea. He said:

Having children through AID is a very big decision. It is not like going to the shop to buy furniture or clothes. There you can choose whatever you like and if you find out that that is not the type you wanted, you can just return to the shop or simply sell it. But having children in that way you cannot reverse it at all. It is there and that is all. For a child is a child. You make decisions about having children and you have them. That is all. You cannot change the decision once the child is there.

Denis decided to go for AID (and he got children through this method), because his wife wanted it, although he was not yet ready for it. He is still blaming his wife because she did not take into considerations his feelings. According to Denis his wife's problem of not becoming pregnant was solved ten years ago, but for him things then became more problematic:

You cannot imagine. For ten years I look at the boy everyday and everyday I think about the donor. Not always sad but it is always there. How does that man look like? For example when he laughs, I start thinking if he was my son biologically how would it sound.

Denis thinks that he would have preferred to go for adoption or to remain childless, because people around would have known that they had a problem and that they had decided to go for another alternative, but not AID.

Besides the fact that the child is not his own, it was embarrassing for Denis to undergo the procedure of AID. Denis had doubts about the procedure and he felt sad on the day when AID was done to his wife. Until now Denis is still very negative about AID, despite the fact that he has got two children through AID:

What I can say about AID is that it is a rape. It is raping. I saw my wife lying on the bed and the doctor was inserting sperms of another man in to my wife. It really hurts and I was thinking, if they make a mistake and she delivers a black baby how will it sound, how people around me will take it...
Finally, Fred and his wife belonged to the 'both husband and wife negative' group. After having had three IVF and two ICSI, they were informed about AID. They did not even want to discuss it. The idea of having children from another man was not an option for both of them. Listen carefully to what Fred’s wife has told me:

It is our problem... I will not be honest to my husband. It will be the same as if I have decided to fall in love with another man.

I discussed with the gynaecologist in one of the hospitals dealing with AID and he explained me as follows:

When considering AID we let them decide whether they want to think further. Men should have already passed their mourning process. They need to take into consideration all these issues during the counselling process. You need to know how far the man is in the mourning process. In the AID the man is a social father, but he needs to think and feel about it and he may be able to adapt to it properly after the mourning process. The man needs to think about it...according to my experience there are some situations when after counselling some men decide not to do AID.

Besides the problems AID raises for the man involved, the interest of the future child should also be taken into account. In his discussion ‘New reproductive technologies and the need for boundaries’ Baird (1995: 491-498) argues that if nothing is known about a biological parent, it often poses a great difficulty for the child’s sense of identity. Denis, father of two AID children, made a remark about this:

I am so scared, my biggest fear is not the way I love them, but the way they will cope with the fact that they are children from another man. How will it feel for them when they are twenty or thirty? May be they will start thinking about it...who is that man, how does he look like...I am so scared of feeling the distance between two of us because I am not their biological father.

The use of donor sperm has raised many questions and many remain unanswered. The anonymity of sperm donors has recently been the subject of public discussion in several countries. In the Netherlands this has brought a very hot discussion in politics concerning the identity of the donor (Brewaeys 1999: 24). In AID there are two possibilities, the use of a known donor in which donor information may be given to a child, when he or she is sixteen. The use of an anonymous donor, the information about the donor is kept in strict secrecy and it is impossible to connect a
donor with a recipient since these records are never established. According to the
gynaecologist I spoke with, currently they are changing the law in such away that there
will not be anymore an anonymous donor in this aspect. Children shall be given the
rights to get the information about their biological father. Of course it is up to the
parents to tell their children about the whole situation or not. He also commented that
it is better for them to do it when the child is still very young, may be four or five
years. Although the issue of informing the child while still very young may be difficult.
Brewaey (1991: 27) argues that young children are not yet interested in details of the
reproduction process.

4.5 Adoption
Adoption is considered as an alternative in case medical interventions fail to
solve the problem (Van Balen 1999: 21-23, Verduren 1999: 205), or when people
decide not to go for all possible treatment, as was the case with two couples in my
study. In his discussion ‘Choices and motivation of infertile couples’ Van Balen
explains that 35% of the couples he interviewed considered adoption as an alternative.
However, only 5% in his study had chosen adoption. Participants in this study were
also asked whether they have considered adoption. Nine of them have at least
discussed the option of adoption with their female partners.

Of the interviewed men one had already adopted two children. One participant
was considering adoption in case medical treatment would fail (they were still on
ICSI). At the beginning he was against the idea of adoption, but after he has discussed
it with his partner and attending a course on adoption he became as positive as his
wife.

Four men had considered adoption, but the main problem was their ages. They
were all almost forty years old at the time when they were considering adoption, and
according to the Dutch law people can only adopt a child of less than one year if their
age is below forty years. Those above forty years, can only adopt a child of more than
one year.

As with decisions on medical treatments, partners do not always share the same
opinion. While Roy wanted to adopt, his wife was not ready for it. She just wanted to
focus on medical treatment (AID). For Reek and his wife this was also a source of
tension while at the beginning of the interview Reek told me that he was against adoption, later in the conversation he said that they discussed adoption but the problem was his age. However, his wife commented that she always had known that her husband did not want to adopt and this brought some tension among them. But not all couples experienced this kind of problems. Fred and May did not have any problem in agreeing with their female partner. They both had positive feelings about adoption.

Almost all participants who considered adoption as an option mentioned as their main reason that they wanted to have a family. By adopting a child one is able to fulfil the desire to raise children and to have a family:

[Rob]: By adopting these two children it has enabled us to fulfil our desire of having children. I don’t regret that they are not coming from my wife...from our body. I love them very much.

[Patrick]: With all knowledge we have on adoption I think it can be a good way of raising and having a family.

In case of male reproductive impairment adoption may be seen as a good solution because it places both members of the couple in an equal situation, compared to AID. Again, one sees that the fact that two people in a couple have taken a decision together is a complicated factor. Denis and Hans’ wife preferred adoption rather than going for AID because adoption would create an equal situation between husband and wife. Their partners, however, did not agree with them. Denis wanted to go for adoption while his wife was only focusing on how to become pregnant and did not want to discuss about it at all. In the case of Hans, his wife wanted to adopt, while Hans did not want it. Hans’ wife preferred adoption because by adopting a child they will both be in an equal situation and they will never be confronted with a donor.

Apart from creating a family by having children through adoption and the advantage of having an equal relation with the child, it is a way of helping children who are in a difficult situation. Fred and his wife wanted to adopt a child in one of the South American countries, because they were aware of the difficult living conditions in those countries.

Two participants did not consider adoption as an option at all. They and their female partners were both negative about adoption. They considered adoption as an
unnatural process. They were also worried about the problems, which may be brought by adopted children. The magnitude of this is captured in the following spontaneous descriptions offered by two participants in this study:

[Jaap] For me adoption is not an option. The main reason is because he/she is not my child and I may be having problems with the child in the future. You know, this is not a natural process. If it is a matter of getting children I want them in a natural way.

[Dan]: We never thought about things like adoption. We were asking why we want to satisfy our needs by removing a child from his natural environments, from his natural parents...

The media can also have an influence on one's decisions about adoption. Hans was against adoption, and he mentioned what he has been observing in one of the TV programs. He commented:

Just imagine: in Holland there is a TV program, which helps people to find their relatives they have not seen for a long time. Most of the time you see children who want to discover their roots because they were adopted. I am worried that this may happen to me when I decide to go for adoption.

Although adoption can be an attractive alternative there has been a growing scarcity of the adoptable babies and prospective parents may have to wait a long time before adoption becomes possible. The procedure also takes a long time. Fred and his wife wanted to adopt but it took a long time before deciding to stop medical treatment. At the time of deciding they were both at the age of forty, which complicated the process of adoption. When I discussed this with the contact person from FREYA he explained me as follows:

When you are still on treatment you are not allowed to adopt a child. Because there is the perception that you are not concentrating on adoption. It may also take you at least three to five years to accomplish all the necessary procedures. May be two years to accomplish the government procedures and another two years in the country were you want to adopt. It also depends where you want to adopt a child, in Holland for example it may take you even more than seven years...
Chapter Five
Cultural Factors Influencing Men’s Desire to Have Children

From the conversations with men I have found two factors being extremely important in explaining why men are so eagerly searching for a child. These are the value attributed of having children and their perceptions of masculinity and fatherhood. These factors will be discussed in this chapter.

5:1 The Value of Children
Birth and death are the most basic of human events and reproduction transcends the boundaries of individual lives to signal survival and continuation of family and species (Bliss 1991: 7). Having children is important in all societies. It is seen as the role of men and women to become parents. The desire to have children is high for almost all people in all societies, although the reason why children are valued may be different in various cultures.

I asked the participants in this study what they see as the value of having children. Among the twelve participants, three had children. The remaining nine participants were either still going on with treatment or they had already decided to stop. I did not find differences in the responses about the values of having children between those men with children and those without children.

First of all, the participants expect that their relationship will be influenced through having children. Most people that get married, expect to have children afterwards. Jaap has been dealing with infertility for more than six years and when asked why struggling that much to have children, he commented:

When confronted with infertility you basically do not know what actually you are dealing with. You are doing things based on the desire that the whole society is build up. You go to school, you fall in love, you get engaged, you get married, you get children and then you become a father... and if you are lucky you become a grandpa, that is the way you are raised.

Infertility comes in as a shock and is sometimes seen as a threat to their relationship. Having children may be seen as strengthening the relationship among the couple. Consider the stories of Hans and Denis on how they see the value of children:

[Hans]: The love that I have with my wife is very romantic but to make our marriage complete we need to have children. The crowns of our marriage between my wife and me are children...
[Denis]: Children are some kind of bridge between my wife and me. In one way or another the relationship with your partner becomes stronger when you have children.

Continuation of species, which occurs by means of reproduction, is another idea behind the child desire. The process of having children means that all societies will be able to progress from one generation to another. Four participants mentioned to me that having children signifies continuation of human generations.

[Patrick]: Like everybody you think about the meaning of life, what are we here for and then I come to the point the way all organisms are living. You can think that the most important thing is to reproduce and to keep your genes to the next generation. If you look at it from Darwin’s point of view, my sperms are weak, that must have something to do with evolution. You know that in the animal world I would have been lost. Sometimes such kind of thoughts come to me, but it is more of a theory rather than that it is something that comes from deep inside that I must reproduce or otherwise I am of no use.

When I spoke with the psychotherapist, she explained me one case that happened during 2000 new year’s eve. In that period a brewing company was advertising one of its products, and the message in the advertisement was referring to the continuation of the generation. One infertile man became saddened when he saw that advertisement on the television. He wrote a letter to the company explaining that they need to be aware that there are other people struggling much to have children but they cannot and that he was hurt by their advertisement. The brewing company wrote an apology letter to that man.

In addition, the biological link between parents and their child seems to be very important, as we have also see in the discussion on AID and adoption (4:4 and 4:5). Children are seen as a reflection of someone’s character. Reek’s stories illustrate this:

Children are mirrors because you can see your own character through your child. That seems to me to be the most beautiful thing. You see your child growing up and see the character of yourself.

Most of the participants also mentioned emotional support and source of love as one the most important reasons to have children, as Fred mentioned to me:

It is something in my heart to give love to. Children are very close to you. We have a lot of friends but there is always a distance and having children it is something that belongs to the family. If anything happens to you your children come first.
Five men in this study mentioned emotional support during old age as the reason why they want to have children:

[May]: I sometimes ask myself when I am old who will come beside me.

[Willy]: When I am too old and very sick, and if I am lucky they can look after me.

5:2 Perceptions of one’s masculinity and fatherhood

Underlying factors explaining gender differences in reactions to infertility are related with gender differences in the importance of parenting. To develop an understanding of reactions to infertility, it is important to consider the importance the individual places on parenting as a life goal or aspect of identity. In his discussion of ‘Parenting role and identity’ Leslie Clark (1991: 160) argues that infertility has been described as the blockage of one or more major life goals. When goals are blocked or interrupted individuals often find themselves thinking more about the goal themselves, along with the ideas and feelings associated with those goals. Individuals who value parenting highly will be more distressed if they find out that they are infertile. Traditional sex roles dictate that women should value parenting, and are inadequate if they do not become mothers. Gender differences in reactions to infertility may reflect this associated difference in the importance of becoming parents (Dunkel-Schetter 1991: 203).

Another issue which need to be understood and may help in analysing the experience of men with infertility is thoughts on idea of concept of masculinity. It is important to recognise that masculinity is a social rather than a biological construct. Masculinity is a collective gender identity and not a natural attribute (Robert 1998: 612-618). Men are often more associated with rationality and women with emotions. Masculine conceptions of men construct them as fit, strong and intelligent. Conceptions of women on the other hand, construct them as passive and emotional (Seidler 1989).

Infertility has been described as a stigma for women and men. For men it may be taken as an assault on their masculinity (Greil 1991: 24). Fertility and manhood have been linked and this has created a culture where to have no children means you are not ‘much of a man’ (Emery 1995: 1647). A man is expected to prove his virility through sexual performance. Infertility may be stigmatising for a man because it has
been linked with sexual performance. The perception of one’s masculinity may influence the ways in which men experience and cope with infertility. Greil (1991: 65) points out that men who themselves had reproductive impairment were considerably more likely than men without reproductive impairment to have a ‘female’ reactions to infertility and he suggests that the actual experience of body failure is a key aspect of suffering a ‘spoiled identity’. He also argues that a major difference exists between men and women: for men the experience of body failure seems to be limited to those with reproductive impairment. However, he recommended that more research is still needed in this area.

In his discussion ‘motives for having children among involuntary childlessness couples in the Netherlands’ Van Balen (1995:143) argues that motives in the area of parenthood and identity are more important among women than among men. He argues that social perceptions about status and identity make it easy to understand why among women motives like motherhood and identity go together strongly with a very intense desire to have children. However, Van Balen argues that when equal rights between men and women lead to a more equal positions and equal burden sharing in the family, the difference between man and women concerning the intensity and desire to have a child and the motives to want a child will decrease. In his study Van Balen found that for the motivation to have children ‘motherhood’ was the second motivation for women (68%), while for men fatherhood was the third motive (46%).

The men with reproductive impairment in this study did explain to me more often how they feel as the men. Some of them referred to it several times during the course of the conversation, without me posing any specific question to them. To the contrary men without reproductive impairment did not discuss how they feel as men, despite the fact that they have been confronted with infertility.

However, most did mention that they do not perceive being infertile as a personal failure, the only thing is that they were not able to have their own children or to give their wife the pregnancy and child she so eagerly wants to have. Three men mentioned to me explicitly that infertility did not damage them as men. They also believe that there is nothing they can do about it and they have to live with it:

[Denis]: I do not have problems with the fact that I am infertile, may be that I am not normal, no, no. I am just scared that for both of us, me and my wife we cannot have our own children,
from my own fresh blood. I am not ashamed that I am infertile. It is something that belongs to me. It is part of me. It is just the way I am.

[Patrick]: Still I do not feel less man yet...that I am incapable of having children. There are some moments that I think it is a sort of sad and unfortunate that I am not capable of doing the thing that may be very important in life. And I can think about it that I will never have a child of my own, and that I cannot see how he or she will grow and if it looks like me or he/she has the same character as me. So if I start thinking about that I can be very sad but I do not think about that too much and that is why I am not shy or afraid in telling people that I am infertile.

One participant mentioned to me that he became more promiscuous after realising that he is infertile. However, he is not sure whether he is doing so because of his infertility or because of the poor relationship with his former partner. But he did mention that most of the time thinks he is doing it in order to prove that he is still capable, despite the fact that he is infertile.

According to the interviewed men, almost all mentioned that their female partners were more affected and more eagerly searching for a solution. George who had a reproductive impairment said to me that his wife was much more involved and depressed than he was. He believes that women want to become pregnant, not mainly because they love children but they don't want to be different from others in that aspect:

[George]: You know they want to walk with the big belly...so that everyone can see that.

[Rob]: I think there is something in their blood especially they have it in their hormones and something happens in their blood, that is why women suddenly and desperately want to be pregnant and give birth to a child'
Chapter Six
Men in Need of Support

[Patrick]: But mostly the issue was more of how many cells were there and then they ask or advice us to try another time. This is much more of the procedure, is very much more of a solution. They do not really search for the deeper meaning of the problem. They just give treatment. They don’t give any sort of support.

Regardless of who is medically infertile, infertility affects the couple as such. However, from what is currently understood about gender differences, men and women typically react differently to infertility (Jordan 1999: 341, Abbey 1991: 78, Van Balen 1994: 162-3). In his discussion on ‘Cognitive examination of motivation for childbearing as a factor in adjustment to infertility’ the psychologist Lesrie Clark (1991: 158) explains that the negativity of medical treatment, repeated failures, and consideration for adoption and other options necessitate going through a cost-benefit analysis regarding one’s desire to have children.

When confronted with infertility individuals ask themselves a number of questions, which help them to reconceptualize their identity and the meaning of parenthood. The society and culture define the conditions that form the setting within which individuals experience life events such as infertility and involuntary childlessness. Society and culture may strengthen the negative or positive impacts of any stressful life events on physical, social and psychological well being of an individual. There is a strong association between social relationships and the ways in which people cope with any acute or chronic stressors (Abbey 1991: 61, Helman 2000: 202). In his discussion ‘Cultural aspects of stress’ Helman points out that individual’s personality and cultural background influence the meaning people give to their stressful experience.

Infertility is not only a medical problem but it affects many other fundamental aspects of life. According to the participants in this study, some experienced the effects of infertility not as a single event, but as a stressful process. The greatest sources of stress identified by the participants in my study were related to medical treatment. Almost all participants explained that the process itself evoked depressions, disappointments, sadness, anxiety or tensions in the relationship with their partners. However, these men saw more stress in their female partners than in themselves.
Infertility is experienced as stressful, although the degree of stress may vary greatly from one individual to another and between men and women. There is evidence, which suggests that every facet of couple’s psychological functioning is affected by the experience of infertility (Jordan 1999: 342). In his discussion of ‘psychological reactions to infertility’ Dunker-Schetler (1991: 52-54) argues that all individuals who desire to have children will experience infertility as stressful. She points out that responses to negative life events in general are characterised by large individual differences in the extent to which particular emotions such as anger, depression, and anxiety are experienced.

The psychosocial aspects need to be taken into account in the treatment of infertility. There are a lot of issues to be considered when dealing with infertile couples. Since almost all interventions are exclusively done on women, the men’s emotional needs may be neglected during the treatment process.

Participants in this study were asked how they experience infertility, how they feel about it and whether it has changed their personal life. Among the participants, I have found that there are different factors besides factors related to treatment itself, which strongly influence the ways in which they are experiencing and coping with infertility and whether they were able to get any kind of support. In this chapter I will discuss where my informant found (or did not find) the support they needed.

6:1 Female Partner

Infertility treatment itself does not seem to be the main problem, although it can be very difficult physically. The main problem is what happens inside the heads of those undergoing the treatment. Here I mean the mental aspect associated with infertility, not only during treatment but also before and after treatment. As I have explained earlier, some participants mentioned that there was tension because their female partners pressurising them to be there all the time during treatment and to share their feelings. According to some of the interviewed men the tensions and stress started to decrease after stopping medical treatment. The decrease in tensions was either caused by the fact that infertility brought the couple closer together or the husband (according to himself) became strong in terms of rationalising and this made his wife too understand the situation.
Participants were asked whether they have ever had any kind of counselling. Some thought that they did not want any kind of counselling. The reason was that they and their partners supported each other. Hans pointed out that he does not need any kind of counselling because his partner is strong enough and he believes that they can support each other. Dan's story illustrates how a couple can cope well with infertility:

Our good relationship is the protection against stress. It is a sign that our relationship has been a good one. That we have been able to come through the disappointments of not being able to have children.

Two participants reported that they themselves did not need any psychological support and they even could support their partners. Although they were sad, they feel strong enough to support their female partner. The stories of Reek and Fred describe how they think they are very important in supporting their female partners, especially after repeated failures of infertility treatment:

[Reek]: When everything was over, my wife was falling in a big hole and there were a lot of moments that I was not there for her. She blamed me about that, and she was right, because physically and mentally it was hard for her. From there I learned that I need to be available for her...

[Fred]: I was not crying much because I wanted to be a man, to be strong, so that I may be able to hold her, to be there all the time and to support her every time.

6.2 Self-help Groups

Self-help groups seem to be a solution for some infertile couples to obtain adequate social support from each other, by sharing their experiences and concerns with other infertile individuals. Both members of the couple should receive affirmation that their feelings are normal and receive information about treatment options and emotional support. FREYA is a self-help group in the Netherlands for infertile individuals. Its main purpose is to help those who are seeking medical treatment and counseling on choices for the reproductive technologies.¹

Five participants were members of FREYA. Some of them were actively involved, while others were mainly contacting with other members through emails and receiving periodicals. Participants were asked how they view themselves by being

¹www.freya.nl
members, what benefits they have gained by the membership and how they perceive the support groups.

Some participants agreed that they could talk openly and meaningfully about the problems with other people having the same problem. By sharing their experiences and concerns with other infertile individuals, participants received information about treatment options, adoption and emotional sustenance, and were able to express their feelings and worries. Some participants even claimed that people in the support group are their real friends. Jaap pointed out that he has met with people with whom he shares the same feelings, and they can understand him more easily than talking with other people who do not have the problem. Denis who joined the group recently expressed how is dealing with his emotions and feelings after he has joined FREYA:

It opened my thoughts, it gave me an opportunity to talk about it. Now I can discuss it with other people.

While talking with other infertile individuals has many potential advantages, there is also the possibility of negative effects. For example Patrick and his wife who have a fertility problem due to Patrick's low sperm count. They were hopeful about achieving a pregnancy through ICSI. Now they feel sad and disappointed because most of the time they hear only sad stories about ICSI failures. They have gained useful information, but they are anxious and do not have much hope to conceive through ICSI. Two men commented that they were frightened by the stories told by others who had received extensive treatment.

Those men who are participating actively sometimes found it difficult because most of the time they are in contact with women:

[Hans] What I see in the group is that a lot of men tend to put away their feelings. They do not talk about what they feel. You know you can't be afraid of your own feelings. Most of them they do not care, they just say no problem, everything is okay, I feel good...But for me I don't believe that. They are just ignoring their own feelings.

6.3 Counselling and Psychotherapy

The contact person from FREYA whom I spoke with explained me that individuals who are counseled properly have lesser psychological problems, compared to those who attend to those hospitals without special counseling services. He pointed out that only forty percent of hospitals have social workers specialized in dealing with
infertile individuals while the remaining sixty percent do not have such care. He also commented on the way he views the gynaecologists:

The gynaecologists are still looking for the medical side of it, they are not qualified to handle mental problems. They do people but do not think about people.

When I spoke with a psychotherapist specialised in dealing with infertile individuals, she explained that men usually tend to hide their feelings. She pointed out that it is not true that men are not affected by infertility and childlessness. Most of the time they ignore it. In her psychotherapy session most of the time she lets them talk freely about their feelings and emotions. It is important that they get aware of the differences between them and their female partners. Most of the time as we have seen these differences are the sources of tensions in their relationship.

6:4 Relatives and Friends

Participant’s and their partner’s relatives and friends have also influenced the ways in which participants are experiencing and coping with infertility. Discussing their infertility problems with family members (parents, brother, sisters) and friends gives them an opportunity to express their feelings and this may relieve the suffering. However, it is not always easy to decide to discuss it with others. There are many issues, which have to be taken into consideration before discussing with relatives and friends. In this study three main factors were found that influence the interaction with relatives and friends: The diagnosis and the kind of medical treatment to be offered, closeness with family members and friends, and reaction from female partners. These factors may interact with each other depending on the stage of the treatment. For example if a man is the one with the reproductive impairment sometimes it may be difficult to discuss it with relatives and friends. This is due to the fact that they are afraid that, if later, as we have seen previously, they may have to solve the problem by AID, others will know that it is not his biological child.

Almost all participants who decided to tell their relatives and friends did that after they have had at least initiated medical interventions. Two participants decided not to tell anybody. Some of the participants talked about how family members and friends have helped them to deal with their infertility. Some relatives and friends were sympathetic about their fertility problem.

In some cases family events, such as the birth day of a child or if someone is pregnant triggered the most uncomfortable interactions. Although the men I
interviewed claimed that this mostly affected their female partners and not themselves. Sometimes they can feel it as well and become sad, but not in the intensive way their partners are reacting.

Most men I spoke with mentioned that most of the time their relatives and friends were supportive. However, sometimes they made comments of which they believed it may help them, but which are experienced as painful, considering all efforts they have been making day and night to become parents. They complained that other people acted as if their infertility was a small and relatively easy problem to solve. In some cases when insensitive comments were made participants did confront the offender. Others suffered in silence or isolated themselves as much as possible from situations that may be uncomfortable for them. The following stories stresses what I have been discussing in this part:

[Willy]: My parents said to me: do not worry. It is okay. That is not the end of the world. They also said it is not so bad, you are still healthy, you have a good job. They try to offer me good responses, thinking it will help me, but I do not want such kind of responses.

[Patrick]: I told my brother about AID...his reaction was for him it would not be an option...But he has children already. ...They call many times, asking how it is going, how were the results, how is the situation? And if there is another disappointment, it can be too tough to explain ten times that it did not work out. I think it is better not to tell them until everything is finished...

[Hans] He said to me why are you worrying, you have no problems, you have a nice life...no children, no responsibility. So why you make it such a big problem. I became very angry...I asked him, do you know the door where you came in. I said to him...okay go out of my house right now...bye-bye and that was the end of story and end of friendship.

With or without support of (professional) others, in all cases, whether treatment has not been pursued or has not been successful at the end people have to find a way to live with the childlessness. How infertile and involuntary childless men (and their wives) managed to do this, will be described in the next paragraph.
6:5 Living with it

[George]: I have this problem but I have to find the positives and advantages of having this problem as well.

The questioning process helps individuals to reconceptualize his identity, ideal self and meaning of parenthood. Before men and their female partners were confronted with infertility, their desire was to become biological parents. Being a biological father or mother may be perceived as a real fulfilled and happy person. After being confronted with infertility they have to ask again many questions whether it is really that important for them to become a biological father or mother. We have seen that the process of questioning, discussion and taking decision sometimes brought tension among men and their female partners. Most decided to try everything possible to achieve biological fatherhood and motherhood. Some decided not to pursue treatment or stop it at a certain moment. But if these treatment options do not work what will happen afterwards?

For all of those who came in one way or another in the position to know that they will remain childless in the future, had to look to the other side of the coin and give life another meaning. Some decided to give more importance to their career without having children and they could do a lot of extra curricular activities, without being restricted by children. However, it is also sometimes difficult to forget about their fertility problem:

[Reek]: At the end of our long suffering there are still some moments when I become sad, but also I see the other side and that there are other possibilities. You can give a place in your heart to other things, but there are always outside influences that make the place open. I mean that our friends have children, that is not the problem, but sometimes you see them growing and you see all kind of steps children make with their parents. And that is not for us, and sometimes I feel sad, but I know 'at my neighbours the grass is always greener. When I look to my neighbourhood, there is always grass looking beautiful...but they also have troubles'.

Having children is a responsibility, but it is also nice. It takes a lot of energy from you. You have to take care, you have to do lot for your children, that is the other side of having children. But I sometimes think: we go for holidays, we take our car and we go. And for people with children they have to take their children. We can go wherever we want, we don't have to be restricted by children. That is the other side of it. We are now more committed to our jobs...we can do a lot of sporting....
[Dan]: We asked ourselves. Is it really, really very important to have children? At the same time we also have very interesting jobs and we like our jobs very much. My work in particular required a lot of absences. What I do realise now is that I have a lot of extra time compared to those people with children because they have to work with strict clocks. I see how much time and energy goes in to raising a child. I appreciate it as a very big responsibility. But at the same time I do realise how pleasurable and enjoyable it is to have children. You do not get one without the other.

Despite having a career, having children to take care of may sometimes fulfil the desire of having children around. Some participants reported to me that they sometimes take care of other children. Fred and his wife are considering taking care of children who have been neglected by their parents. One of the reasons why Dan and his wife did not pursue medical treatment was because his wife’s twin sister had already three children at the time when they were looking for solutions. Because of their close relationship with her, they thought they could do a lot with those children. They indeed have enjoyment of seeing them from time to time and participating in taking care of them.

Some participants reported that infertility has changed the way of their life. One participant pointed out that he became more involved in the patient support group. He started as a member and later on he became a contact person. Although he is still dealing with infertility himself, he gives advise to many infertile couples who need advise. Another participant became a psychotherapist and now he is participating more in spiritual healing. He now partly works as a psychotherapist apart from his normal job. He believes that if there had not been a fertility problem he would have concentrated more on his normal profession.
Chapter seven  
Discussion and conclusions

Infertility is distinguished from other medical conditions because, while only one member of the couple is diagnosed to be infertile (with the exception of combined male and female factors), it is conceptualised as a couple's problem. It is often assumed that infertility impacts women more than men. In reality, as seen from previous chapters, infertility can strongly impact men as well. However, men tend to react in a different way than women do. This is contributed to the fact that women appear to have more emotional reactions to infertility than men. But, since men are mostly not expected to show emotions it may be regarded as if men are not primarily impacted by infertility. It has also been stated that infertility is seen more as a women problem, because women have been the focus of more research (Jordan 1999: 343).

My study focused on men. What have we learnt from it? How do men experience and cope with infertility?

7:1 Results of Semen Analysis: Making A Big Difference

My study findings show clearly that men do not only react differently in comparison with women, but also that - not surprisingly - not all men react in a similar way. The result of semen analysis, which all interviewed men have gone through, is found to be a crucial factor regarding the way men react to infertility. Semen analysis creates basically two categories of men: those with reproductive impairment and those without such impairment.

After receiving the results the men in my study had different kind of feelings. Those men who did not have a reproductive impairment felt - according to themselves and to some of their female partners - a kind of relief after receiving the results of the test. To the contrary, those who were diagnosed to have a reproductive impairment generally became sad and disappointed. In my study, almost all men who were found to have a reproductive impairment told me that they cried after receiving the results. However, they commented that the reason for their disappointment was because of their failure to give their female partners what they mostly wanted: to become pregnant and give birth to a child. They did not perceive being infertile as a ‘failure’. They cannot be blamed for it. They just felt that it is part of their life and they have to live with it. It is the same kind of attitude, Greil (1991), who interviewed infertile
couples in America points out in ‘Not Yet Pregnant’: when men are diagnosed with the impairment they seldom describe themselves as having ‘spoiled identities’, as women are bound to do. He argues that although men are disappointed by infertility, they do not perceive it as life threatening, but rather they could get over.

It seems also that especially the initial reaction depends on how the results of the semen analysis are judged (i.e. how serious the impairment is) and the kind of advice they receive regarding future perspectives. For example, some of those with a low sperm count reported that they were given hope that it still could be possible to impregnate their partners with their own sperm. However, in all of my informants who were given hope, conception never happened.

The way they were informed about the results of the semen analysis also seems to influence the way men experience infertility. Some men I spoke with claimed that they were not satisfied with the approach from the medical experts and required more time and sensitivity for explanation about their situation. My findings suggest that the interaction and communication of results between men and doctors needs more attention.

Besides that men with reproductive impairment feeling bad because they cannot give their wife what she most wants - a child of herself – they also feel bad that their wives have to undergo all the treatment, while the physical problem does not lie with them. In addition, male reproductive impairment may imply that couples have to choose for AID or adoption which will exclude biological parenthood for respectively the man or the couple, and therefore that couples with an infertility problem have to go through complicated and painful decision making processes. Both issues will be discussed below.

7:2 Focus of Treatment and Support on Women

After having gone through the diagnostic procedures, the question arises how to solve the problem. In my study - with the exception of two men who underwent a surgical procedure to remove varicose veins - all medical interventions were done on the female partners, which confirms what has been mentioned in the literature (Bliss 1999, Greil 1991). According to Jordan (1999: 345), since all these interventions focus on the woman’s body, there is the tendency for the woman to perceive the situation as
her problem. In my study the men claimed that their female partners were much more involved in seeking medical help than themselves.

According to the men in this study, the main thing they could do during treatment is to be there all the time, providing support as much as they can and trying to give attention to the feelings of their partners. Some (especially those with a reproductive impairment) reported that they even denied or did not deal properly with their own feelings. It appears that their thoughts and feelings could only be directed towards their female partners and the medical interventions, which were offered. Some of them were claiming that they were doing some of the medical interventions only because of the strong desire of their female partners. Some of them also felt guilty that all interventions were focusing on their wives, despite the fact that they were the ones with the problem.

Despite the fact that – according to the men themselves – they gave a lot of attention to the concerns and wishes of their wives, my study findings indicate that some men - regardless of their own fertility status - had conflicts with their female partners. The source of the conflict, according to the men I interviewed, was because their partners blamed them that they were not much supportive and involved in searching for solutions.

7:3 Taking Decisions

The availability of various technologies means that individuals are inclined to utilise them. Whiteford (1994: 27) points out that the wide availability of these options can imply that couples have to undergo treatment for many years and resolutions are postponed. Individuals react according to the demands placed on them, and the solutions available to fulfil their needs. For a few men in this study, the medical intervention (AID) has resulted in a child. For most, the promises of new medical technologies are unfulfilled. It seems that the process of decision-making is a very crucial issue among the couple confronted with infertility.

In the literature it has been mentioned that women tend to be more consumed and devastated by the experience of infertility (Greil 1991: 65, Van Balen 1994: 162-3). According to Greil, he mentioned that women give infertility a ‘master status’ and becomes the focus of the relationship and most of the time they think of themselves as
inadequate. He also points out that, frequently men's feelings are in response to their wives' reactions to the infertility. It seems men are less used to express their feelings over their female partners. It is also possible that they respect women's wishes and feelings to become mothers. This might influence the decision on the (treatment) options available among a couple to solve their fertility problem and the way they experience infertility and involuntary childlessness.

Despite the fact that infertility is a couple’s problem, it has not been easy to reach an agreement during decision making. In my study I found that it is sometimes difficult to consider the couple as a unit. By considering Verdurmen's categories of couples with regard to decision-making (p. 25-26), sometimes I find it difficult to place the two partners in the same category. My result clearly indicate that there is a need to have an individual (men and women) and couple based approach to have a better understanding of the whole process of decision making. The results of the present study suggest that infertile couples, both men and women, need support and help on how to make well-balanced decisions. For example which option to go for, or what kind of treatment to be sought created tension among the couple.

7:4 AID or Adoption

In this study it is found that male reproductive impairment may imply that couples have to choose for AID or adoption, options which will exclude biological parenthood for respectively the man or the couple. Discussing whether to go for AID or adoption clearly plays a crucial role and deserves attention. These options will be briefly discussed here.

The effect of pursuing AID (in case it works, i.e. a child is born from it) on the man, couple and the child probably is not yet well appreciated. My findings with regard to AID give insight in how this procedure seems to be more complicated for the couple to decide upon than IVF and ICSI. According to Brewaeys (1993:32) in most couples thoughts about the donor still create tension. She also points out that the donor remains a potential rival among the couple who did not come to terms with their infertility.

Results in this study indicate that there are three groups of couples based on how they discussed and decided about AID: 1) husband positive-wife negative 2) husband negative - wife positive and 3) both husband and wife negative. The women
who preferred AID wanted to experience pregnancy and delivery of a child themselves. Some of the men wanted AID because of the love they have towards their partners. Since they love their wife most, they felt that even the child to be born would be loved in that way. It seems that those against AID took in consideration their feelings in the future towards their children and the donor. AID also places the member of the couple in an unequal situation: the husband is excluded from being a biological father, while the mother has that biological link. AID seems to have an impact on the relationship among between the partners (as the case of one of the participants in this study clearly indicated) and on the child, and this needs to be taken in to account when deciding to pursue AID.

Whether to go for adoption or not, the couple has to decide this as well. As in the case of AID, to some extent there are tensions in the relationship when deciding to go for adoption or not. The strength of tension seems to be less as compared to AID. Almost all participants had discussed adoption. In my study I have found that adoption is considered as one way of having children and being able to raise a family. In case of male reproductive impairment, adoption seems to be a good option as it enables the partners to have an equal relationship with the child. Some considered adoption as positive because it is a way of helping children who are in difficult situations. Those who were against adoption considered it as an unnatural process. Some claimed that if they want to become parents they want it in a natural way (becoming pregnant and giving birth to a child physically). The commitment to biological parenthood, for both men and women, is a main issue in deciding to go either for AID or adoption.

The decision to go for AID might influence the openness about their infertility problem with others (relatives, friends, and colleagues). How will people around the couple perceive AID or adoption? People are less inclined to tell their friends and relatives about their infertility problem in case of serious male reproductive impairment, because in the future they might have to opt for AID. In case they had told others about the infertility problem of the man, and they would prefer that others would not know that the man is not the biological father (i.e. keeping the AID as a secret) people might react on that. And that will not be the case when opting for adoption, because then it is for everyone obvious that both of them are not the biological parents.
When both members of the couple are willing to adopt, the age (of one or both partners) seems to be another crucial issue and needs to be considered early at the beginning of medical interventions. I have found that some couples failed to adopt because of their age. They spent much time in pursuing medical interventions and at the end it was difficult for them to adopt, the more because adoption procedures also take a lot of energy and time.

7:5 The Desire for Children and the Couple’s Relationship

Procreation is significant and it is normal in the life of men and women. It is seen as a source of happiness, and human happiness is said to be incomplete without procreation (Oner 1994: 303). The importance of having children played of course a big part on how participants experienced their infertility and in their search for a solution. Of the men I spoke with, almost all recognized highly the value of having children. However, most of them acknowledged that their female partners were much more affected than themselves, with the fact that they cannot have children of their own. Van Balen (1995: 143) found also that of the couples he interviewed women were much more guided to motherhood than men to fatherhood. According to the interviewed men, some perceived their female partners to be very much committed to becoming pregnant and giving birth to a child. Some mentioned that for their partners the main desire of having children is to have a physical experience of how it is to become pregnant.

By asking themselves what it means for them to be a father I have found that at different points in their lives, participants in this study have rationalized their thoughts and feelings about their infertility to keep it under control. Participants have been modifying and reconstructing their understanding of infertility to accommodate their changing circumstances. An explanation that previously worked may no longer fit. For example the relationship among the couple sometimes seems to be determined by the presence of children. Living together in a relationship without having children seems to be a very crucial issue. Does the relationship, which is full of happiness, have to be determined by having children? Or is it a matter of husband and wife who care about and love each other being able to live happily together without children? Answering these questions can help individuals confronted with infertility to reconceptualise their
desire of becoming parents and try to cope well with disappointments associated with medical treatments and infertility in general.

Given that children are, and will remain, the main way of continuation of generations and to some extent the source of emotional support, analysing the effect of infertility on the general well being of men and their female partners is very important. Infertility, according to the men I spoke with, has had a significant effect on the relationship with their partners, and on issues pertaining to communication and decision-making. In the cases of two men I spoke with, infertility triggered the already existing tensions in the relationship. For other couples infertility strengthened their relationship. However, this happened only after a period of tensions especially during medical interventions. Others claimed that their good relationship with their partners was an important asset to make wise and well balanced decisions. The quality of the relationship between men and their female partners might influence how men and their female partners experience infertility and involuntary childlessness.

7:6 Support and Coping in Case of Infertility

In a review of the empirical evidence on gender differences in coping with infertility among heterosexual couples, using meta-analytical procedures, Caren Jordan 1999 (341-359) found that women use more emotion-focused coping strategies than men. She describes emotion-focused strategies to be targeted at managing the emotional distress created by the problem. Men on the other hand, apply a problem focused coping strategy. She concludes by pointing out that emotion-focused problem solving is both less effective and leads to poorer mental health outcomes than problem-focused coping.

In this study I found that the experiences and coping strategies of men are not only influenced by the availability of medical interventions, but also by the people around them such as his partner, friends, family and colleagues. It is clearly indicated in the previous chapters how men and their female partners may support each other when confronted with infertility. The roles of both members of the couple in influencing one’s experience need to be well appreciated. There is a need for the female partners to understand the feelings of their husbands when diagnosed that they have a reproductive impairment.
The myths that exist in some cultures, that masculinity is associated with fertility and sexual performance, may explain why there is secrecy surrounding infertility: people do not talk openly about their infertility problems with others very often. In addition, information that a couple is unable to conceive is considered very private and embarrassing (Dunkel-Schetter 1991: 204). Family members and friends seem to have played a great role in the participants’ experiences. This, in turn, has had effect on the ability to cope with infertility. Discussing openly with friends and relatives might influence their experiences. My findings revealed that those men who discussed openly with their friends seem to have coped well with infertility compared to those who decided to keep it a secret.

Counselling and support is important to infertile individuals. Some men claimed that they did not need any kind of support. However, they commented that they were the source of support to their female partners who were much affected with infertility. For those who attended the psychotherapist, claimed that there was a relief to their problems after the therapy. Patient support groups such as FREYA helped some men and their female partners to understand their problems. They found useful information and could share experiences with other people having the same problem. It seems that the men and their female partners need a lot of information, good communication and proper counselling to have a better understanding of their problem. The actual and perceived differences existing between men and their female partners on how they are dealing with infertility might influence partners negotiation in the infertility treatment. There is a need for the members of the couple to be aware of their differences.

Factors, which seem to influence the way men in this study are experiencing and cope with infertility include: the diagnosis (who is biomedically infertile), and the quality of relationship with their female partners. Poor relationship seems to bring more tensions in the relationship. Good relationship makes the couple to be in a position to understand each other and make well-balanced decisions. Sometimes infertility may bring the couple closer together. Openness and discussing infertility with their friends also may help individuals cope well with the situation.
Conclusion

My study findings show that the existing medical technology has a big impact on how men experience and cope with infertility. The diagnosis of infertility in men (having a reproductive impairment or not) makes a big difference between men in how they react to infertility and infertility treatment. The narratives of men partly depend on their fertility status. The availability and wide acceptance of advanced reproductive technologies in the Netherlands implies that men must deal with difficult choices, that sometimes challenges their personal wishes (consider the case of AID) and beliefs. Giving attention to both partners (men and women) is highly needed, especially in the decision taking process. In the decision-making and treatment procedures men need to be considered as playing an equal role as their wives.

How does Dutch culture impact the way the men experience infertility? The availability of medical technology seems to make it difficult to judge which part of my findings is typical to the Dutch culture. While the choice of not having children may be acceptable in the Netherlands, which would not be accepted for example in my own society, many people feel inclined to utilize all available technologies. In particular the wish of women to become mothers seems to be highly respected by men. This too has implications on how men -according to their fertility status- experience and cope with infertility, infertility treatment and involuntary childlessness.

I consider my findings as preliminary. More research should examine the experience and coping strategies of men who are confronted with infertility and its treatment. There is a need to consider all aspects of men’s experiences mentioned in this thesis (meaning of infertility as seen by men themselves, the consequences associated with biomedical technologies which excludes men from being biological fathers, relationship with their female partners). This will enable us to describe and analyze the problems and needs of men confronted with infertility.
Interview Guide for Infertile men**

1. I have heard that you have been trying to have children, when exactly did you start thinking of having children?

2. Could you please explain to me when exactly you became aware that you had problems in getting children?
   a. What made you aware of your infertility/childlessness?
   b. Were you thinking of any fertility problem in particular?

3. What did you do in particular to find out the source of your fertility problem?
   a. Did you seek any kind of help/advise from friends, relatives, doctors etc?
   b. If you went to the doctors, did they do any kind of test(s)? Did they examine you? Could you please mention the type of test(s) they did to you?
   c. Who was first to be examined, between you and your partner?
   d. Who initiated the process of seeking help between you and your partner?
   e. How did you experience the test(s), which were done specifically to you? Please explain to me the whole process of handling the semen for analysis? How did you feel about it?
   f. What was the diagnosis made after the test(s)?
   g. What was your reaction after receiving the results?

4. Have you sought any kind of treatment/solutions for your childlessness/infertility?
   a. What kind of treatment was offered?
      • Artificial insemination?
        By whom: Yourself
        Donor (If yes, probe more later)
      • In vitro fertilization?
      • Others

   b. Could you please explain to me how did you make decisions about the kind of treatment you selected?
- Who gave you the advice about the type of treatment?
- Was the information about treatment sufficient to you?
- Was it easy to reach an agreement between you and your partner?

  c. How was the treatment? Was it successful?
  d. Are you still on treatment?
  e. If not, could you please explain to me the reasons why you are not on treatment?
  f. Why did you decide to stop the treatment? Please explain to me

h. About Artificial insemination by donor: I would like to ask you more about artificial insemination, how did you experience it? Please explain to me more about Artificial insemination?

  • Were you comfortable with it?
  • Was the information about artificial insemination sufficient to enable you to make decision about it?
  • How did you make the decision about AID?
  • What made you to choose or not to choose artificial insemination?
  • What do you see as the advantages and disadvantages of artificial insemination?

5. If you haven’t sought any kind of treatment, what are/were the main reasons for you not to seek medical treatment?

6. Apart from medical treatment, have you considered any other alternative solutions? What kind of alternative solutions?

  a. Have you considered alternative medicines?
  b. What kind of alternative medicines have you considered?
  c. Did you ever think of joining a patients’ support group?
     • If you are a member, where did you get the information about this patients’ group?
- Could you please explain to me what you see as the advantages and disadvantages of the patients’ group?

d. Have you attended any kind of counselling?
   If yes, explain to me which kind of counselling?
   I.e. Psychotherapy, Why did you decide to attend psychotherapy?

7. Please tell me more about other alternative solutions?
   a. Have you considered adoption?
      - What do you see as the advantages or disadvantages of adoption?
      - Is there any difference between you and your partner in considering adoption?
      - Why did you make decision(s) to adopt children?
      - Is there any problem or difficulties in the procedures for adoption?
      - What do you consider to be the best solution between adoption and artificial insemination by donor? Please explain
   b. Fostering and caring for other children? Do you think that this could also be a good solution?

8. Could you please explain to me your personal experience with infertility and involuntary childlessness?
   a. Does this affect the way of communication and all other aspects of relationship with your partner? Please explain to me in which aspect does this affect your relationship?
   b. Was your partner supportive especially after receiving the result of your test?
   c. How do the choices that you made in treating/solving your fertility problems affect the relationship with your partner?
   d. Do you think infertility/involuntary childlessness have brought you closer together or further apart? Please explain how?
e. In which ways does your infertility/involuntary childlessness affect or influence the relationship with your relatives and close friends? Especially those with children.

f. In which ways it has affected other aspects of your life?
- Have you considered changing your job?
- Have you considered achieving other life goals? Please explain
- Withdrawal from some of social activities? Could you explain the reasons why you decided to withdraw?

9. Did you discuss your infertility/involuntary childlessness with your relatives or close friends?
   a. With whom have you discussed about it?
   b. Is/was it easy for you to tell or discuss about it?
   c. What was their reaction?

10. Could you please explain to me what does it mean to you not having children? What do you see as the value of having children?

   **For the women I used a slightly adapted version.**
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