"It's Different for Men"

Masculinity and IVF

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Drawing on interview data with men and women who have engaged with in vitro fertilization (IVF) unsuccessfully, this article explores the ways in which men experience and make sense of the failure of treatment. Focusing on men's experiences of infertility, their perceptions of IVF as a technology, and their involvement in the IVF process, the analysis highlights the ambivalent relationship between men and IVF as a technology; the predominance of hegemonic masculine culture in mediating the meaning of IVF for both men and women, particularly in relation to the association of fertility and virility in the normative construction of masculinity; and the very traditionally gendered emotional scripts that structure the experience of IVF and its failure.

Key words: IVF; masculinity; technology

Given the notion of a close connection between masculinity and technology (e.g., Wajcman 1991; Cockburn and Ormrod 1993; Faulkner and Arnold 1985; Webster 1996; McNeil 1987; McNeil, Varcoe, and Yearley 1990; Grint and Gill 1995), it is perhaps surprising that relatively little work has been done to get inside the relationship between specific groups of men and specific technologies. This is especially true in relation to the new reproductive technologies (NRTs), and the aim of this article is to do just this. It investigates men's feelings, beliefs, and practices in relation to in vitro fertilization (IVF)—the medical procedure whereby eggs are collected from a woman's ovaries following hormonal stimulation, fertilized outside the body with sperm supplied by a man, and then transferred to the uterus.

Our analysis is based on in-depth interviews with 13 heterosexual couples and 15 women (whose male partners did not participate in the interviews), all of whom have undergone at least one unsuccessful IVF cycle within the past five years and who have since stopped treatment. The approach taken is a feminist one. We start from the understanding that men and women have structurally different relationships to IVF, because of both normative assumptions about the different significance of childbearing/rearing for heterosexual men and women and the material impact of the technological

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interventions on men's and women's bodies.[1] However, in articulating a feminist perspective, we have avoided assuming a priori anything about the nature of the relationship between men and IVF technology. Instead, we want to examine the complex ways in which IVF, as a technology and a process, is understood by men in their engagement with treatment.

Before presenting the analysis of our material, we first review some of the relevant literature on masculinity, fatherhood, and NRTs, and we describe briefly the scope and methods of the larger study of which this article forms a part.

LITERATURE REVIEW

The academic literature on men's experiences of infertility/subfertility, involuntary childlessness, and interventions into reproductive health is extremely small. This can be understood as an extension of the general paucity of academic work on the meaning of fatherhood for men. Furthermore, the cultural associations of reproduction with women and the focus of reproductive technological intervention on the female body add to the invisibility of the male experience of that engagement. Therefore, this article aims to make a contribution to both the literature on men, fathering, and fertility and also to feminist scholarship on the NRTs, which is extensive but has remained woman-focused and has largely failed to address the male experience of those technologies.

This section will begin by reviewing the feminist perspectives on the NRTs. The second section will consider the limited literature on fatherhood and will review briefly those studies that have explicitly addressed male experiences of infertility and of fertility treatment.

Feminist Perspectives

The NRTs comprise of a range of technological interventions into reproduction, including contraception, abortion, antenatal scanning or testing, prenatal genetic diagnosis, and technologies of conception. These technologies—particularly, conceptive technologies such as IVF—have generated considerable controversy and debate over the last twenty years. Nonfeminist bioethical debates have been dominated by concerns over the status of the embryo, and the legislative framework that emerged in the United Kingdom in 1991 is strongly focused on controlling the use of embryos for research (see Franklin 1993; Steinberg 1997; Challoner 1999). Feminist researchers have resisted the invisibility of women as active agents in these debates and have positioned women at the center of concerns. However, one consequence of this has been to ignore male experiences.

Perhaps the most vocal feminist response has come from the Feminist International Network of Resistance to Reproductive and Genetic Engineering (FINNRAGE) formed in 1984. Their radical feminist critique regards the NRTs as irretrievably patriarchal and, therefore, inimical to women as individuals and as a class. In particular, criticism is directed at the extent to which the NRTs treat women's bodies as objects for experimentation, the association of womanhood with motherhood, and the development of increasingly high-technology and experimental solutions at the expense of low-technology methods over which women could retain control (Corea et al. 1987; Spallone and Steinberg 1987; Corea 1988; Klein 1989; Rowland 1992; Raymond 1993). Our study builds on the FINRRAGE approach of highlighting the significance of gendered power relations in the structuring of NRTs. However, it rejects their unnecessary reliance on essentialized, homogeneous and opposing categories of man and woman, which fail to account for the socially constructed nature of gender relations and which cannot account for women's engagement with NRTs except in terms of false consciousness (Wajcman 1991; Farquhar 1996; Shildrick 1997). While offering a valuable critique of the construction of IVF as a "couples" technology and highlighting the substantial interventions into the female body necessitated by IVF, this perspective offers no means for a nuanced understanding of the male experience of treatment.

The liberal feminist perspective on the NRTs is generally supportive, arguing that the technologies themselves are neutral or progressive and that they can be separated out from the context of gender-power relations in which they operate (Petchesky 1987; Stanworth 1987). From this perspective, technologies such as IVF can be seen as adding to women's reproductive choices although again, the male experience of the technology is rendered invisible from this perspective. And again, this position leaves unchallenged definitions of women based on sexual difference (Farquhar 1996, 19). Furthermore, it is heavily dependent on the assumption that the desire to reproduce in women is both natural and inevitable while simultaneously ignoring the fact that the privilege of motherhood is not extended to women who fall outside of the heterosexual norm (Shildrick 1997, 190).

By contrast with both the radical and liberal feminist positions, we share the insistence of feminists within the field of technology studies that both technology and gender are socially constructed (e.g., Wajcman 1991, chap. 3). Within this framework, NRTs are not seen as inherently oppressive, progressive, or neutral. Rather, a range of complex and contradictory outcomes is expected, contingent on the particular contexts in which specific technologies are designed and used. From this perspective, it is important to understand the ways in which all actors experience a technology to gain a better understanding of how its meanings are produced and resisted.

Men, Fatherhood, and the NRTs

Given the pervasive naturalization and normalization of motherhood for women and the almost exclusive focus of medical interventions on the female body, it is not surprising that male experiences have been largely excluded from studies of the NRTs. However, the absence of male experiences from this research is also reinforced by the relative infancy of academic writing on fathering and fatherhood. While discussions of masculinity have been central to a number of disciplines for more than twenty years, surprisingly few contributions to this field have devoted any space to fatherhood. In recent years, this absence has begun to be redressed, and a literature on fatherhood is developing, with three key themes predominating: (1) the cultural construction of fatherhood, focusing on figures such as the "new father" or the "absent father" (Lupton and Barclay 1997; Daniels 1998; Burgess 1997); (2) the impact of fathers' involvement in children's lives (see Lamb 1994 as cited in Marsiglio 1995 for review); and (3) the practices of fathering, such as the division of labor in the household, childcare, and paid employment (O'Brien and Jones 1995; Brannen and Moss 1987). However, these approaches offer a strongly instrumental perspective on fatherhood and exclude of the meanings that men themselves attach to fathering (O'Brien and Jones 1995; Clarke and Popay 1998; Gerson 1997).

A fourth, significantly less-developed, perspective constitutes an attempt to address this paucity of writing on fathers' experiences qua fathers, in the form of autobiographical accounts, in philosophical and psychoanalytic reflections on the nature of fatherhood, and in practice-based literature advocating a "generative ethics"[2] of "father work" (Seidler 1997; Samuels 1995; May, Strikwerda, and Hopkins 1996; Hawkins and Dollahite 1997). In addition, there is a growing sociological and psychological literature on fathering that is examining the transition to fatherhood as a major life event for men and is exploring how it is lived and understood (e.g., Lewis 1986; Lewis and O'Brien 1987; Lupton and Barclay 1997; Burgess 1997; Clarke and Popay 1998; O'Brien and Jones 1995). This research shows us a contradictory and complex picture of fatherhood at a private and relational level and is increasingly interested in how experiences of fatherhood are classed and racialized in contemporary society.

If we are only now beginning to take seriously the experience of fathering for men, it is hardly surprising that not being a father has received so little attention. There are, however, notable exceptions, particularly in relation to male infertility, and these clearly demonstrate the grief and guilt that men experience when they are diagnosed as infertile (Owens 1982; Mason 1993; Lee 1996; Webb and Daniluk 1999). Other studies have focused on how infertility and IVF is experienced by couples (Imeson and McMurray 1996; Greil 1991; Becker 2000) or on differences between men's and women's

coping strategies (Daniluk 1997; Epstein and Rosenberg 1997; Leiblum 1997).

In this article, we aim to contribute to this growing body of literature by offering some insights into the nature of men's experience of and investment in IVF as a technology. In particular, we focus on the ways in which those experiences are accounted for when IVF is unsuccessful.

METHODOLOGY

This research is part of a wider study that is aimed at considering the experiences of women and couples who have had one or more unsuccessful cycles of IVF and who have made the decision to stop treatment at least two years before the interviews. The study attempted to identify the factors that informed that decision and to explore how the participants felt about IVF and their own experience of infertility in the light of the failure of the technology in their own cases. Participants were recruited through the dormant patient records of a specialized unit in a large NHS hospital. In total, fifteen women, whose male partners did not wish to participate, and thirteen couples agreed to participate in two semistructured interviews, which were conducted by one of the authors (a white female aged about thirty), six to eight months apart. Apart from one participant who was separated from her husband and another whose relationship broke down in the course of the study, all the participants were in stable, heterosexual relationships; the couples were interviewed together. They were predominantly, although not exclusively, middle class, white, and educated to degree or professional level, reflecting not only the exclusivity of IVF itself[3] but also the demands of articulating those experiences. This outcome is common to other studies of IVF (Sandelowski 1993; Daniluk 1996; Franklin 1997). There were three cases where the infertility was acknowledged as a male factor only, although none of these men participated in the interviews. In addition, three men who did participate and one who did not had low sperm counts, which were not acknowledged by either partner as causative of their infertility (see also Meerabeau 1991). These three men, along with the remainder, attributed their inability to conceive to identifiable or unidentifiable female factors.

The interviews lasted, on average, sixty to ninety minutes, although a few ran up to several hours. The interviews were taped and transcribed, and all the participants were given an opportunity to review the transcript and make any changes they felt were necessary. This large body of data was analyzed using discourse analysis (Potter and Wetherell 1987; Burman and Parker 1993; Gill 2000). The transcripts were coded using a qualitative data analysis software package in ten broadly thematic categories that emerged from repeated rereadings. This initial process facilitated the breaking up of the extensive transcripts and laid the foundations for a more iterative analytical process by

which the relationships between those coding categories became more apparent. All the names of the participants have been changed, and any other identifying information has either been removed or changed in the writing of this article.

All research data bears the imprint of its context of production, and this is no less the case here. A number of points are noteworthy. First, the sex of the interviewer is significant, and it is possible that the interaction between the topic and the interviewer's status as a woman of child-bearing age may have had an inhibiting or normative effect on what the male participants said. Of greater significance, we suggest, is the fact that all the men interviewed were in couples, and their partner was present. We believe this may have restricted what the men said about both the desire to have a child and the experience of IVF because, as our study and others (e.g., Webb and Daniluk 1999) have shown, men often strive to protect their partners from their own distress. It is therefore possible to surmise that other issues might have come up had the men been interviewed singly or in focus groups with other men.

It is also important to note that the interviews took place at least two years after their most recent cycle of IVF, and the participants who were recruited were no longer actively pursuing further treatment. This is very important in understanding the interview data. Expressions of active desire for a child are largely missing from the interviews since the expression of this desire is disruptive to the achievement of closure around the engagement with IVF. Instead, the interviews should be understood as predicated on the desire for parenthood. Most of the interviewees took this as given throughout, and neither male nor female participants were able to articulate clearly why they wanted children, arguing that it was simply a natural and obvious progression (see also Owens 1982). In fact, many expressed profound distress when they recalled moments when others had mistakenly assumed that they had chosen not to have children. A theme that runs throughout the interviews, then, is not the desire to parent but the construction of themselves as normal, in spite of their childlessness, where normality is always normatively determined according to conventional understandings of masculinity and femininity. Therefore, while these accounts tell us little about the pain that men feel in relation to infertility, they tell us a lot about discourses of gendered normality used to make sense of those experiences.

We now turn to the substantive analysis, focusing on three key themes: men's experiences of infertility, men's perceptions of IVF as a technology, and men's involvement with IVF treatment.

MEN'S EXPERIENCES OF "INFERTILITY"

For both men and women, the experience of not being able to conceive a child they very much want constitutes a major life crisis, precipitating

feelings of grief, anger, guilt, envy, profound loss, and depression (Greil 1991; Mason 1993; Lee 1996; Becker 2000; Owens 1982; Webb and Daniluk 1999). This is the context in which most attempts at IVF are undertaken. The IVF process, in turn, may involve significant lifestyle changes, social isolation, and a cycle of feelings of hope and despair (Imeson and McMurray 1996). What emerges from our study is that for men, the inability to conceive with their partner also produces an additional and gender-specific set of difficulties associated with a perceived threat to their masculinity—a finding that is duplicated in studies of men who have been diagnosed as infertile (Lee 1996; Mason 1993; Meerabeau 1991; Owens 1982). This theme was central to the interviews and is a consequence of a strong popular association between male fertility, potency, and masculinity. In finding themselves unable to make their partner pregnant (for whatever reason), men felt that their sense of themselves as men was called into question. This finding supports Connell's (1995) powerful notion that masculinity flows from the body of the male (and especially his penis). It also reinforces earlier research that found that fertility problems in men were often consciously or unconsciously equated with impotence (Humphrey 1969)—a profoundly traumatic experience for most men.[4]

Hegemonic Masculine Culture

This difficulty is exacerbated for men by other men's (and less commonly, women's) reactions. While female-factor infertility generally elicited sympathetic responses from people, even the suspicion of male-factor infertility could lead to the man being singled out by friends and work colleagues as the target of thoughtless or hurtful comments and jokes:

> **Beth:** I sent [my partner] a card on Valentine's Day last year, saying, "To the world's greatest lover," and there's a friend of mine in here, who actually has four children, . . . and her boyfriend said, "Oh, how come I didn't get a card saying, 'Greatest lover?'" and she said, "You've got children to prove that you are."

> **Matthew:** I was actually at a meeting, conference kind of thing, . . . and it was sort of said, "I could come round and see your wife."

The kind of banter Matthew describes was experienced by many men, particularly in the workplace. Indeed, for the female authors of this article, this was one of the most shocking insights into masculine culture. Our transcripts are full of accounts of men having their potency or virility questioned; for example, "do you want me to stand in?" (Rebecca and Jeff), or "you must be doing it wrong!" (Nancy and Martin). Whether blame was placed on the man's wife or partner, the job of solving the problem was left with the man—for example, "you'd better take her on holiday, get her to relax, get her drunk!" (Nancy

and Martin)—a finding reproduced in Imeson and McMurray's (1996) Australian research. In addition to comments like these, some men were subjected to cruel pranks, such as being bought a pot of seedless jam or jaffa (pipless) oranges (see also Mason 1993).

Only one man who participated in the study did not perceive comments of this nature in a negative way; rather, he understood them as a form of support and friendship. Jeff enjoyed the "stick" he was given by his workmates because it demonstrated that his experience of fertility treatment had not affected the way his friends and colleagues perceived him. He was still "one the lads." However, it is important to note that the joke depends precisely on the assumption of his colleagues that his fertility is not in doubt. For most of the men interviewed, the favored strategies for avoiding having their own fertility (and therefore, virility) questioned were secrecy and/or placing the blame either explicitly or implicitly onto their female partner.

Secrecy. The structural positioning of men in the context of IVF makes it easier for them to distance themselves from the treatment; that is, they do not have to attend every clinic appointment (and many in this study did not) (see also Meerabeau 1991), and their bodies are generally not materially affected by the treatment. Although the degree to which the men chose to keep the treatment secret varied, one of the key motivations for doing so was to avoid having to discuss the causes of the fertility problem. The silence in men's talk around emotional, relationship, and reproductive issues facilitated this:

> **Susan:** But men don't go down the pub and say, "Oh, sorry mate, to hear about your sperm count."

> **Tim:** Men are not particularly interested, actually. . . . [they would] far rather talk about football than anything like that.

Many of the men in the study reported that their colleagues did not know that they were having problems conceiving or even whether they had children or not. It was easy for them to keep it a secret if they chose to.

This silence exploits the widespread assumption that in the majority of cases, the fertility problem lies with the woman. This erroneous assumption is encouraged by the extent to which (even in the case of male factor infertility) it is the woman who is the focus of medical intervention and also by the traditional perception of women's bodies as fundamentally unpredictable and liable to failure (Oudshoorn 1994; Shildrick 1997). Consequently, male silence allows the assumption to go unchallenged:

> **Anne:** No, he didn't talk about it anything like as much as me, and he wouldn't say, you know, . . . he wouldn't tell people about the cause. He'd just let people's assumptions go. . . . I think he just couldn't bear to talk about it.

This assumption of female bodily fallibility combined with a reluctance to accept male bodily failure fits with Meerabeau's (1991) finding that when men's sperm counts were low, they downplayed the significance of this (e.g., "it could be a hell of a lot worse") or produced reasons why the result was not an accurate representation of their capability.

Blaming women. While some men merely allowed assumptions that it was a "woman's problem" to go unchallenged, others actively promoted this view to avoid their own fertility being called into question.

> **John:** Now it's like, "Do you have any children?" I say, "Well, no, unfortunately, my wife couldn't have any. We've tried, but we couldn't."

Some men were quite reflexive about this, even as they reproduced it.

> **Martin:** But one of the really funny aspects about telling people, especially from a male point, is that you let people know that, without really realizing, the next bit a male person throws in is, "There ain't nothing wrong with me. . . ." Because . . . you don't want people to think, "Oh, he can't have a baby. There's something wrong with him. He's not up to it." So it becomes a very male ego sort of situation . . . that you're prepared to tell people that you've got a problem, but you want to quickly make sure that they're aware that it ain't you.

Both John and Martin were eager to remove any doubt as to where the fertility problem lies when talking to friends and family, although this was not in a context of blame or resentment toward their partners for the fact that they are unable to have children—a point that was repeatedly emphasized by many of the male and female participants. Instead, the assertion of female responsibility demonstrates their desire to emerge from the encounter with their sense of masculinity intact. In Connell's (1995) terms, they produced a discourse that bought into, rather than challenged, hegemonic masculinity.

The female participants in the study were frequently complicit in protecting men against the negative associations of infertility, leading them to share the blame (see also Webb and Daniluk 1999). Angela, for example, described her and her husband as "a pair of old duffers," even though her husband had been diagnosed as infertile, not her. It is important to note, however, that while the women shared the blame in all three cases of confirmed male-factor infertility, the male partner sharing responsibility when female factors were confirmed only occurred in one case and, then, only in private.

IVF AS TECHNOLOGY

One striking finding of this research has been the degree to which the men and women felt positive about IVF as a technological procedure (see also Franklin 1997). This attitude was closely connected to their initial optimism

that the technique was going to produce the desired baby, but even after its failure to do so, many people continued to regard it with appreciation and respect—a perspective that is closer to the liberal view of the NRTs and appears to contradict the radical feminist perspective of the NRTs as inherently harmful. Men's attitudes to NRTs—and to IVF in particular—are of special interest because of their ambivalent nature. In line with the constructivist approach to technology (Faulkner 2001), we can discern two apparently contradictory attitudes to IVF, which throw light on the masculinity-technology relationship in general.

Giving Nature a Helping Hand

On one hand, men repeatedly disavowed that IVF is a technological procedure, although this was not a view that their female partners necessarily shared following their very bodily experience of the technology and its effects. However, the men's response was less about denying the obvious features of medical science and technology—test tubes, surgical tools, and visualization technologies, and so on—than about claiming this particular technological intervention as "natural." It is fascinating to note how frequently the men elaborated this view through outright assertion, and it contrasts with their perceptions of other potential medical interventions into the reproductive process, such as gene therapy and cloning.

> **Robert:** It was natural. . . . It was just the mechanisms of it that were assisted. It wasn't like cloning sheep or growing ears on the back of mice or things like that.

The contrast with new, "futuristic," high-tech interventions was commonly deployed so as to render IVF as low-tech, familiar, and knowable by comparison and to enhance the claim that it is barely a technological intervention at all—just another way of doing what nature does. The notion that infertility is essentially a "mechanical problem" and the use of contrastive machine-age/gene-age metaphors would repay further analysis in the future.

A Scientific Approach

Alongside this discourse, however, another apparently contradictory one existed. IVF was elevated to the status of the "ultimate" in measures to promote fertility, the very best chance for a couple to conceive. A widely shared belief among men was that as the best medical science has to offer, if IVF did not work, then nothing would. This was accompanied by a confident belief that future IVF-related technologies would improve on the currently limited success rates. By comparison with their partners, men were scathing about low-tech approaches to enhancing their own fertility, such as dietary changes,

stopping smoking, giving up alcohol, and measures such as using warm rather than hot water to bathe (something that is supposed to aid sperm production). It is not clear, however, to what extent the rejection of these lifestyle changes is due to a genuine skepticism about their value or whether they are problematic because they would constitute a tacit acknowledgment of possible uncertainty regarding their own fertility.

It is interesting that given the ambivalence discussed above, many men characterized their own approach to IVF as scientific, thereby indicating a synergy between their own attitude to IVF and the treatment itself. In the example below, the hopeful father is presented as a lay scientist who links his scientific approach to two other stereotypically masculine domains, business and problem solving.

> **Lisa:** You [Simon] were great. . . . Because he was very realistic. Every time, . . . after every cycle, when something has gone wrong and I was distraught, he would say "this is great because we're getting closer each time to finding out what the problem is. And here we are, . . . we should look upon this as a positive thing."
> **Simon:** Business teaches you that—99 percent of solving a problem is recognizing what the problem is.

Although in the above example, Lisa was very positive about her husband's response ("you were great"), such reactions to treatment failure were not always appreciated by women who very often would have preferred their partner to have expressed grief-stricken feelings rather than a quasi-scientific response, regardless of how upbeat it was.

MEN'S INVOLVEMENT WITH IVF TREATMENT

IVF is often seen as a procedure that a couple undergoes in order to have a baby, although the reality, as has already been discussed, is that it is the woman who is the target of the interventions, and the medical records are kept under her name. Meerabeau (1991) reports how men are easily excluded from medical consultations as a result. However, technology is not just hardware or knowledge, but it is also something that people do (Wajcman 1991, 14-15), and it is, therefore, important to consider the ways in which the men interacted with the IVF process. It is interesting that in contrast to the stereotype of men as active, purposeful agents—particularly in relation to technology—men in this study frequently presented themselves, and were regarded by their partners, as only passively involved in the process. Both women and men commonly regarded males as "doing it for their wives" or "just going along with" what the women in a couple wanted. However, four key roles emerged in the course of the accounts.

The first and most obvious role for the male partner was the provision of sperm samples. The topic proved to be very sensitive in the interviews, and very few men were willing to discuss it. Where it was discussed, it was often in a very light-hearted, jokey way, so as to downplay any embarrassment they might have felt:

> **Jeff:** The bloke actually has quite a good time through the IVF!

This use of humor not only closed off the discussion, it also put their own relatively minor discomfort compared with their partners into perspective. The humor masks the pressures that men are under to "perform."

Meerabeau (1991) notes that the provision of sperm through masturbation has sexual rather than medical connotations, further distancing the male partners from the technological aspects of the process. Several of the men in this study found the process unnecessarily public and sordid, feeling more like a "dirty old man" than a potential father, a feeling that was exacerbated for some by the presence of pornography in the room:

> **Len:** [The hospital consultant] must have been walking around buying I don't know what! But it was bizarre—the magazines, they were so well read. Even the print was . . . and this is on glossy paper.

Although the hospital through which the participants were recruited had a dedicated room for the men to use, when it was not available, they were sent to the public toilets, which carried particularly negative connotations for many. For Len, these negative images were confirmed by the graffiti on the toilet walls, which contributed to anxieties about his own "performance" and may also have been connected to fears of associations with homosexuality, an association that is also threatening to many straight men's masculinity:

> **Len:** In the first three attempts, I had to go to the public toilets. . . . You know, "if you want to meet a really nice, big man, . . . I'm black, I'm one of the hospital porters, this is my telephone number." On the wall! And try and produce a sperm sample. [shakes his head]. Well, you can do it, but it was so unbelievable.

The second element of the treatment process in which men can play a significant role is in giving the injections. Administering injections at home has the obvious advantage of saving women daily general practitioner (GP) or hospital appointments and is actively encouraged by the hospital as a way of getting men more involved in the process (as well as saving resources). In some cases, the female partner preferred to administer the injections herself, with the man helping to prepare the medications, providing cups of tea and moral support, or by helping to keep track of when the injections were due. But in the majority of cases in this study, the women felt unable to do this themselves. For those male partners who agreed (approximately half of the men),

this was a very new experience, one which raised concerns about inflicting pain or even permanent damage on their partners. Furthermore, the administration of the injections made them acutely aware of the large quantities of hormones going into the women's bodies. However, several of the men felt unable to administer the injections, expressing a squeamishness about needles:

> **Cathy:** I can't give myself an intramuscular injection. No, I can't give it myself. John is . . . can't even talk about it.
> **Researcher:** So you never did them yourselves?
> **Cathy:** He did, actually. He did eventually. He did give me one. And he had to have a cup of tea afterwards, and a lie down.
> **John:** I have a hatred of needles.

Squeamishness about needles was considered by the women to be an acceptable weakness, and it was not perceived to cast any doubt on the man's desire to be a parent. However, one consequence of this was that the women had to seek assistance elsewhere, meaning that more people had to become involved—either a GP, or friends, or colleagues. This made it more difficult to control the number of people who knew about the treatment.

The third role that men described is that of providing emotional support for their partners. For example, Martin said, "I had to be strong and say the right things to get her out of the depression." John had a similar perspective:

> **John:** But really, I just saw it as being there when I was needed, but the one thing I probably should have done while we were doing it was maybe sat down and listened to Cathy a bit more. But I was in a position where I didn't want to sit there and discuss it every night, and that's what it was becoming.

This emotional support work was constructed in traditional terms of the "sturdy oak" or emotional rock, but while the men in this study clearly understood themselves as being supportive, the women did not necessarily experience it in this way. For example, John's wife found his inability to talk with her about the IVF process and the feelings it engendered both frustrating and upsetting:

> **Cathy:** I think I found it hard because he's not a talker—I think the reason that I did want to talk about it every night was that at least I'd get something out of him, whereas maybe I'd tried to talk about it one night, and he didn't want to talk, so I tried again another night. So it did always feel as if I was talking about it, but at the end of the day, I wasn't getting the conversation I wanted, so I would keep on.

The description of the male partners as "not being talkers" became extremely familiar to us during this research. In general, women wanted their partners to talk about their feelings and to share their emotions rather than to be "strong," which was experienced as distancing and invalidating of their own grief. In

one couple, the woman helped herself to cope with her husband's emotional distance by jokingly calling him "the Ice Man." For this couple, interestingly, the research interview offered the first insight for the woman into how her husband actually felt. In the interview he spoke about feelings that he had never disclosed to his wife, particularly in relation to his concerns about the damage the treatment might do to their relationship and his concerns for her health and well-being. The interview was regarded as a momentous occasion for both of them—"The Ice Man Melts" (Denise).

Hearing or reading accounts of some men's behavior and responses, it is hard not to characterize them as heartless or unfeeling. However, this reading oversimplifies what is going on and is politically reductive. In fact, the vast majority of the men were well intentioned, seeking to do the best they could to support their partner. What prevented them from offering the support the women wanted was not a lack of goodwill or the lack of desire for a child but rather an emotional script of masculinity, which not only left many of the women feeling that they were going through the emotional aspects of the experience alone but also left the men isolated and without any source of support.

The fourth role is that of the agent of rational veto, a role that contrasts with the passive stance taken by many of the men in relation to the treatment and the decision-making processes. The interviews revealed many examples of men presenting themselves as the "rational brake" on the entire process, effectively saying, "that's it—no more—we've had enough":

> **Melanie:** I think Paul set the boundaries.
> **Paul:** Well, I mean, to be honest, you would have carried on forever and a day, wouldn't you, so I suppose somebody's got to sort of set the boundaries. It's just not realistic to carry on forever, is it . . . with fertility treatment.

One way of reading the male veto is an exercise of authoritarian male power, and a few women did perceive it as such. This led them to deploy coaxing and occasionally manipulative strategies to persuade their partners to "allow" them to continue with IVF treatment. However, another way of reading men's role here is that in deciding to stop treatment, men are making a decision for the couple that is both harder and less acceptable for a woman to make. The normative pressures on women to have children make it particularly difficult for a woman to make and publicly announce the decision to stop trying. There is some support for this interpretation in our interviews. Men almost always defended their veto in terms of the physical and emotional effects the treatment was having on their wives. In this context, it is a protective rather than an authoritarian act, although it preserves the familiar gender trope of masculine rationality and feminine emotionality, which leaves no space for either rational female agency or male emotionality in relation to treatment.

CONCLUSION

This article has reported on our attempt to explore men's relationship to and experience of unsuccessful IVF treatment, thus filling a gap in research on gender-technology relations. In what must necessarily be a brief discussion, we want to highlight three sets of initial conclusions.

First, our analysis shows that the relation between men and IVF as a technological intervention in reproduction is a contingent and ambivalent one. On one hand, the men in our study were highly invested in positive discourses about science and technological innovation. They were positive about IVF as a medical intervention and were keen to present their own approach to the process as scientific. They were also dismissive of low-tech interventions that women sought to try to enhance their fertility as a couple, reflecting conventional gender tropes of masculinity and femininity in relation to technology. On the other hand, when faced with the practicalities of the intervention—particularly the hormone injections—men were very often uncomfortable and squeamish. In addition, while laying claim to the authority of science, they also attempted to disavow the technological aspects of IVF, presenting it simply as a mechanical aid to a natural process. Moreover, the purposeful, active approach that might have been expected of the men was almost nonexistent, and men frequently presented themselves as passive in the treatment process and decision-making process. Therefore, far from finding evidence that the men were involved in attempting to control women's fertility, as the radical feminist position argues, we found that they regarded themselves (and were regarded by their partners) as just "going along with" whatever the women wanted (at least up to the point when they exercised a veto and "put their foot down"). This ambivalence in relation to IVF highlights the usefulness of a constructivist approach to technology, which embraces rather than erases its multiple and contingent meanings.

The second conclusion that can be drawn from this analysis is that the meaning of IVF for both men and women is mediated by a hegemonic masculine culture, which equates "real masculinity" with heterosexual conquests and with the potency or virility indexed by fathering a child—a finding that is apparent in other studies, particularly of male-factor infertility. However, this analysis also highlights the relevance of these concerns even where male factors are not implicated. As we have shown, even for the predominantly middle-class men in this study, this assumption constitutes the backdrop against which both infertility and IVF treatment are experienced and presented to others. It engendered feelings of humiliation and inadequacy for many men. It also significantly affected women's experiences, as was evident in the negotiations about who to tell and in their taking responsibility for the couple's infertility.

Finally, we have shown that IVF treatment takes place in the context of gender relations, which remain—for the vast majority of participants in this study—highly traditional. It is a sobering aspect of the experience of doing this research that despite many years of feminism, the emotional scripts for partners in heterosexual couples seem to have barely changed. Women experienced devastating feelings of isolation and loneliness during and after the treatment process, attributable to the fact that their partners seemed not to want to talk about their feelings and share their grief and sorrow. In turn, men shouldered the burden of, in their terms, "needing to be strong for her." For both, we would argue, these gendered emotional scripts of heterosexual relationships have deleterious consequences.

NOTES

1. That is, drugs, injections, and surgery for women, compared (in most cases) with ejaculation of sperm for men.

2. *Generative ethics* refers to the "set of expectations for care that fathers have for themselves, and communities have for fathers" (Dollahite, Hawkins, and Brotherson 1997, 19).

3. Access to health-authority-funded treatment is limited as a result of scarce resources, and private treatment is expensive, costing several thousand pounds per cycle. Furthermore, those who live outside of heterosexual reproductive norms may be excluded from treatment, particularly in a National Health Service (NHS) context.

4. Witness the medical finding that many men would rather leave a life-threatening condition untreated than risk a treatment that might cause impotence (see Candib and Schmitt 1996 for a review).

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